THE LOUIS DE LA PARTE FLORIDA MENTAL HEALTH INSTITUTE

Improving the Effectiveness of Medicaid Funded Children's Mental Health Services

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Louis de la Parte Florida Mental Health Institute

The Louis de la Parte Florida Mental Health Institute at the University of South Florida has a mission to strengthen mental health services throughout the state. The Institute provides research, training, education, technical assistance, and support services to mental health professionals and agencies as well as consumers, consumer organizations, and behavioral health advocates statewide. At the state level, the Institute works closely with the Departments of Children and Families (DCF), Corrections (DOC), Elder Affairs (DOEA), Education (DOE), and the Agency for Health Care Administration (AHCA), as well as with members and staff of the State Legislature and providers of mental health services throughout Florida.

Comprised of three primary research departments, Mental Health Law & Policy, Child & Family Studies, and Aging & Mental Health and a number of specialized centers, the Institute conducts research and program evaluations, provides training and consultations, and offers a number of academic courses at the masters and doctoral levels.

Improving the Effectiveness of Medicaid Funded Children's Mental Health Services

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Improving the Effectiveness of Medicaid Funded Children's Mental Health Services

Executive Summary

Florida's Agency for Health Care Administration (AHCA) has a stated interest in providing the citizens of Florida with accessible, affordable, quality health care. In 2004-2005, the Florida Mental Health Institute (FMHI) conducted a study that focused on the accessibility and quality of the current children's mental health system in Florida through the examination of (a) the array of services that were offered, (b) the quality improvement/performance measurement mechanisms that were in place, and (c) existing efforts to implement evidence-based programs and practices. As part of that study, a national scan was conducted to identify exemplary practices in each of those areas and to make it possible to compare practices within Florida with exemplary practices across the nation. Given the amount of money that is spent on children's mental health services, it is critical that effective services are utilized to ensure the desired outcomes.

That study determined that while there were many positive efforts being made within Florida and both funders and providers were eager to make improvements, there were significant discrepancies between current practice and exemplary national practice. In addition, it was determined that although there was planning focused on discrete aspects of the system, there was a general absence of comprehensive planning to develop an effective, high quality system.

The present study builds on last year's research and represents the next step in an effort to build community capacity to enhance the quality of the children's mental health system as well as to further understand the current realities of the system. More specifically, the present study has three main purposes:

I. To develop and implement a mechanism ("system coaching") to build the community capacity to create a high quality children's mental health system;

II. To enhance FMHI's capacity to serve as a resource to state and local policymakers and providers in Florida with regard to the use of evidence-based practices and programs and their integration with individualized care and systems of care;

III. To develop recommendations for enhancing the effectiveness of case management services for children with serious mental health challenges and their families.

The "systems coaching" component has as its goal the development and preliminary testing of a model of coaching key stakeholders in strategies for system change that ultimately can be applied statewide. The intervention model developed this past year employed a "systems coach" to work with policymakers and stakeholders in one DCF district in the following ways:

- Assisting the community in assessing needs, readiness for new efforts, etc.

- Providing knowledge of systems change strategies and facilitating change initiatives through community coaching
- Serving as a resource person related to evidence-based programs, practices and processes
- Connecting the community and the teams to evidence-based program developers
- Introducing the community to systems change and Evidence-based Programs and Practices pathways
- Building "buy-in" across sectors and stakeholder groups for the initiatives defined by the community

While it is too early for a full-scale evaluation of the systems coaching model, this project successfully developed an evidence-based selection process, an initial training curriculum, and a process for coaching the coach. Further exploration of this model will allow for the consideration of how systems coaches might be placed throughout the system to achieve the most positive outcomes.

The research completed last year found that there was greater interest in evidence-based practices than there was actual implementation of such practices. This was not surprising or unusual and represented a common condition across the country. Both the FMHI research team and the stakeholder group that met last year to provide FMHI with feedback believed that the implementation of evidence-based programs and practices and their integration within systems of care would be facilitated by enhancing the capacity of FMHI to work with state- and district-level people around these issues.

This study has identified evidence-based and promising practices and programs for particular types of disorders. A concerted effort was made to identify programs and practices for children with co-occurring mental health and substance abuse disorders and for children with mental health disorders and developmental disabilities. In addition, the results of this research summarize the characteristics of the populations that have been included in the studies on dimensions such as age, gender and racial/ethnic background. Where available, information has been gathered about the use of such practices and programs within organized systems of care and not just as separate, self-contained programs. Information has also been gathered about the use of evidence-based practices and programs in a manner that is consistent with system of care values and principles (see Appendix A) and that relates to system-wide performance measurement procedures.

This year's study, which builds a database of information that is available to agencies through the state, found that although there are many evidence-based programs and practices for youth with a variety of emotional and behavioral challenges, there are still significant limitations. The extent to which programs and practices have been tested on a diverse population is limited; few programs have addressed the impact of a co-occurring substance abuse problem on the outcomes of the program and none of the programs reviewed in this study mentioned the inclusion of children or youth with developmental disabilities in the research that was completed to attain the Evidence-based Program or Practice standing.

Based on the information gathered throughout the year, very few communities or states have integrated the use of evidence-based practices (beyond case management and Wraparound) into a system of care, with or without a system-wide performance measurement system. Some states, such as Hawaii, Nebraska, New York, Ohio, Arizona and California, have demonstrated successes in this area. Where there has been success, however, it is often with the implementation of a single evidence-based program, such as Multi-systemic Therapy or Functional Family Therapy.

For children with mental health challenges and their families, case management is one of the most frequently provided services and is potentially one of the most useful. An earlier report, based on interviews with families and providers from five communities across the country, found that parents of children with significant needs emphasized the importance of a respectful, positive relationship with a case manager or other key helping person (Worthington, Hernandez, Friedman & Uzzell, 2001). Recognizing that there are numerous models of case management (Friesen & Poertner, 1995), there is a need to identify effective models or key ingredients for particular populations and purposes and to develop strategies for implementing those models with high fidelity. Consistent with system of care values, and with national and state planning documents (New Freedom Commission on Mental Health, 2003; Children's Workgroup of the Governor's Commission on Mental Health and Substance Abuse, 2001), this study focused on case management models that are individualized, strength-based, focus on multiple life domains, are culturally competent, and assessed how case management is currently being implemented.

The literature and national scan identified nine case management systems across the nation that have implemented case management practices that are cost effective and improve the functioning of children and families. The case management systems have a number of characteristics in common. These characteristics include: meaningful family feedback and roles in system implementation; family-focused services available when, where and for as long as families need; clearly defined outcomes; data collection and monitoring that allows real-time assessment of the service process and progress toward meeting family and child goals; ability to demonstrate cost savings; and the ability to demonstrate that services result in better home and community functioning for children and families.

Our research found that case management services in Florida for children with serious mental health challenges are marked by several strengths. These strengths include relatively low caseload sizes (generally 20:1), uniform education requirements for case managers (Baccalaureate degree), and a set of clearly identified outcomes. However, these strengths alone are not sufficient to create optimal case management practices. Available research on the implementation of new practices indicates that ongoing supports are needed to facilitate a system's adoption of best practices. Survey data from Florida and across the nation indicate that, in particular, case management systems do not currently have in place the types of feedback mechanisms that would allow for maximally effective change. The needed feedback mechanisms include: consistent, frequent supervision for case managers from highly

trained case manager supervisors; outcome and process monitoring systems that allow for the collection and communication of real-time data on the performance of individual case managers and case management agencies; and procedures and incentives to include family voice and choice in the ongoing development of case management practices. These mechanisms need to be designed within a strategic framework for systems change such as the implementation framework developed by the National Implementation Research Network (NIRN), part of the Department of Child and Family Studies at the Florida Mental Health Institute (FMHI) at the University of South Florida.

Recommendations

This study yields four primary and interrelated recommendations:

- An Integrated Approach: It is recommended that research and development efforts take an integrated approach that focuses not just on any one single feature but on the entire system and the interconnection between the components as well as the combined effect that any efforts have on bringing about improvements in services and outcomes for children with mental health challenges and their families.
- A Focus on Implementation: It is recommended that the implementation framework developed by Fixsen, Naoom, Blase, Friedman, and Wallace (2005) be incorporated into system development efforts at all levels. Before making changes in a practice, program, or policy, an analysis should be conducted to determine how well it is being implemented.
- Enhance Capacity: It is recommended that AHCA and DCF at the state level work in partnership with their local counterparts and with other local entities to enhance the capacity of communities to develop, manage and sustain effective systems. The use of system coaches, still in its early developmental stage, is one potential mechanism for doing this.
- Strengthen Case Management: It is recommended that there be more attention to staff selection, training, and coaching, and to the identification and promotion of a model, such as Wraparound, that has empirical support and is consistent with system of care values and principles.

Background

Florida's Agency for Health Care Administration has a stated interest in providing the citizens of Florida with accessible, affordable, quality health care. In 2004-2005, the Florida Mental Health Institute conducted a study that focused on the accessibility and quality of the current children's mental health system in Florida through the examination of (a) the array of services that were offered, (b) the quality improvement/performance measurement mechanisms that were in place, and (c) existing efforts to implement evidence-based programs and practices. As part of that study, a national scan was conducted to identify exemplary practices in each of those areas and to make it possible to compare practices within Florida with exemplary practices across the nation. Given the amount of money that is spent on children's mental health services, it is critical that effective services are utilized to ensure the desired outcomes.

That study determined that, while there were many positive efforts within Florida and both funders and providers were eager to make improvements, there were significant discrepancies between current practices and exemplary national practices. In addition, it was determined that although there was planning focused on discrete aspects of the system, there was a general absence of comprehensive planning to develop an effective, high quality system.

The present study builds on last year's research, including input provided by stakeholders within Florida, as well as previous work done by the Florida Mental Health Institute (FMHI) (e.g., a prior study initiated a look at case management – Berson, Vargo, & Roggenbaum, 2003). The present study has three main purposes:

1. To develop and implement a mechanism ("system coaching") to build the community capacity to create a high quality children's mental health system;

This intervention will be developed to assist key mental health stakeholders in one district (DCF District 7) in bringing about positive systems change;

2. To enhance FMHI's capacity to serve as a resource to state and local policymakers and providers in Florida with regard to the use of evidence-based practices and programs and their integration with individualized care and systems of care;
3. To develop recommendations for enhancing the effectiveness of case management services for children with serious mental health challenges and their families.

These efforts are very consistent with national policy and program direction. For example, the report of the President's New Freedom Commission on Mental Health (2003) emphasized the importance of developing a family- and consumer-driven system in which children with serious emotional disturbances and their families were given a strong voice in the development of an individualized treatment plan. The New Freedom Commission also emphasized the importance of evidence-based practices, and a recent report looked specifically at the integration of systems of care, evidence-based practices and individualized care (Friedman & Drews, 2005).

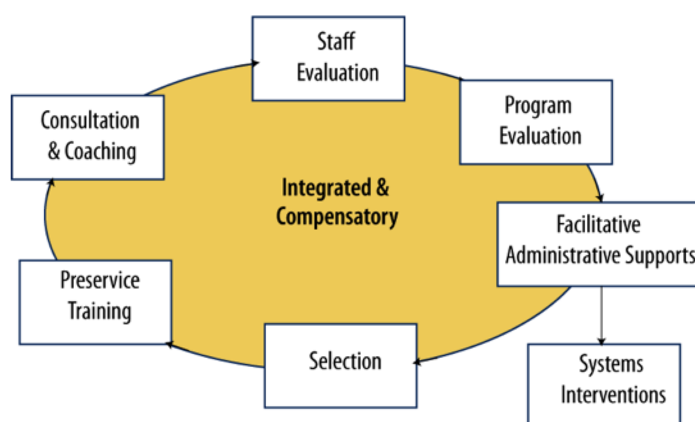
It is striking, however, that although efforts to develop effective systems of care have been underway for about 20 years (Stroul & Friedman, 1986), there are many

indications that implementation has been very challenging (Friedman, 2004). Further, in recent years there has been growing recognition that unless sound programmatic and policy initiatives are accompanied by effective implementation strategies, they are likely to be of limited use (Fixsen et al., 2005). Efforts are increasingly being promoted both to provide assistance to organizations and systems in using effective implementation strategies and to develop a rigorous science of implementation to support efforts at the practice level. Through its National Implementation Research Network (NIRN), FMHI has developed an implementation model of Core Implementation Components, shown in Figure 1, which focuses on such key elements as selection of staff, training, coaching and supervision, ongoing feedback on performance, and system change (Fixsen et al., 2005). This framework, which emphasizes that these elements operate in an integrated and compensatory manner, is pervasive throughout this overall project, and several of the specific studies included a strong focus on coaching and other implementation elements.

Figure 1

Core Implementation Components.

to successfully implement evidence-based practices or practices within evidence-based programs



For children with mental health challenges and their families, case management is one of the most frequently provided services and is potentially one of the most useful. An earlier report, based on interviews with families and providers from five communities across the country, found that parents of children with significant needs emphasized the importance of a respectful, positive relationship with a case manager or other key helping person (Worthington, Hernandez, Friedman, & Uzzell, 2001). Recognizing that there are numerous models of case management (Friesen & Poertner, 1995), there is a need to identify effective models or key ingredients for particular populations and purposes and to develop strategies for implementing those models with high fidelity. Consistent with system of care values and national and state planning documents (New Freedom Commission on Mental Health, 2003; Children's Workgroup of the Governor's Commission on Mental Health and Substance Abuse, 2001), this study focused on case management models that are individualized, strength-based, focus on multiple life domains, are culturally competent, and assessed how case management is currently being implemented.

Study Issues/Hypotheses

1. To develop and implement a mechanism ("system coaching") to build the community capacity to create a high quality children's mental health system;
2. To serve as a resource to state and local policymakers and providers in Florida with regard to the use of evidence-based practices and programs and their integration with individualized care and systems of care;
3. To develop recommendations for enhancing the effectiveness of case management services for children with serious mental health challenges and their families.

System Coaching

Background

The idea for "systems coaching" emerged from a number of prior projects at the Florida Mental Health Institute whose findings converged around the need to enhance community capacity to identify and solve problems in meeting the needs of children with mental health challenges and their families. In last year's study, districts identified the populations that were of greatest concern. All of the identified populations were receiving services from multiple systems, such that interventions required multi-agency planning and coordination. In other studies looking at the implementation of Systems of Care, the communities that were successful at systems transformation had long-standing working coalitions of multiple organizations. A common factor of success was a strong local capacity for working together for continuous quality improvement at the community level. Bringing about change in complex systems is enormously challenging, and the use of coaches, a practice that is growing in the business world as well as in the human services world, can help policymakers do this successfully. In addition, the literature on coaching as reviewed by Fixsen et al. (2005, pp. 44 – 47) demonstrates the critical importance of coaching to ensure any type of behavior change, including system reform.

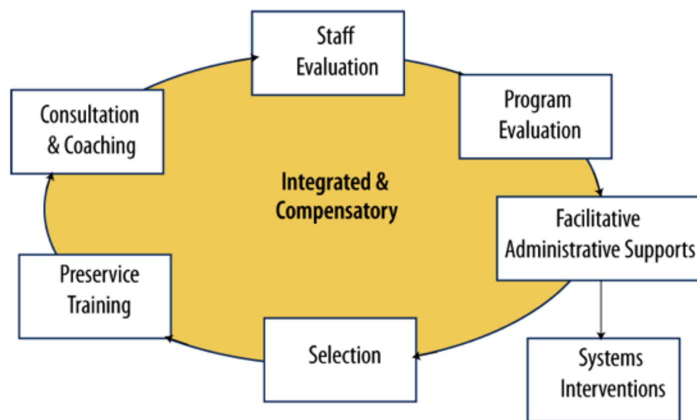
The systems coaching component has as its goal the development and preliminary testing of a model of coaching key stakeholders in strategies for system change that ultimately can be applied statewide. The intervention model employed a "systems coach" to work with policymakers and stakeholders in one DCF district in the following ways:

- Assisting the community in assessing needs, readiness for new efforts, etc.
- Providing knowledge of systems change strategies and facilitating change initiatives through community coaching
- Serving as a resource person related to evidence-based programs, practices and processes
- Connecting the community and the teams to evidence-based program developers
- Introducing the community to systems change and Evidence-based Programs and Practices pathways
- Building "buy-in" across sectors and stakeholder groups for the initiatives defined by the community

Methods

Although Systems Coaching is not yet an evidence-based practice, lessons learned from the science of implementation (Fixsen et al., 2005) have been used to inform the implementation of the Systems Coaching Model to support mental health transformation at the community level. Therefore, as displayed in Figure 1, each of the Core Implementation Components or "drivers" (Fixsen et al., 2005) was addressed in the development of this model in an integrated and compensatory fashion.

Figure 1
Core implementation components



Pre-service Training Curriculum Development

Pre-service and in-service training are efficient ways to provide knowledge of background information, theory, philosophy and values; introduce the components and rationales of key practices; and provide opportunities to practice new skills and receive feedback in a safe training environment (Fixsen et al., 2005, p. 29).

Multiple sources were reviewed/consulted to develop the Systems Coaching Pre-service Curriculum (e.g., Effective Curriculum Characteristics, What Works Initiative: Basics of Motivational Interviewing curriculum, Peace Corps training materials, and Tools for Development, DFID) (Dearden, Jones, & Sartorius, 2002; Kirby, 2001; Peace Corps on-line library, 2006; What Works Initiative, 2006). In addition, the results of two national meetings of purveyors and implementers, as represented through a concept mapping process, were reviewed for this curriculum development process (Blase, Fixsen, Naoom, & Wallace, 2005). Furthermore, a series of meetings were convened and consultation sessions were completed with internal and external experts in the field of implementation and system change. Having reached consensus on the initial list of requisite knowledge and skills needed by a systems coach, topics were categorized as background information, micro-skills, tools, and selection criteria. Examples of topics in each category are listed below:

- Background information, theory, philosophy, values: Implementation Science, Evidence-Based Practices, Systems of Care, etc.
- Micro-skills: Observing and Describing Behavior, Second-Hand Observation, Conceptual Feedback, Developing Effective Rationales, etc.

- Tools: Problem and Situational Analysis, Meeting Facilitation, Negotiated Decision Making, etc.
- Selection criteria: Ability to "read" people and adjust approach appropriately, strong observation skills, flexible/adaptive communicator, etc.

The full curriculum incorporated opportunities to discuss new information (from assigned readings and presentations) with experts in the field, micro-skill development training sessions (including behavior rehearsals and feedback) and introductory sessions on systems coaching tools (see Appendix B for Systems Coach Pre-service Training Curriculum). In response to input from the AHCA Advisory Board, a training component is being developed to equip the Systems Coach to understand Florida's health care reform plan and its impact on the context and funding of mental health services for various populations.

Systems Coach Selection

Beyond academic qualifications or experience factors, certain practitioner characteristics are difficult to teach in training sessions so must be part of the selection criteria (e.g., knowledge of the field, common sense, social justice, ethics, willingness to learn, willingness to intervene, good judgment (Fixsen et al., 2005, p. 28).

As mentioned in the previous section, certain skills and/or attributes were determined to be difficult to train and therefore more critical for use as selection criteria. Hence, the following selection criteria were developed (including academic qualifications and experience):

- Masters degree; eight years of professional work experience; at least two years of which must be in a human service setting (education, mental health, social services, juvenile justice, child welfare, etc.)
- High-level conceptual and analytical skills
  - Ability to synthesize information and communicate both concepts and specific knowledge
  - High-level strategic skills
- Ability to engage in structured and informal problem solving
  - Ability to negotiate agreement, find common ground and advocate for important processes and principles
- Ability to collaboratively develop plans, organize and assist in executing plans, analyzing results and revising plans
- Excellent communication and interpersonal skills
  - Ability to "read" people and adjust approach, material and interactions appropriately
  - Strong observation skills
  - Flexible/adaptive communicator
  - Ability to guide and lead groups
  - Comfortable around senior administrators
  - Provides strong and consistent role modeling

- Demonstrated leadership skills
- Proven track record in team management and the development of staff

Having made this determination, a selection tool was created to assist in assessing the best candidate through an interview protocol, which included behavior-based interviewing questions, self-assessment ratings and skill-based behavior rehearsals (role-plays) with feedback and opportunities to re-practice the skill based on the feedback (see Appendix C for Systems Coach Selection Tool).

Coaching the Systems Coach

Most skills needed by successful practitioners can be introduced in training but really are learned on the job with the help of a consultant/coach (e.g., craft information, engagement, treatment planning, teaching to concepts, clinical judgment). . . . Training and coaching are the principle ways in which behavior change is brought about for carefully selected staff in the beginning stages of implementation and throughout the life of evidence-based practices and programs (Fixsen et al., 2005, p. 29).

As a part of the planning for the Systems Coach's exploratory phase work with the community, arrangements were made for the coaching of the Systems Coach. A variety of methods of coaching were utilized, including direct observation of interactions followed immediately by coaching, scheduled weekly coaching sessions, impromptu coaching sessions and verbal or written feedback to the Systems Coach's completed Reporting Form (see Appendix D for Systems Coaching Reporting Form). Skills taught during the training period, such as Connecting with People through Rationales, Maximizing Feedback Opportunities, Conceptual Feedback and Communicating Effectively, were integrated into the coaching sessions. Based on the selection of a highly competent individual, less direct observation and immediate coaching were necessary. In addition, the Systems Coach demonstrated the ability to seek out coaching and guidance when necessary. For example, when a request from a community stakeholder was made of the Systems Coach, the Systems Coach was able to seek out the information needed to respond effectively to the request.

Evaluation of the Systems Coach (Staff Evaluation)

Staff evaluation is designed to assess the use and outcomes of the skills that are reflected in the selection criteria, are taught in training, and reinforced and expanded in consultation and coaching processes. Assessments of practitioner performance and measures of fidelity also provide useful feedback to managers and purveyors regarding the progress of implementation efforts and the usefulness of training and coaching (Fixsen et al., 2005, p. 29).

Although a refined staff evaluation process for the systems coach has yet to be created, the method of training used (with behavior rehearsals) and the frequency and intensity of coaching have allowed for a continuous assessment of the systems coach's competency in the skill areas that were a part of the selection criteria, taught in training and reinforced through coaching. In addition, although the

Systems Coach is still in a stage of developing relationships and exploration with the community, feedback (evaluation) has been gathered from a small but diverse group of community stakeholders about the Systems Coach's helpfulness to their community thus far.

Evaluation of Systems Coaching Model (Program Evaluation)

Program evaluation (e.g., quality improvement information, organizational fidelity measures) assesses key aspects of the overall performance of the organization to help assure continuing implementation of the key components over time (Fixsen et al., 2005, p. 29).

Given that the Systems Coaching Model is in the exploration stage of implementation and the community has not yet defined a specific need or goal with which the Systems Coach can be of most assistance, intermediate measures have been established as proxies for the broader goals which will become more clearly defined over time. Data are being collected based on the following intermediate measures:

- Invitations in: To what extent is the Systems Coach invited in to a process, a group, etc.?
- Requests received: What type and how often does the Systems Coach receive requests for consultation, facilitation, information?
- Offers received: How often does the Systems Coach receive offers to assist, introduce, include, etc.?
- Offers made: What type and how often are offers from the Systems Coach accepted?
- Network/Connection: To what extent is the Systems Coach able to connect individuals and groups with others who have similar interests or goals?

When the Systems Coaching Model is fully operational, a refined program evaluation process will be utilized.

Results/Discussion

While it is too early for a full-scale evaluation of the systems coaching model, this project successfully developed an evidence-based selection process, an initial training curriculum, and a process for coaching the coach. Further exploration of this model will allow for consideration of how Systems Coaches might be placed throughout the system to achieve the most positive outcomes.

As part of this effort, steps were taken to evaluate the effectiveness of the Systems Coach Training based on expert observations, as well as examine the degree of helpfulness of the new Systems Coach intervention by interviewing key district people involved in the process. Even though implementation of the Systems Coaching Model was based on lessons learned from the science of implementation (Fixsen et al., 2005), an evidence base does not exist to attest to its effectiveness, nor have measures been developed for assessment. Moreover, neither an evaluation process nor methods have yet been created to assess the training curriculum. Thus, in the absence of data and assessment tools, two strategies were used to collect preliminary data on the curriculum and the effectiveness of the Systems Coach intervention to date.

First, systems of care experts who are FMHI faculty were encouraged to attend the training sessions and fully participate in the creation of a training experience for the Systems Coach. All participants engaged in discussions and role play activities. In addition, all who attended were asked to provide candid feedback on the content and presentation of each session to be used to improve future iterations of the curriculum. Following each training session, respondents completed a 5-item questionnaire, the Systems Coach Training Evaluation Form (see Appendix E), which assessed the relevancy of the material presented, clarity of presentation, effectiveness of the training methods in facilitating learning, complexity of the content, adequacy of training time and helpfulness of the materials across the training sessions (e.g., Connecting with People through Rationales, Conceptual Feedback, Consensus Building, Team Work, Co-Occurring Disorders, Theories of Change and Logic Models, Getting and Giving Information, Recognition, etc.), using a 7-point rating scale (1 = very dissatisfied, 7 = very satisfied). They also responded to several open-ended questions. On average, three faculty members participated in each session.

The results revealed the greatest satisfaction with the relevancy of the curriculum material to the roles and responsibilities of a Systems Coach (mean = 6.34) and the least satisfaction with the level of complexity of the material presented (mean = 5.05). The respondents reported satisfaction with the clarity of the presentation of the material (mean = 6.06), the training methods used to facilitate learning (mean = 5.91) and the amount of time spent on each topic to gain knowledge and skills (mean = 5.96).

In order to assess the System Coach's helpfulness to the community thus far, information was obtained from a small, diverse group of community stakeholders via phone interviews. Because the Systems Coach is still in the stage of developing relationships and familiarizing herself with the community and its resources,

information obtained reflected impressions based on limited interactions, specifically one group meeting attended by all respondents and a couple of individual meetings and phone calls. The interviews were conducted by an FMHI faculty member who was not involved in the intervention. Questions addressed included: 1) initial benefits to the community/partnerships derived from the System Coach's participation in meetings, 2) role of the Systems Coach early in the process, 3) which of her contributions had been most helpful to date, and 4) ways in which the role might evolve over time. Because of the limited contact with the Systems Coach, respondents were asked several questions pertaining to her potential role in the future and expected benefits of having a person in this position.

All respondents expressed enthusiasm about the addition of the Systems Coach to their community effort. They indicated that they had been impressed with the Systems Coach, particularly her openness, eagerness to learn about the partnership, thoughtfulness, and ability to grasp what had transpired prior to joining the community. They also were impressed with the knowledge and experience that she brings. They think that the Systems Coach will play a critically important role in the community's transformation efforts because she is a person from the outside with a broad vision that can help to identify needs as well as available resources and can facilitate making connections. Moreover, she can accomplish this from a neutral perspective rather than representing the interests of any particular stakeholder. They expect the System's Coach to be an important liaison among the local agencies but also with state agencies with regard to available services and resource information—currently information does not make it to the top and vice versa. It was noted that having an advocate who can tap into all resources will inevitably save the State of Florida money; so much so that they think it will probably be important to have a Systems Coach within every district across the state.

These are preliminary data collected in the early stages of development and implementation of the intervention. Data will be collected on an ongoing basis for the purpose of evaluating the overall effectiveness of the intervention, with implications for changes that may be needed to achieve the goals of the plan. It is expected that the lessons learned from this experience and the evaluation of it will be put to use to work with other districts in subsequent years through the implementation specialist/coach mechanism.

Enhancing Capacity to Implement Evidence-Based Practices

Background

The research completed last year found that there was greater interest in evidence-based practices than there was actual implementation of such practices. This was not surprising or unusual and represented a common condition across the country. Both the FMHI research team and the stakeholder group that met last year to provide FMHI with feedback believed that the implementation of evidence-based programs and practices and their integration within systems of care would be facilitated by enhancing the capacity of the National Implementation Research Network (NIRN) within the Department of Child and Family Studies at FMHI at the University of South Florida to work with state- and district-level people around these issues.

As a first step, NIRN has identified evidence-based practices and programs and promising practices and programs for particular types of disorders or problematic behavior. In addition, the results of this research summarize the characteristics of the populations that have been included in the studies on dimensions such as age, gender and racial/ethnic background. A particular effort was made to identify programs and practices for children with co-occurring mental health and substance abuse disorders and for children with mental health disorders and developmental disabilities. Where available, information has been gathered about the use of such practices and programs within organized systems of care, and not just as separate, self-contained programs. Information has also been gathered about the use of evidence-based practices and programs in a manner that is consistent with system of care values and principles and that relate to system-wide performance measurement procedures.

Furthermore, NIRN has used its website, publications and meetings as means of sharing information with state and local stakeholders. As agreed to in this year's contract and in support of the Systems Coaching intervention, NIRN will convene a meeting in Orlando on June 20, 2006. Sponsored by the Deborah Dickerson Juvenile Justice Mental Health Task Force, the meeting will facilitate sharing of what NIRN has learned and will generate discussion and recommendations for next steps in creating more effective, quality services to ensure more positive outcomes for children with mental health challenges and their families in that community.

Methods

The first step in enhancing capacity is to identify evidence-based programs and practices for children with mental health challenges. Although different sources have slightly different definitions of "evidence-based," it may be helpful to use the definition from the Substance Abuse and Mental Health Services Administration (SAMHSA) Model Programs website (http://modelprograms.samhsa.gov/template_cf.cfm?page=model_list) to provide a general understanding of the qualities being sought.

Evidence-Based Programs:

- Conceptually Sound and Internally Consistent
- Program Activities Related to Conceptualization
- Reasonably Well Implemented and Evaluated

To develop this inventory of evidence-based programs for children with mental health challenges, approximately 670 entries were reviewed from the following databases and sources on evidence-based programs and practices:

- American Youth Policy Forum
- Blueprints Model Programs
- California Healthy Kids Resource Center
- CASEL (The Collaborative for Academic, Social, and Emotional Learning)
- CDC (Centers for Disease Control and Prevention)
- Center for the Study and Prevention of Violence/Safe Schools-Safe Communities
- Center for the Study of Social Policy
- Coalition for Evidence-Based Policy
- Communities That Care-Developmental Research and Programs
- CSAP's (Center for Substance Abuse Prevention) Center for the Application of Prevention Technology (CAPT) Northeast
- Greenberg et al./CMHS
- Hamilton Fish Institute
- Kauffman Report
- Mental Health Association of New York City
- GNIRC (Gerontological Nursing Interventions Research Center)
- Mihalic & Aultman-Bettridge (2004)
- NACCHO (National Association of County and City Health Officials)
- National Clearinghouse on Child Abuse and Neglect Information
- NIDA (National Institute of Drug Abuse)
- NREPP (National Registry of Evidence-Based Programs and Practices)

- NASMHPD (National Association of State Mental Health Program Directors) Research Institute (NRI)
- NW Regional Educational Laboratory/The Center for Comprehensive School Reform and Improvement
- OJJDP (Office of Juvenile Justice and Delinquency Prevention)
- President's New Freedom Commission on Mental Health
- Promising Practices Network
- ReCAPP (Resource Center for Adolescent Pregnancy Prevention)
- Safe, Disciplined and Drug-Free Expert Panel
- SAMHSA Workplace Model, Effective and Promising Programs
- Sherman et al.
- Strengthening America's Families
- Suicide Prevention Resource Center
- Youth Violence: A Report of the Surgeon General

Inclusion criteria: Each entry was scanned for its population of focus; only programs and practices with a children's mental health focus were reviewed. Within the subset of children's mental health programs and practices, only programs and practices that address problems that already exist (as opposed to "at risk") or referenced diagnostic criteria of a mental health disorder were included. Programs that focused on problematic parental behavior were excluded if the child's behavior was not referenced as problematic.

Ninety-eight programs or practices were found to meet the inclusion criteria for a children's mental health evidence-based program or practice for this study.

As a first step in assessing the availability of evidence-based programs and practices for children with mental health challenges, information was organized into tables by diagnostic categories and/or behaviors (see Appendices) as follows:

- Depression
- Anxiety (including avoidant behaviors and phobias)
- Anger/Aggressive behavior
- PTSD/Trauma
- ADHD
- Conduct Disorder and Oppositional Defiant Disorder (including disruptive behaviors, antisocial behaviors, serious criminal behavior, negative behaviors)
- Substance Abuse
- Autism
- Emotional and Behavioral Disorders (including SED) and miscellaneous

Programs or practices that have been shown to be effective in more than one of the categories listed above are listed in each category.

Within each table, information was gathered about the following aspects of the evidence-based program or practice:

- Specific population on which the research was focused or the setting in which the intervention occurs
- Program availability and/or contact information
- Age and gender of participants engaged in the research (Note: unless otherwise noted, both genders are included)
- Ethnic population of the participants engaged in the research that established the "evidence"
- Research to support use with youth with co-occurring disorders (substance abuse, developmental disability, or other)

In addition, throughout the year, information has been gathered through conversations and meetings about the extent to which evidence-based program or practices were currently integrated into a system of care, were consistent with the system of care values and principles (see Appendix A) and were integrated into a system-wide performance measurement system.

Results/Discussion

A brief summary of the findings within each diagnostic category follows. Complete information can be found in the tables in the appendices.

Depression

In the category of depression, eight programs or practices were identified, two of which were forms of Cognitive Behavioral Therapy (CBT) (see Appendix F). Only one practice for young children, Primary and Secondary Control Enhancement Training for Youth Depression PASCET (3-6 years), was identified in this review. Behavior Therapy was found to be effective for youth as young as six. For older youth (ranging from 11 – 18), five practices were found to be well suited. Few programs or practices specify the race or ethnicity of the participants who participated in the research; in the category of depression, only C-Care/CAST and Interpersonal Psychotherapy for Depressed Adolescents reference participants in their research from various racial/ethnic backgrounds. Finally, it should be noted that only two practices in Table 1 are listed as appropriate for a co-occurring (substance abuse) population.

Anxiety (Including Avoidant Behaviors and Phobias)

In the category of anxiety (including avoidant behaviors and phobias), 13 programs or practices were identified, three of which were forms of Cognitive Behavioral Therapy (CBT) (see Appendix G). Three practices for anxiety were identified as appropriate for children under the age of seven, including CBT plus CBT for Parents, which has been identified as suitable for children ages 3 - 18. In addition, for older youth (ranging from 7 – 16), six practices were found to be well suited. In this category, only Client-Centered and Play Therapy-Adolescent Portable referenced the inclusion of participants from African-American and Hispanic backgrounds in their research. Finally, it should be noted that none of the practices in Table 2 are listed as appropriate for a co-occurring (substance abuse) population.

Anger and Aggressive Behaviors

In the category of anger and aggressive behaviors, 21 programs or practices were identified (see Appendix H). Eleven practices were intended for use in school/classroom settings; two practices were intended for use with an incarcerated population. Seven practices for anger and aggressive behaviors were identified as appropriate for children five and under. In addition, most of those practices were also appropriate for older youth and numerous other practices were found to be well suited for this population. In this category, five practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research. Finally, it should be noted that none of the practices in Table 3 are listed as appropriate for use with a co-occurring (substance abuse) population.

PTSD and Trauma

In the category of PTSD and trauma, seven programs or practices were identified, four of which were forms of Cognitive Behavioral Therapy (CBT) (see Appendix I). Four programs or practices designed to address PTSD and/or trauma were identified

as appropriate for children age five and under. In addition, most of those practices were also appropriate for older youth. In this category, half of the practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research. Finally, it should be noted that only one of the practices in Table 4 is listed as appropriate for use with a co-occurring (substance abuse) population.

Attention Deficit/Hyperactivity Disorder

In the category of Attention Deficit/Hyperactivity Disorder, only four programs or practices were identified (see Appendix J). None of the practices for ADHD were identified as appropriate for children under age five. In addition, none of the practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research. Finally, it should be noted that only one of the practices in Table 3, Behavior Therapy, is listed as appropriate for use with a co-occurring (substance abuse) population.

Conduct Disorder (and Other Disruptive Disorders/Behaviors)

In the category of Conduct Disorder and Oppositional Defiant Disorder (including disruptive behaviors, antisocial behavior, serious criminal behavior and negative behaviors), 47 programs or practices were identified (see Appendix K). A number of the most widely known and implemented programs are listed in this category: Aggression Replacement Training (ART), Functional Family Therapy (FFT), Incredible Years, Multidimensional Treatment Foster Care (MTFC) and Multi-systemic Therapy (MST). Eight practices were intended for use in school/classroom settings. Nine practices for this category were identified as appropriate for children under age five. In addition, most of those practices were also appropriate for older children. In this category, 16 practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research. Finally, six of the practices in Table 6 are listed as appropriate for use with a co-occurring (substance abuse) population.

Substance Abuse

In the category of substance abuse, 16 programs or practices were identified, including three drug court models (see Appendix L). Most of the substance abuse specific programs have been tested on youth 13 years and older. In this category, six practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research. Finally, seven of the practices in Table 6 are listed as appropriate for use with a co-occurring (substance abuse and mental health) population.

Autism

In the category of autism, five programs or practices were identified. All of the practices for autism were identified as appropriate for children age five and under (see Appendix M). Only one program, Functional Communication Training (FCT) and Applied Behavior Analysis, was listed as appropriate for use with older youth (up to age 15). In this category, none of the practices referenced the inclusion of participants from various ethnic/racial backgrounds in their research.

Emotional and Behavioral Disorders (including SED) and Miscellaneous

This final table groups together practices for youth with serious emotional disturbances, such as Family Therapy, Filial (Play) Therapy, Think Time Strategy, Mentoring and Wraparound approaches, with a variety of interventions for very specific disorders, such as Dialectical Behavior Therapy for young women who are showing characteristics of Borderline Personality Disorder, Multi-systemic Therapy for Sexual Offenders and an interventions for Adjustment Disorder in response to divorce (see Appendix N). In addition, intensive and regular case management are recognized as evidence-based practices regardless of diagnosis.

Although information about the use of medication was not reflected in the databases used for this study, it should be noted that there is clear evidence to support the use of medication in the treatment of children and youth with specific diagnoses (such as ADHD). It should be further noted that the use of medication is most often encouraged in combination with other therapeutic interventions.

While there are many evidence-based programs and practices for youth with a variety of emotional and behavioral challenges, there are still significant limitations. The extent to which programs and practices have been tested on a diverse population is limited; few programs have addressed the impact of a co-occurring substance abuse problem on the outcomes of the program, and none of the programs reviewed in this study mentioned the inclusion of children or youth with developmental disabilities in the research that was completed to attain the Evidence-based Program or Practice standing. In addition, evidence-based programs and practices continue to be inaccessible to most families. At the present time, only a handful of programs and practices are widely available and consistently implemented with fidelity and good effects for children and families (e.g., Multi-systemic Therapy, Functional Family Therapy, some forms of Cognitive Behavior Therapy).

Based on the information gathered throughout the year, very few communities or states have integrated the use of evidence-based practices (beyond case management and Wraparound) into a system of care with or without a system- wide performance measurement system. Some states, such as Hawaii, Nebraska, New York, Ohio and California, have demonstrated successes in this area. Where there has been success, however, it is often with the implementation of a single evidence-based program such as Multi-systemic Therapy or Functional Family Therapy.

Within Florida, it does not appear that there have been any significant changes in the past year with regard to the status of use of evidence-based practices, their integration with individualized care and systems of care, or the use of system-wide performance measurement systems.

Conclusions

As communities become more and more interested in ensuring the availability of quality services for their children and families, the interest in evidence-based programs and practices continues to grow. However, identifying evidence-based practices is only a first step. Without a system of care, most children and families will only receive fragmented care; without a system-wide performance measurement system, it will be impossible to accurately assess which interventions are working and which are not. Evidence-based programs and practices offer the hope of providing quality services to children and their families. Presently, however, only a few evidence-based practices are widely available, even fewer are implemented with fidelity and not all of those have been tested on, and adapted to, diverse populations, if necessary. Even fewer programs still have been tested on a co-occurring substance abuse population, and no evidence-based programs were identified for the population of children or youth who have mental health challenges and a developmental disability. In addition, very few communities have used evidence-based practices as an integrated part of a system of care or within a broader, system-wide data driven system.

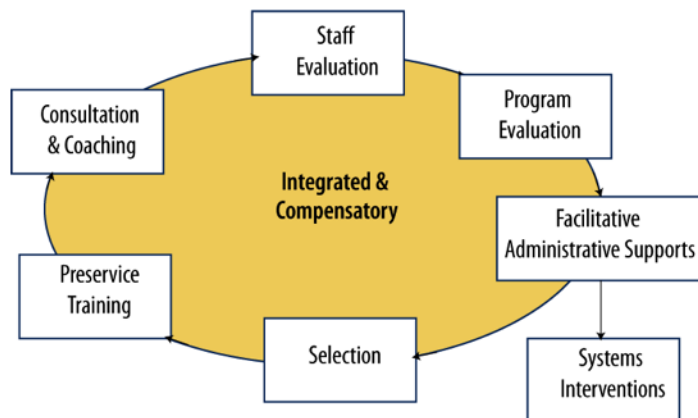
To build on this year's effort, a study will be initiated for 2006-2007 that will assess the relationship between the mental health needs of children, local practice across service sectors, the relationship between child mental health needs and system capacity to respond to those needs It will make recommendations for aligning policy and practice so that the needs of children and their families may be served effectively.

Challenges: Moving To Best Practices in Florida

The Department of Child and Family Studies at the Louis de la Parte Florida Mental Health Institute (FMHI), University of South Florida, has studied aspects of the state public mental health care system for children to create a system consistent with the goals of the President's New Freedom Commission on Mental Health. Study efforts during the previous year focused on the service array available for children and families, quality improvement efforts and the implementation of evidence-based practices. The current year study is designed to understand and apply that work in the context of a single type of service--case management--which is frequently available for children with serious emotional disturbance who are served by the public mental health system. Specifically, the goals of the current year study are to: (a) complete a scan of both the professional literature and practice around the country to identify effective case management models, (b) gather data on case management practice within Florida, and (c) recommend a model for implementation in Florida.

The National Implementation Research Network (NIRN), within the Department of Child and Family Studies at FMHI, has developed an implementation model that guides our thinking around implementation of mental health services. The model advanced by NIRN guides the types of questions we ask in understanding the system's current performance in meeting best practice standards around case managements well as the aspects of current practice investigated in potentially effective case management models. The implementation framework advanced by NIRN specifically states that the implementation process consists of actions that are "integrated and compensatory" (see Figure 1).

Figure 1
Core implementation components.



This means that to the extent that a single component of implementation is less present, other components may act in a compensatory manner. As it quickly becomes clear, effective implementation is compromised to the extent that components are not able to compensate for specific weaknesses at any point in the implementation process. For instance, if staff selection processes are not well

implemented in accordance with best practice, pre-service training must then be enhanced to compensate. Should this not happen, effective implementation is jeopardized. In order to capture this complexity, this study examines a variety of indicators of system design and performance, from staff selection criteria to training, supervision and program evaluation efforts.

This report is organized into three sections according to the goals of the study. First, the results of the literature review and national scan are presented, characterizing what is known about best practice in case management and providing concrete examples of actions that systems have taken to implement best practices. Second, data from state and national surveys of current case management practice are presented. This offers an opportunity to see the strengths and needs of the Florida mental health case management system and to compare Florida's system with other state systems. Results from a survey of families served by these case management systems are also presented. Data from families are critical to identifying necessary changes for services to become more family-driven. Third, recommendations are made for statewide implementation of the components of an effective case management model. We begin by reviewing the literature on effective case management practices for children and youth with serious emotional disturbances.

Definitions of Case Management

The goal of this national scan and literature review is to describe how effective case management models are configured. Identifying the configuration of effective case management systems allows for comparison with current practice to identify strengths and areas for targeted intervention. This national scan and literature review will focus on the identification of common elements of effective case management practice found in case management programs specifically designed to serve children and youth with Serious Emotional Disturbance (SED) and their families. In order to do so, we must first define what constitutes case management and then identify what constitutes "effective" case management for the purpose of this study.

Common definitions of case management describe similar sets of activities directed toward meeting the needs of individuals or families. These activities include mobilizing, coordinating and maintaining an array of services and resources over time (Evans & Armstrong, 2002, p. 41). Case management may be particularly relevant for families with children with serious emotional or behavioral support needs. These children and youth are often involved with multiple child-serving public sectors and require an array of services coordinated across providers from these sectors. Case management is widely used as an intervention to address the need to access, coordinate and maintain these services over time.

A number of models of case management exist to meet the diverse service needs of children and youth in families (Evans & Armstrong, 2002). These models differ in the emphasis they place on particular aspects of the case management process and the roles of the case manager. For example, a service broker model of case management primarily involves assisting families in accessing and maintaining

services and de-emphasizes or prohibits direct service provision by the case manager. However, in other models the therapist provides direct clinical services and also functions as the family's service broker, coordinating referrals to services and monitoring the appropriateness of services in meeting the family's needs.

Though the focus of particular models may differ, case management is most frequently conceived of as a set of actions and services. Very few studies have systematically varied the service "package" available to families, and of the studies that have, few reliable differences in outcomes have been found (for reviews see Farmer, Dorsey, & Mustillo, 2004 and Burns, Hoagwood, & Mrazek, 1999). The entire array of supports represented by or accessible through case management may be more important than any single element of case management. In this sense, the case management models may be integrated and compensatory; to the extent that other aspects of case management can compensate to meet the needs of families, any single element is not critical (see Fixsen, Naoom, Blase, Friedman, & Wallace, 2005 for further information on the application of integrated and compensatory frameworks).

Two recent reviews of the evidence base for case management for children and adolescents have reached two complementary conclusions. The first review, published in 1999, summarized the results of five different randomized trials of case management, as well as numerous quasi-experimental and uncontrolled study designs. This review concluded that there is currently a small evidence base indicating that case management may be effective for children and youth with serious emotional disturbances (Burns, Hoagwood, & Mrazek, 1999).

The second review summarized the data available for the effectiveness of case management in general and the Wraparound approach in particular; the studies reviewed heavily overlapped with the literature cited in the first review (Farmer, Dorsey, & Mustillo, 2004). The review examined four randomized clinical trials of case management, as well as a quasi-experimental study, and concluded that there is a "respectable evidence base" pointing to the efficacy of case management for children and youth with mental health problems. Also reviewed were studies of the Wraparound care coordination process, including two randomized clinical trials, three quasi-experimental studies and nine studies with pre-post designs. The authors concluded that the Wraparound care coordination process "shows positive gains" for children but that more rigorous study designs, and clearly operationalized measures of fidelity, were needed to draw more definitive conclusions.

The current literature review is not designed to replicate these findings; rather, it is designed to describe the set of characteristics shared by systems that implement case management models to support and better the lives of children and youth with serious emotional and behavioral disorders. The focus of this review is on providing information regarding the specifics of what these systems have implemented to effectively support these children and youth. We describe the practices of case management systems that meet five criteria. They:

1. serve children and youth with serious emotional disturbance (as defined by federal criteria)

2. are currently in operation at the time of the review
3. use case management as a service coordination mechanism
4. demonstrate significant functional improvement for children and youth served
5. possess published peer-reviewed data on their system performance.

These systems are described in terms of three broad categories of characteristics: family engagement and shared decision-making, family-focused services and system feedback and outcome management. These characteristics were chosen as indicators or proxies of a goal-directed relationship process that results in effective supports for children, youth and families, guided by the principles of the President's New Freedom Commission on Mental Health (2003) and the mission and vision of the Florida Department of Children and Families. Characteristics were identified through a review of the literature on the predictors of family satisfaction with public mental health services, the characteristics of well-functioning mental health programs and systems and the design of case management systems. Each category of characteristics is addressed in turn below.

Family Engagement and Shared Decision Making

Truly hearing the strengths and needs of families and empowering them to meaningfully participate in the support process is a core value identified by family groups and by federal agencies that support children's mental health services (http://www.ffcmh.org/systems_whatis.htm; SAMHSA, 2006). Equally important, people do not respond well to interventions for which they have no say. Programs where participants have some ownership because of their active involvement and sharing in decision making are much more likely to be effective. Programs indicated four types of actions that facilitated engagement and shared decision making: orienting families to roles and services, providing frequent contact and communication between case managers and families, putting structures in place to increase family voice in treatment team meetings, and involving family members in system policy, service design and evaluation activities.

Orienting activities of sites included the creation and web-based dissemination of a handbook for families explaining roles, care processes and services and the training and utilization of other family members of children with behavioral health needs as parent partners and parent navigators in the care system (Handbook available at http://www.county.milwaukee.gov/display/router.asp?docid=10149; Armstrong, 2005, p. 14; Pires, 2002, p. 38). Frequent contact between families and case managers was accomplished in part through a low client-to-case manager ratio. In the sites identified in this review, that ratio was typically 10:1 or less[1]. Additionally, systems actively encouraged and supported family voice and choice. In several systems, family decision making was evident in the design of the care coordination system at the treatment team level, the community level and at the state level. For instance, in Nebraska, families co-led treatment teams and had "meaningful involvement

[1] Hawaii has established an empirical basis for its client-case manager ratio; studying naturally occurring fluctuations in caseload size, they have shown that caseload sizes above 15:1 are associated with poorer treatment outcomes (Daleiden & Tolman, 2005).

of parents, family members, and consumers in advisory and policy development capacities" (Nebraska Department of Health and Human Services, 2004, p. 5). Parents have been similarly active in ongoing system development efforts in Hawaii, Milwaukee and Massachusetts (Chorpita & Donkervoet, 2005, Pires, 2002, p. 38; Grimes & Medeiros, 2006; Milwaukee County Behavioral Health Division, 2004, p. 7). At the level of the treatment team, several policies and practices were implemented in these systems so as to create a family-driven treatment process. These included the following goals and policies: no treatment team meetings held without the family present, a standing goal for case managers of 50% of persons on the treatment team being family-identified nonprofessional supports, the inclusion of trained parent advocates on all treatment team meetings and systematic collection and monitoring of data regarding family perceptions of voice and choice in the treatment team (Armstrong, 2005, p. 14; Choices, Inc., 2005, p. 40; Bruns, Suter, Force, & Burchard, 2005). Systems supported families and family organizations, in part, by integrating them both into the service delivery process (by hiring and training family members as coaches or partners to help new families) and into the quality improvement process (by training paying families and family organizations to complete and collect satisfaction data regarding services). These findings indicate that both small caseload sizes and policies and practices that empower families to direct their care and the structure of the service system are important to achieving family-directed case management service systems.

Family-Focused Services

Focus of Services on the Whole Family

Sites indicated that their focus of services includes the whole family rather than a singular focus on the child or youth. This focus on the family is consistent with findings and recommendations from the President's New Freedom Commission on Mental Health (2003) regarding family-directed and family-focused service delivery. One of the most important influences on the progress of a child is his/her family. Children with serious emotional disturbances have an impact on the rest of the family, which can cause stresses and strains that need to be addressed. It is important that families receive training and support when necessary to ensure that they are reinforcing any outside treatment efforts and not contradicting them. Therefore, services that focus only on the child and ignore the family are not likely to be successful. The focus on the family is reflected in a number of intentional processes designed to identify family needs, offer choices of services and ultimately strengthen the family. Actions of programs to accomplish these goals have included: creating individualized family service plans, providing services targeted to and desired by the family and improving and monitoring family functioning over time (Anderson & Matthews, 2001; Indiana Consortium for Mental Health Services Research, 2005, p. 15-1 to 15-4; Pires, 2002, p. 44; Roberts, Jacobs, Puddy, Nyre, & Vernberg, 2003; Taub, Smith, & Breault, 2005, p. 159).

The creation of the individualized service plan differs somewhat across systems but typically includes a team-based exploration of family strengths, family needs and strategies that utilize professional and natural supports to achieve family

and child outcomes (Anderson & Mathews, 2001; Armstrong, 2005, pp., 14-15, 26, 30; Nebraska Department of Health and Human Services, 2001, p. 19; also see http: www.region3.net/html/PPP/child_family.htm). Services reflective of this family focus include family support groups, family education provided by trained members of local family organizations for children and youth with a serious emotional disturbance, family and multi-systemic therapy, respite care and the use of flexible funds to meet unexpected needs or provide non-traditional supports to families (Armstrong, 2005, p. 17; Rowland et al., 2005; Pires, 2002, p. 38; Nebraska Department of Health and Human Services, 2004; Taub, O'Garr, Simons, & Smith, 2004). Collectively, these systems use of individualized service plans driven by family identification of needs and goals, as well as the availability of a wide array of family and child supports, make real the idea that families have choice and control in determining their future.

Services in the Home and Community

Home and community-based services exemplify the desire to provide care in the most appropriate, least restrictive environment for children, youth and families. The case management systems identified as effective in this review typically justified their continued existence to legislators and funders, in part, by demonstrating cost savings over restrictive care. Frequently, systems put services in place expressly to lessen the likelihood that a child or youth would be placed out-of-home in a restrictive setting (Anderson, Wright, Kooreman, Mohr, & Russell, 2003; Kamradt & Meyers, 2002; Rowland et al., 2005). Specific home-based supports identified by these systems included: in-home family therapy, in-home case aides, crisis intervention and independent living skills mentors. Also included are non-traditional services such as mentoring, tutoring, child care and housekeeping (Choices, Inc., 2006; Chorpita & Donkoervoet, 2005, p. 321; Wraparound Milwaukee, 2006). These services are targeted to functioning in the natural environments of children (the home, school and community) and support normalization and success experiences in typical settings.

Flexible Funds for Non-traditional Services and Family Needs

Families served by public behavioral and mental health services have diverse support needs to stabilize and strengthen child and family functioning. Flexible funds offer one way to meet those diverse needs. Even though flexible funds were frequently cited as an important component of service delivery, available data indicate that the amount of flexible funds spent represented a small fraction of total funds spent on services. For instance, the DAWN Project reports flexible fund expenditures for nearly every participant; however, spending of flexible funds represents only about 5% of total expenditures per child or youth (Indiana Consortium for Mental Health Service Research, 2005, p. 16-2, 16-3). The DAWN Project is able to provide flexible funds because they receive case-rate funds that they are able to allocate and spend. The Director of the DAWN Project, Knute Rotto, reported that these funds are critical to meeting the basic needs of families (such as the need for housing, utilities or other basic services) and insuring family stability (Personal communication, Knute Rotto, March 22, 2006). Similar to the

DAWN Project, the MA-MHSPY program provides flexible funds via a case-rate; expenditures of flexible funds total 9% of all clinical service costs (Pires, 2002, p. 40). Often, it is the rapid availability of small amounts of funds (e.g., less than ten dollars) that is necessary to overcome transportation or other barriers to access to care or needed services. Flexible funds represent one way in which these systems have designed practices that empower case managers to help family members in ways that families have determined are most important and that support normalization. Flexible funds also allow for additional resources to be directed to families when traditional services are inadequate for the family.

Services Available after Business Hours

Child and family needs can be unpredictable and often occur outside of business hours. In recognition of this, sites indicated several distinct types of services that are available after traditional business hours. Some services were designed to be used in crisis situations, others as part of typical (non-emergency) care and still other promoted informal opportunities and settings for making connections and sharing. Crisis services included crisis response teams that were available 24 hours a day (Pires, 2002, p. 46; also see http://www.region3.net/html/PPP/service_array.htm). Several sites also made service coordination teams available 24 hours a day, seven days a week (Armstrong, 2005, p. 15, 32). Other services available after traditional business hours included respite services, Multi-systemic Therapy, family support groups, family outings and recreational activities (Armstrong, 2005, p. 17; Nebraska Department of Health and Human Services, 2001, p. 29). These services allow families, children and youth to access a wide range of supports as needed to enable their functioning at home and in the community.

Service Duration Based on Need

Intensive case management services were made available to families for as long as significant needs were present. Sites indicated that children and youth typically received intensive services for 12 months or longer. One Massachusetts site indicated that members stay in the program an average of 20 months, with a completion rate (retention until goals are met) of 58%; other sites indicated typical stays of 12 to 15 months (Grimes, 2004; Grimes & Mullin, 2006; Kamradt, 2002; Stroul, 2003, p. 39; Vernberg, Jacobs, Nyre, Puddy, & Roberts, 2004). Sites indicated that intensive services were typically "stepped down" to less intensive services as functioning improved and after the formal recommendation of the family or care team. For example, one site stated that discharge from the program occurs when several criteria are met: identified goals are accomplished, the child or youth and family have been functioning well for at least three months and the child and family decide to discontinue the use of the program (Nebraska PPP Discharge Criteria, http://www.region3.net/html/PPP/discharge.htm). One site described discharge planning as an ongoing process that begins with the selection of family and child goals. A conscious effort is made to make the process of discharge a non-threatening event for the family by identifying goals that must be accomplished before discharge is considered, assessing needs as goals are met and providing follow-up supports needed after discharge (Grimes, 2004). Typically, sites provided step-down or continuing services

after intensive services were discontinued. These services often reflected a move from clinically based services to natural supports and non-clinical services (i.e., involvement with youth groups, mentoring) available in the community.

Feedback and Outcome Management Identified Outcomes

The identification of core outcomes has allowed systems to justify their service approach and funding levels and to build interagency partnerships that help to create stable and flexible funding streams. Many of these successful care management systems specifically focused on finding and developing effective community supports for youth at risk for expensive inpatient or other restrictive placement, greatly reducing service costs. Outcomes frequently identified by these systems included: reduction in emotional or behavioral symptom severity; increased home, school and community functioning; reduction in delinquent or criminal acts; lessened substance use; better developed personal strengths; and improved family functioning. Systems used a number of measures to assess these outcomes. Measures typically employed by systems included the Child and Adolescent Functional Assessment Scale (CAFAS), the Child-Behavior Checklist (CBCL) and the Behavior and Emotion Rating Scale (BERS). Though all systems utilized measures of clinical and social functioning, these measures were subject to change over time. For instance, two systems mentioned that they will be moving from using the CAFAS to using the Child and Adolescent Needs and Strengths measure (CANS) because of the greater perceived utility of the CANS. Data from other service systems were often assessed, such as juvenile justice offense data, days in school and school services received (Choices, Inc., 2005; Indiana Consortium for Mental Health Service Research, 2005; Koppelman, 2005; Vernberg et al., 2004). Systems also typically tracked service use outcomes, such as days in restrictive settings, costs per child and service mix (Choices, Inc., 2004, 2005; Indiana Consortium for Mental Health Service Research, 2005, Grimes, 2004). These findings indicate that sites collected and used data on specific targeted treatment outcomes as well as data on service system access and service use.

Regular Feedback Re: Achieving Outcomes

All sites indicated the importance of regular feedback to case managers as an important component of program development and success. This included regularly scheduled weekly supervision, feedback from real-time service and outcome tracking information systems, and quarterly or semi-annual system-wide performance reviews. Several sites indicated the development of specific in-house tools to assist in real-time clinical decision making. For example, in both the DAWN Project in Indiana and the Hamilton County Mosaic Project in Hamilton County, Ohio, real-time management information systems allow case managers to monitor clinical functioning, eligibility for services, expenditures and service utilization at the individual client and caseload levels. Group level data are also available for other categories of information (such as client satisfaction data). The software allows the instant generation of reports containing individual or aggregate information. This allows staff to continuously monitor their progress toward meeting performance goals. Similarly, at the Wraparound Milwaukee site,

monthly reports to service providers track performance on indicators of "successful disenrollments, out-of-home versus in-home placements, use of informal supports, cost per plan" and other aspects of the service process (Personal communication, Bruce Kamradt, 2006). In Hawaii, mental health centers (called Family Guidance Centers) make quarterly presentations to the public regarding their progress in meeting performance goals. These opportunities for regular feedback from the public help case management systems identify what actions they are performing well and in what areas changes need to be made. They also allow the community to have buy-in regarding their local mental health system.

In addition to measuring clinical outcomes, systems also monitored the practice of care coordination. Several sites indicated that they use a measure to assess the fidelity of case management practices to their particular model of care coordination. For instance, the Coordinated Family-Focused Care program in Massachusetts, the Professional Partners Program in Nebraska and the Wraparound in Nevada program all have recently used or currently use the Wraparound Fidelity Index, which measures fidelity of the treatment planning process to the Wraparound model and values (Bruns, Rast & Walker, in preparation; Bruns, Suter, Force, & Burchard,2005; Taub & Breault, 2006). Hawaii is currently developing a similar instrument to measure care coordinators' adherence to Hawaii's care coordination principles, which are very similar to the original System of Care value set laid out in Stroul & Friedman (1986) and updated in Stroul & Friedman (1994). Together, the use of real-time service and cost data for clinical decision making--coupled with ongoing assessment of care coordinators' fidelity to well-defined, model-specified case coordination values and practices--allow for the empowerment of care coordinators to make informed treatment decisions and for supervisors to detect and address the need for case management practice to be modified.

Demonstrated Cost Savings vs. Restrictive Placement

Nearly all sites featured in this review completed cost analyses that demonstrated that increased development and use of case-managed, community-based services resulted in cost savings over restrictive care or care as usual. For instance, over several years Wraparound Milwaukee has been able to nearly double the number of children served while keeping service costs essentially flat; this indicates substantial cost savings over services as usual (Koppelman, 2005, p. 18). The Hamilton County Mosaic Project reports that over three years it has been able to (a) reduce the number of paid residential days; (b) reduce the percentage of all service dollars spent on placement services; and (c) reduce costs per client over time (Choices, Inc., 2005). These findings indicate that case-managed care can contain costs and produce positive outcomes for children and families. These data also point to the importance of monitoring specific aspects of service cost (such as residential care costs), which reduces overall costs.

Demonstrated Effectiveness with Children and Youth with Most Severe Needs

Site data on effectiveness are presented in Appendix R. These data indicate that children and youth who remain in treatment over time are likely to see substantial improvement in emotional and behavioral functioning. Between 50

and 80% of children and youth in treatment demonstrate clinically meaningful improvement over time. Sites that reported data on child functioning at about 12 months post-enrollment noted an average 49 point drop in clinical severity. A 20-point drop on the CAFAS is typically recognized as clinically meaningful[2]. Sites that reported data on child functioning at 18 months noted an average drop of 32 points on the CAFAS. Only ten to fifteen percent of children and youth who stay in treatment decline in functioning over time. Data from the Nevada system are of particular note. These data indicate that case management service as usual was ineffective in producing meaningful change in functioning; however, services provided within a service coordination intervention with demonstrated fidelity to the Wraparound care coordination model produced clinically meaningful changes in child and youth functioning (Bruns, Rast & Walker, in preparation). These data are encouraging in that they indicate that public mental health care coordination services can be effective under specific circumstances. Across the nine sites, children and youth also typically show statistically reliable improvement on measures of academic performance, school attendance, juvenile justice involvement and personal strengths. Although treatment dropout remains a problem in public mental health case management services, the available data indicate that case management services are potentially a very important part of the process that empowers and enables children, youth and families to lead healthier, happier lives in the community.

Current Case Management Practice in Florida and Across the Nation

The scan of the empirical and practice literature across the nation makes clear that public mental health systems can implement case management systems that effectively meet the service needs of a majority of children and youth with serious emotional and behavioral problems. We now examine the state of current case management practices for children and youth with serious mental health challenges within Florida's publicly funded mental health system and use national data as a comparison to understand Florida's practices in relation to typical practices in other states and communities.

State and National Perspectives of Current Case Management Practices

Participant Recruitment

Respondents were recruited statewide from Florida AHCA case management providers via an e-mail sent by the State Director of the Department of Children and Families. National respondents were recruited through an e-mail sent to all State Directors of children's mental health. The exact number of persons contacted cannot be precisely determined. However, a reasonable estimate can be made of the number of different states and agencies represented. In Florida, persons at approximately 60 agencies were contacted, and responses were received from 30 different persons. Nationally, 32 responses representing 19 other states were obtained.

[2] These average scores were derived by multiplying the sample size of each study by the average change, summing this score across studies, and then dividing the sum by the pooled sample size. This creates a weighted change score that is less likely to be biased by change scores reported by any one site or by sites with small sample sizes.

Participant Characteristics

Half of all respondents from Florida and the nation were Directors of Programs or Divisions (50% of all respondents). Survey respondents from other states included a large number of State Directors of Children's Mental Health (32% of respondents); survey respondents from Florida included a large number of "Other" responses. Four of these respondents indicated that they serve as Children's Mental Health Specialists. Two others indicated they are Case Managers and Case Management Coordinators, respectively. The other nine respondents did not specify their current position.

Table 1
Respondent Characteristics

Question	Florida	Nation
Years Experience (Mean)	10.0	13.6
Current Position[a]		
State Director CMH	1 (3%)	7 (32%)
Division Head / Director	4 (13%)	9 (20%)
Program Director	10 (33%)	8 (24%)
Other	15 (50%)	6 (24%)
Did not answer	15	2
Number of Valid Florida Respondents	30	
Number of Valid Out of State Respondents		32

a Position is inconsistently related to the reporting of program and respondent characteristics. For instance, limiting respondents across Florida and the nation to Division Directors results in similarities regarding focus of services, Medicaid requirement, and number of children served per year but differences in results for eligibility (DSM diagnosis less likely to be required by Florida providers) and age (nationwide, the 'median age served' changes from birth to 2 years of age, indicating the exclusion of statewide programs targeting children ages 0-3 years).

Caseload Characteristics

Nationwide, case management typically serves children from birth to 21 years of age; in Florida it typically serves children ages 3 to 18 years of age. The focus of services nationwide is on the family; in Florida the focus is typically on the child. In Florida and nationwide, a DSM diagnosis is usually needed to obtain case management services. Florida providers are twice as likely as national providers to require Medicaid enrollment to obtain services. Providers serving fewer than 1,000 clients annually were twice as likely to require Medicaid enrollment or eligibility to qualify for services. Half of all agencies indicated that eligibility for case management was not determined by DSM diagnosis. These agencies indicated several common criteria for qualifying, typically involving the presence of specific need or risk, a history of need or risk, compromised behavioral functioning or involvement with a specific state agency or agencies.

Table 2
Characteristics of Population Served

Question	Florida	Nation
Age Range		
Youngest (Median)	1 year	Birth
Oldest (Median)	18 years	20 years
Focus of Services		
Child	20 (69%)	8 (32%)
Family	9 (31%)	17 (68%)
Eligibility		
DSM Diagnosis Needed	24 (83%)	20 (77%)
Other Criteria	5 (17%)	6 (23%)
Medicaid Requirement		
Medicaid Enrollment	11 (39%)	5 (19%)
Medicaid Eligibility	3 (11%)	3 (12%)
Neither	14 (50%)	18 (69%)
Number of Children Served per Year	350 (Median); 1670 (Mean)	1900 (Median); 11897 (Mean)

Caseload characteristics examined included the unit of caseload size (families counted as a single unit or children counted as a unit), typical and maximum caseload size, definition of maximum caseload size and caseload mix. The vast majority of agencies count individual children as the unit of caseload size.

Typical caseload size is 16 to 20 children in Florida. About twenty percent of Florida agencies have typical caseloads of 21 to 25 children. Agencies nationwide were more likely to report somewhat larger caseload sizes and caseload ceilings (see Table 3). Half of agencies nationwide have caseworker caseloads that are dedicated to families of children with SED; less than twenty percent of Florida agencies have such dedicated caseloads. Typical caseload sizes were similar for those respondents endorsing mixed and all-SED caseloads. Typical and maximum caseload sizes were smaller for agencies endorsing the use of a Wraparound case management model than for agencies not using this case management model. The majority of "Other" responses per caseload size indicated that they do not currently have a maximum caseload size.

Table 3
Caseload Characteristics

Question	Florida	Nation
Unit of Caseload Size		
Families	2 (7%)	4 (17%)
Children	25 (93%)	20 (83%)
Typical Caseload size		
0-7	0	0
8-12	2 (7%)	2 (9%)
13-15	4 (15%)	4 (17%)
16-20	16 (59%)	9 (39%)
21-25	5 (19%)	3 (13%)
>25	0	4 (17%)
Other		1 (4%)
Maximum Caseload Size		
0-7	0	0
8-12	0	0
13-15	1 (17%)	4 (19%)
16-20	3 (50%)	4 (19%)
21-25	1 (17%)	6 (29%)
>25	1 (17%)	7 (33%)
Caseload Ceiling		
Absolute	2 (33%)	2 (19%)
Monthly Average	0	3 (24%)
Yearly Average	4 (67%)	4 (19%)
Other	0	8 (38%)
Caseload Mix		
Only SED	1 (17%)	12 (55%)
Mixed Caseload	5 (83%)	10 (45%)

Service Characteristics

Intensity of service is overwhelmingly based on need, in Florida and nationally; typically a formal procedure is undertaken to determine service intensity (see Table 4). However, Florida respondents were less likely than national respondents to specify the types of measures or decision-making tools used in arriving at a determination of appropriate service intensity. The vast majority of providers do not set time limits on service. The results regarding service quality and determination of need are qualified by the very small number of Florida respondents to these questions.

Table 4
Service Characteristics

Question	Florida	Nation
Intensity Based on Need		
Yes	6 (100%)	20 (87%)
No	0	0
Other	0	3 (13%)
Formal Procedure for Determining Intensity		
Yes	5 (100%)	16 (70%)
No	0	7 (30%)
Maximum length of CM services		
0-3 months	0	0
4-6 months	0	0
7-12 months	0	0
> 12 months	1 (20%)	0
No time limit	4 (80%)	24 (100%)

Caseload Funding Structure

Programs, nationally and in Florida, that are solely funded by Medicaid are in the minority. Case management programs in other states were more likely than Florida programs to receive funding from sources other than Medicaid. Providers in Florida were equally split as to whether funding mechanisms are the same statewide or vary by district or county. Within Florida, the reimbursement rate per unit of service varied from $35 per billable hour to $64 per billable hour. Across the nation, payment structures varied from monthly case rates to hourly fees. These reimbursement rates varied more widely than the Florida rates, with the highest reimbursement rate at approximately four times the lowest rate. Hourly rates varied from $28 per hour to $100 per hour.

Table 5
Funding Structure

Question	Florida	Nation
Source		
Medicaid	10 (37%)	2 (8%)
Medicaid + Other	17 (63%)	21 (84%)
Other		2 (8%)
Geographic Variation in Funding		
Same Statewide	14 (52%)	14 (56%)
Varies by District or County	13 (48%)	9 (36%)
Other	0	2 (8%)
Reimbursement Rate (Hourly)	$35-64	$28-100

Caseworker Characteristics

Caseworkers in Florida have a minimum education level (a Bachelor's degree) higher than that required in many other states. Medicaid program eligibility is unrelated to worker education level. Exceptions to the requirement of an Associate's or Bachelor's degree were rare. Nationally, there was some flexibility in substituting

specific experience in working with persons with SED for formal education. Noted examples included a system that integrates family members as providers and systems facing extreme worker shortages.

Florida caseworkers are less likely to receive training on a specific type of case management and less likely to receive extensive initial training (Table 6). In Florida, two-thirds of case managers stated they were trained in Targeted Case Management or the Person-to-Person model of case management. It is of note that neither the Person-to-Person model nor Targeted Case Management has measures to assess fidelity of implementation or data linking fidelity of implementation of these practices with child outcomes. Across the nation, approximately two-thirds of case managers were trained in Wraparound and System of Care approaches to case management. Both of these approaches have fidelity measures (the Wraparound Fidelity Index and the System of Care Practice Review, respectively) that have been demonstrated to relate to child outcomes.

Table 6

Case Worker Characteristics and Training

Question	Florida	Nation
Minimum level of Education		
GED	0	6 (25%)
Associate's	0	4 (17%)
Bachelor's	25 (100%)	12 (50%)
Master's	0	2 (8%)
Area of Degree		
Human Service	20 (80%)	12 (67%)
Any Field	5 (20%)	3 (17%)
Other	0	3 (17%)
Experience Substitute for Education		
Yes	1 (20%)	7 (41%)
No	4 (80%)	10 (59%)
Length of Initial Training		
0-10 hours	6 (25%)	2 (12%)
11-39 hours	6 (25%)	5 (29%)
40 hours	4 (17%)	3 (18%)
80 hours	5 (21%)	2 (12%)
120-160 hours	3 (13%)	3 (18%)
200-240 hours	0	0
240+ hours	0	2 (12%)
CM Trained on Specific Type/Model of CM		
Yes	16 (67%)	15 (79%)
No	8 (33%)	4 (21%)
CM Received Child MH Training		
Yes	15 (94%)	17 (100%)
No	1 (6%)	0

Caseworker Mental Health Training

There was wide variation in the mental health training provided to case managers and in the requirements for training across agencies and states. In Florida, training ranged from a specified number of hours of mental health training to no pre-service mental health training and occasional speakers. There was no clear sense of a program of initial or continuing mental health training that emerged from Florida case management providers. Nationally there was also variety in mental health training, though as a whole respondents were better able to specify the components of mental health practice on which case managers were trained. Trainings varied from training on specific assessment tools and diagnoses to training on specific models of case management applicable to populations with mental health concerns.

Caseworker Supervision and Feedback

Supervision in Florida and across the nation was typically conducted at a formally scheduled time each week. Examination of responses regarding supervision practices indicated that National respondents were likely to either have formally scheduled, frequent supervision, or to have informally scheduled, infrequent supervision. Supervision practices among Florida respondents showed greater diversity, with half of all respondents receiving some combination of informally scheduled or infrequent supervision.

Table 7
Supervision Practices

Question	Florida	Nation
Scheduling		
Formal, Frequent[a]	8 (50%)	10 (62%)
Informal, Frequent	2 (12%)	—
Formal, Infrequent	4 (25%)	2 (12%)
Informal, Infrequent	2 (12%)	4 (25%)

[a] "Frequent" supervision refers to supervision provided at least once a week; infrequent supervision is any supervision that happens less frequently than once a week.

Florida providers were more likely than other states' case management providers to endorse the use of targeted outcomes for case management. Other states were less likely to rely on state-level case record databases to measure outcomes and more likely to use multiple assessment methods to measure outcomes. Florida providers endorsed more frequent feedback regarding meeting outcomes than did other providers nationwide.

Table 8
Outcomes and Feedback Mechanisms

Question	Florida	Nation
Specific Outcomes Targeted		
Yes	21 (88%)	14 (70%)
No	3 (12%)	6 (30%)
Measurement of Outcomes		
No Formal Measurement	1 (5%)	0
State Level Case Record Database	9 (43%)	3 (21%)
Survey or Questionnaire to Families	0	0
Multiple Methods	11 (52%)	11 (79%)
Feedback re: CM Impact of Outcomes		
Weekly	3 (13%)	1 (7%)
Monthly	7 (30%)	3 (21%)
Quarterly	7 (30%)	5 (36%)
Annually	3 (13%)	2 (14%)
Never	0	0
Other	3 (13%)	3 (21%)

Targeted Outcomes for Case Management

Targeted outcomes endorsed by Florida case management providers ranged from very general statements such as “discharge from case management service” to specific indicators such as “percent school days attended; days spent in the community.” Generally, case management providers endorsed outcomes in terms of school functioning (behavioral and academic), retention in the community (out of restrictive placements) and improvement on clinical measures. Nationally, providers endorsed a similar set of functional and clinical outcomes. National providers differed from Florida providers in that they were more likely to talk about targeted outcomes in terms of both child / youth and family functioning. Specifically, 40% of national respondents and 5% of Florida respondents listed family functioning or family satisfaction as outcomes.

Core Tasks and Barriers

Core tasks endorsed by both local and national providers included advocacy, support, linking services and monitoring the adequacy of supports. A few providers also mentioned specific relational and clinical functions of case management. These included listening empathically to family members, teaching and modeling parenting skills, offering hope, and providing counseling in crisis situations. Providers also mentioned empowering families and teaching and providing opportunities for families to begin to make decisions for themselves as ways that case management helps families.

Providers across Florida and the nation identified a similar set of barriers that impede delivery of effective case management services. Half of all respondents endorsed funding restrictions as key barriers to effective case management. One-third of Florida respondents identified service restrictions as impediments to effectiveness. One-quarter of Florida respondents identified limited provider networks as a barrier.

About ten percent of Florida providers mentioned limits on transportation and staff turnover as impediments to effective case management practice. Providers in Florida were twice as likely as national providers to specifically endorse Medicaid restrictions as barriers to care (25% in Florida versus 12% nationally).

Summary of Common Practice Indicators: State, National and Selected Effective Case Management Sites

Table 9 summarizes practice parameters for which there are data on practice in Florida, the nation and selected effective case management sites. These are not the only important practice parameters; however, for several practice parameters there are only state and national data, or only data from the selected sites. Any system-level intervention to affect practice should consider evidence for the importance of particular parameters in effecting change, as well as how any change contributes to or impedes effective implementation, as outlined in the implementation model in this report (see Figure 1).

Table 9

Selected Case Management Practices by Sample

	Florida	Nation	Effective
Caseload Size[a]	18:1	18:1	10:1
Formal Supervision[b]	50%	62%	100%
Child Outcomes[c]	100%	100%	100%
Family Outcomes	5%	40%	100%
Testable Model[d]	0%	66%	89%[e]
Blended Funding[f]	63%	84%	78%

[a] This refers specifically to the median typical caseload size.
[b] This refers to regularly scheduled weekly supervision lasting at least one hour.
[c] This refers to the identification of specific child outcomes the system is working to attain.
[d] This refers to the use of a case management model for which there is a readily available, empirically validated instrument that measures case management practice (and has been shown to relate to child outcomes).
[e] One site did not utilize a case management approach for which there is an already developed measure of case management / care coordination process. However, this site developed its own measure of care coordination and then empirically demonstrated that the measure relates to child outcomes (see Puddy, 2005).
[f] This refers to the use of Medicaid funding designated for children's mental health and any other funding source.

Parent Survey: Methodology

Parents were recruited to participate in online or paper and pencil survey collection through local chapters of the National Federation of Families for Children's Mental Health. A total of 14 parents volunteered to complete the survey. Ten parents indicated that they have received case management services for their child within the past two years. These ten parents were equally likely to be Spanish speaking (N = 5) as English speaking (N = 5). Surveys were administered by Federation of Families representatives after consultation with FMHI project staff members. Survey data were collected electronically and by mail.

Survey content was divided into three sections: point of entry and logistics, experience with case management services and preferences for service design (see Appendix O for the survey instrument).

Point of Entry and Logistics

These questions were designed to give information regarding which agencies served as entry points for case management services, where parents would prefer to receive services and what times of day they would prefer to receive services.

Entry points

Parents gained access to case management services through a number of referral sources. The most frequently cited referral source was the community mental health agency (endorsed by three families), followed by schools (three families), the Department of Children and Families (DCF) (two families) and children's medical services (one family). One family did not indicate their referral source.

Service locations

Parents indicated a preference for services to be provided outside of the case manager's office and in the family home, school or a neutral community setting. Forty percent of parents indicated a preference for services to be delivered in the school setting. Thirty percent of parents indicated a preference for services to be delivered at an "Other" location not included in the choices; one parent indicated "anywhere available" as their preferred location. Two other parents did not specify a location.

Preferred time for meetings

Parents stated a preference for meetings in the morning and early afternoon; eight of ten parents endorsed either 'morning' or 'late morning / early afternoon" as their preferred meeting time. One parent endorsed 'afternoon' and one parent chose "varied times" as their most convenient meeting time.

Parent Ratings of Recent Case Management Service Experiences

This section was designed to obtain both open-ended (qualitative) data and quantitative data regarding families' experiences with case management services for their child. The section began with a question asking parents to describe the most important qualities of a case manager (see Appendix P). This was followed by a series of questions asking parents to rate their experience of case management services across five domains: involvement and availability, respect, hope / control, communication and informal services (see Appendix Q). Parents were then asked to rate the importance of 14 different service components (summarized below). All items were rated on a five point scale. For the purposes of this report, all data are presented so that higher scale values mean greater service satisfaction or higher importance and lower scores indicate lower satisfaction or lower importance.

Involvement and Availability

Five questions assessed parents' access to case managers and attendance at meetings. Parents indicated the greatest satisfaction with the ease with which they could talk to case managers and case managers' efforts to schedule and hold meetings at times they could attend. Parents indicated relatively less satisfaction with the availability of case managers and the effort required to communicate with case managers.

Respect

Three questions assessed the degree to which parents felt case managers showed respect for their child and family. Parents indicated that case managers showed respect for their religious beliefs. Parents indicated moderate agreement with the idea that case managers showed respect to their family and child and some disagreement over whether the case manager "showed he/ she really cared."

Hope/Control

Parents endorsed the idea that case managers were able to help them better understand their child or youth's behavior or diagnosis. Parents indicated more modest agreement over whether case managers provided them a sense of hope about the future or let them choose services supports for their child or youth.

Communication

Throughout this domain, parents endorsed modest agreement with the idea that their case manager helped them communicate with professionals and obtain needed supports for their child. Parents were most likely to agree with the statement, "Helped me communicate with school staff" and least likely to agree with the statements regarding obtaining needed classroom and mental health supports.

Informal Supports

Parents showed the most modest levels of agreement in response to items in this domain. Half of the parents surveyed agreed that case managers were able to obtain informal services and supports.

Concerns of Families

Families indicated that there were several aspects of case management practice as currently implemented that pose concerns. Their chief concern, endorsed by about 70% of respondents, centered around limited access to or choice of services. Forty percent of Spanish-speaking respondents indicated concern over a lack of Spanish-speaking case managers. On a similar note, one-fifth of respondents indicated that delay in receiving services was a concern. Lack of coordination and continuity of care was also cited by one-fifth of respondents. Twenty percent of respondents also indicated that they had experience with case managers who did not listen to nor honor family input. These findings highlight the importance of building strong, trusting relationships for case management to be accepted and effective.

What Works for Families

Families were clear in their indication that truly listening to and empathizing with families is critical to the success of case management. All respondents stated that being heard and feeling understood were critical to an effective case management process. Families also endorsed several desirable characteristics of case managers, including: being flexible and creative in problem solving, taking initiative with a family, involving the family and coordinating services. These characteristics form a picture of a good case manager as someone who is a clear communicator, culturally and linguistically competent, an effective problem solver and a team builder. These findings are closely related to the findings of other studies of parent and youth satisfaction with public mental health and case management services, including a recent study of parent experiences in Florida. All of these studies indicate the importance of a trusting relationship between family and case manager, clear communication about roles and services and true partnership in meeting family goals (Lazear & Worthington, 2004; Martin, Petr, & Kapp, 2003; Measelle, Weinstein, & Martinez, 1998; Riley, Stromberg, & Clark, 2005).

Recommendations

This study yields four primary and interrelated recommendations.

I. An Integrated Approach

This study confirms and supports the importance of taking a systemic look at bringing about improvements in services and outcomes for children with mental health challenges and their families. The System Coach component, which looks at the interrelationship among all the components of the system, is off to a promising start but is still in its early stages. The focus on evidence-based practices has identified a number of interventions that are potentially very useful, but there is a need to look beyond those discreet interventions to how they are integrated within a broad system of care and how they are adequately supported. The study on case management points out that case management is an intervention designed to strengthen a system at the same time as its very effectiveness depends upon many systemic conditions that go beyond case management. These include the types of services that are available, the funding mechanisms, the provider network, the training and coaching that is available and the overall performance measurement system. Any effort to study case management, or to improve it, must focus on the broad system in which it is embedded. Such research and development efforts must take an integrated approach that focuses not just on any one single feature but on the interconnection between the components and the combined effect that they have. The System Coaching intervention, in particular, should be continued and must be carefully evaluated.

II. A Focus on Implementation

Within these projects, the implementation framework developed by Fixsen et al. (2005) has been used to help analyze the current status of the children's mental health system in Florida. This has proven to be a very valuable framework. It is evident, for example, that no matter how dedicated an individual case manager may be or how

well-conceived a particular intervention might be, unless adequate attention is devoted to sound implementation practices, it is not likely to be effective. The data on case management indicate a need for improvement in all aspects of the implementation framework: initial selection of case managers, training, coaching, feedback and the degree to which facilitative administrative supports are present. Too often, when an intervention does not yield the intended results, the inclination is to immediately change it or replace it with something else. The implementation literature suggests that before making changes in a practice, a program, or a policy, it is critical to determine how well it is being implemented. One of the recommendations of this study is that the framework be incorporated in system development efforts at all levels.

III. Enhance Capacity

It is also the case that even under the best of circumstances, it is challenging and complex to develop and implement effective service delivery systems for children with mental health challenges and their families. Even when funding is adequate for direct services, if the infrastructure is not present to provide the supports that are needed, the impact of the services will be limited. The System Coaching component of this project is directly targeted at building the capacity of a community to develop and sustain an effective system. Such community capacity-building efforts are extremely important, and it is recommended that at the state level AHCA and DCF work in partnership with their local counterparts and with other local entities to enhance the capacity of communities to develop, manage and sustain effective systems. This can take place through such mechanisms as ongoing training, consultation and coaching, as well as through the provision of the infrastructure resources needed for managing the system.

IV. Strengthen Case Management

With regard to case management, it is critical that providers' develop effective feedback processes. The identification of the desired outcomes and practices of the case management system is a first step in this regard. This may begin with the identification of a case management model that is consistent with the values and outcomes desired by key stakeholders, including the state, families and providers. Florida case management providers do not appear to be implementing well-specified case management models. Other states are more likely to report implementing such models. The model for which there seems to be the greatest research support for children with serious mental health challenges and their families is the Wraparound model, based on system of care values and principles. Yet the data do not suggest that this model is used often in Florida. This model--or models like it that have measures that allow for the assessment of fidelity to the model and have demonstrated that that fidelity is associated with better outcomes for children and families--may be particularly useful for developing effective case management practice in Florida.

A first step in implementation of any model would likely be to assess the extent to which current practice by front-line workers is consistent with models that have demonstrated effectiveness. Identifying necessary changes in recruitment,

supervision and ongoing coaching supports to achieve fidelity of practice may be the next step in implementation. The use of ongoing process and outcome measurement is critical in developing system capacity for effective case management practice and identifying areas of success and areas for change. Ultimately, performance measures need to be consistent across the state and need to reflect the state's goals for the wellbeing of children and families. Current data indicate that one of Florida's strengths is in the consistent measurement of child outcomes. The measurement of family outcomes, as well as the measurement of case management practice, is noticeably absent in Florida. Creation of clear standards and supports for case management model selection, implementation and ongoing practice and outcome evaluation have great potential for advancing case management practice and the welfare of Florida's children and families.

References

Background

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Appendix A. System of Care Values and Principles

Effective systems of care are built on three core values:

- Child centered and family focused
- Community-based
- Culturally and linguistically competent

These values are then guided into practice by ten principles:

- Comprehensive, incorporating a broad array of services and supports
- Individualized to the strengths and needs of the child and family and guided by an individualized service plan
- Provided in the least restrictive appropriate settings
- Involving families as full partners in all decisions
- Coordinated at both the administrative and service delivery levels
- Integrated as well as linked and coordinated through a designated care manager
- Emphasizing early identification and intervention

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Appendix B. Systems Coach Preservice Training Curriculum

Tools for Systems Transformation

A handbook for those engaged in systems coaching

National Implementation Research Network
Louis de la Parte Florida Mental Health Institute
University of South Florida
January 2006

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Foreword

Tools for Systems Transformation draws together a range of techniques designed to help Systems Coaches and others who undertake systems transformation and implementation activities and interventions of any size and kind.

This is a manual from which to pick and choose: you may need to employ different skills at different times or several skills at the same time. Some are more likely to be employed at the outset or in the exploration stage. Some skills may be employed once, while others will need to be revisited and may be revised as the activity or intervention continues. Also, the skills and techniques you start out with may need to be added as you progress.

This document began life as an attempt to draw together many people's years of experience undertaking international development activity, entitled Tools for Development. However, many of the skills outlined here, such as those relating to team work, facilitating group activity, influencing, or conflict resolution, are ones that you will need in everyday life, whether within the context of systems coaching or outside it. They will prove particularly useful when engaged in team-based and multi-disciplinary work that is becoming increasingly the means by which systems transformation initiatives are accomplished.

Some skills and techniques, such as Situational Analysis, Risk Assessment, and the ability to complete a logic model, should be regarded as essential professional tools if you are to participate fully in achieving the goal of a transformed mental health system.

A guide, not a leader

You may not need to read this handbook from cover-to-cover to begin working with communities on an initiative to improve or transform mental health services and outcomes. You should, however, read all of Chapter 1 to give you an overview of what Tools for Systems Transformation is about.

Use of the tools should be tailored to the specific circumstances you face. They should be applied in a proportional manner. For complex systems transformation activities, full-scale application of most of the tools may be appropriate. In contrast, for discrete Evidence-based Program implementation, it may be more appropriate to apply only a sub-set of the tools in a more limited manner.

For experienced agents of systems change, this handbook should be regarded as an aide-memoire. For others called on to use a particular skill or technique in a particular circumstance, Tools for Systems Transformation may provide an introduction to issues that may arise and offer potential solutions. Specialist training and coaching, however, will still be encouraged. Indeed, it is expected, even intended, that you will analyze your professional development needs in relation to the project the community is envisioning, and will supplement the material introduced here by formal and structured training from NIRN or external providers.

What is next?

This handbook does not offer answers to everything, is not the last word on any particular subject, and is a living document. If you find something particularly useful, it may be valuable for us to expand upon it; alternatively, there may be areas which still need refinement. Many organizations, large and small, successfully use different techniques and skills from those mentioned here; if you know of any others of particular value, the Systems Coaching staff in NIRN would welcome information about them to possibly include in future editions.

Contents

1. Project Overview
2. Evidence-based Practices and Implementation
3. Introduction and Overview of Training Materials

- Documentation and Coaching

4. Foundation Skills for Systems Coaching
5. Getting and Giving Information: Observing and Reporting Skills
6. Connecting with People through Rationales
7. Developing and Maintaining Relationships – Recognition for Colleagues and Stakeholders
8. Maximizing Feedback Opportunities
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12. SCOCS
13. Problem and Situational Analysis
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19. Building Partnerships
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21. Organizational Cultural Competency
22. Meeting Facilitation
23. Consensus Building
24. Environmental Scan
25. Monitoring, Reviewing, Evaluating
26. Appendices

Appendix C. Systems Coach Selection Tool

Interview Protocol

IMPLEMENTATION SPECIALIST/SYSTEMS COACH

INTERVIEW PACKAGE

NAME OF APPLICANT ______________________________

INTERVIEWER #1 ______________________________

INTERVIEWER #2 ______________________________

DATE ______________________________

V.4 December 27, 2005

Interview Protocol Development
Systems Coach - AHCA

I. Introduction and Background

Interviewer Instructions for Structured Questions

For each question please provide an overall rating of your satisfaction with the applicant's response in relation to the requirements of the position. Use the following 7-point scale:

Use a 1 to 7 rating scale for each question as follows, along with comments:

1 = Very Dissatisfied

2 = Dissatisfied

3 = Slightly Dissatisfied

4 = Neutral – Neither Satisfied nor Dissatisfied

5 = Slightly Satisfied

6 = Satisfied

7 = Very Satisfied

The Florida Mental Health Institute has a long history of working with state agencies on efforts to improve the mental health system in Florida. This year, Florida's Agency for Health Care Administration has asked us to explore the efficacy of a "systems coaching" model to assist in the transformation of the mental health system. The system coach will work with a team of policymakers and stakeholders in Orlando to assess their current system and to choose the desired outcomes to be achieved.

As a Systems Coach, your role would involve:

- Assisting the community in assessing needs, readiness for new efforts, etc.
- Providing knowledge of systems change strategies and facilitating change initiatives through community coaching
- Serving as a resource person related to evidence-based programs, practices and processes
- Building "buy-in" across sectors and stakeholder groups for the initiatives defined by the community
- Spending 2 - 3 days a week in Orlando (driving back and forth, some overnights)

We have certain funding through June 30, 2006 but expect the contract to be renewed for next year (a long history of FMHI providing a variety of contracted services to AHCA).

Are you still interested in this position?

Do you have a driver's license and adequate transportation?

Will you be able to travel and stay over as needed on a flexible schedule (including some nights and weekends)?

Do you have any questions?

II. General Interview Questions

1. What about this position caused you to apply?

2. Given the description of the position, what do you believe would be your greatest strength in this position?

   What would be your greatest weaknesses?

3. Describe your last job in a sentence or two.

   Describe your last supervisor in a sentence or two.

4. What can you tell us about your understanding of Evidence-based Practices?

5. Tell us what you know about the concepts of resilience and recovery?

6. What can you tell us about your knowledge of the mental health system in Florida?

7. Tell us what you know about the President's New Freedom Commission on Mental Health's report, entitled Achieving the Promise: Transforming Mental Health Care in America.

Self Assessment of Skills and Abilities

Rate yourself on your ability 1 = Very Little, 10 = Very High. Explain in one sentence.

[ ] Writing Skills ______________________________

____

[ ] Public Speaking ______________________________

____

[ ] Facilitating Groups ______________________________

____

[ ] Organization ______________________________

____

[ ] Creativity ______________________________

____

[ ] Persistence ______________________________

____

[ ] Solve Problems ______________________________

____

[ ] Work Under Pressure/Meet Deadlines ______________________________

____

[ ] Advocate ______________________________

____

[ ] Flexible ______________________________

____

[ ] Give and Accept Corrective Feedback ______________________________

____

[ ] Optimistic View in Crisis/Problem Situation ______________________________

____

[ ] Ability to Support Colleagues ______________________________

____

Describe the most stressful situation you have ever dealt with involving two or more people.

How did you handle it? Do you think you were "successful"? Why or why not?

Looking back, what would you do differently today?

Possible probes:

- Did you purposefully use particular skills or approaches or was your response more intuitive?
- What did you learn about yourself in the process?
- Did you "report" this to anyone? Why or why not?

Please rate yourself on a scale from 1 to 10 on how experienced you are in this area. 1 is Very Inexperienced and 10 is Extremely Experienced.

Briefly, why did you give yourself that rating?

Please rate yourself on a scale from 1 to 10, on how comfortable you are in this area? 1 is Very Uncomfortable and 10 is Extremely Comfortable.

Briefly, why did you give yourself that rating?

___ Rating:

What we are looking for:

- Ability to see conflict as "normal"
- Ability to learn from conflict and incorporate learning into future planning and behavior
- Relative comfort and lack of avoidance
- Recognition that avoidance or denial of conflict causes more problems
- Non-confrontational approach to resolving conflict

When you are in the midst of interacting with someone to solve a problem, how aware are you of what you are doing? Take your time and make this a fun question. Start with the general and proceed to the specific as you ask lots of questions to see if the person has a "third eye" – they see/hear themselves and note the other person's reactions as if they were outside their body observing the whole interaction while the interaction is occurring. Some applicants are keenly aware of what is going on and aware of analyzing and considering options while the interactions is occurring. Others get through the interaction then are able to replay the whole thing in their head and hear the conversation and think about how to do things differently next time. Many are simply reactive and are not especially aware. Try to get at how immediately adjustable their behavior is in problem solving situations.

Using the STAR principles, please tell us about a time when you were able to influence a group of people to initiate a long-term goal and/or a change in a system, or organization, that would move it in a new direction.

Please rate yourself on a scale from 1 to 10 on how experienced you are in this area.

1 is Very Inexperienced and 10 is Extremely Experienced.

Briefly, why did you give yourself that rating?

Please rate yourself on a scale from 1 to 10, on how comfortable you are in this area? 1 is Very Uncomfortable and 10 is Extremely Comfortable.

Briefly, why did you give yourself that rating?

Rating: ___

What we are looking for:

- Ability to describe a process
- Ability to get others invested
- Ability to find the "right" people to get involved (e.g. champions, opinion leaders)
- Understanding of time and effort involved
- Lessons learned (what worked and what did not work and WHY)

Tell us about a time when you were *faced with an unexpected situation,* such as

- a job suddenly changed and required very different skills and activities than you were led to believe would be needed or required of you
- timelines for a project didn't go as expected
- the resources or tools weren't available
- a team member left a project and you were expected to complete the task

Probes:

- How did you feel?
- What did you do?
- What were you thinking during this time?
- How comfortable was that for you?
- Is this how you generally would respond to a shift in expectations of requirements?

Rating: ____

What we are looking for:

- Ability to seek support, information and resources
- Ability to analyze the new "requirements" and define appropriate changes in strategies or behaviors
- Comfort with change
- Extra points if they enjoy change and express comfort with being flexible
- Non-blaming attitude (e.g. "not everything can be known", "things happen")

Notes on Applicant Response:

Please rate yourself on a scale from 1 to 10 on how experienced you are in this area. 1 is Very Inexperienced and 10 is Extremely Experienced.

Briefly, why did you give yourself that rating?

Please rate yourself on a scale from 1 to 10, on how comfortable you are in this area?

1 is Very Uncomfortable and 10 is Extremely Comfortable.

Briefly, why did you give yourself that rating?

It is your first week on the job as a systems coach, tell me some of the things you see yourself doing and why you are doing those things?

___ Rating of Response:

What we are looking for:

- Relationship development activities
- Advice seeking
- Information Seeking
- Activities and behaviors that give the person a view of the community from diverse perspectives
- Comfort with initiating activity
- Ability to seek out nodes and existing networks and leaders

The concept of 'diversity' can mean multiple things to different people. We would like you to share your perspective and experience regarding diversity.

a. What is your view of diversity? What does diversity mean to you?

b. Please describe a time when you needed to work in a way that embraced respecting and valuing diversity.

Please rate yourself on a scale from 1 to 10 on how experienced you are in this area.

1 is Very Inexperienced and 10 is Extremely Experienced.

Briefly, why did you give yourself that rating?

Please rate yourself on a scale from 1 to 10, on how comfortable you are in this area?

1 is Very Uncomfortable and 10 is Extremely Comfortable.

Briefly, why did you give yourself that rating?

Rating: ___

What we are looking for:

- Understanding that "diversity" is a broad concept (e.g. language, race, ethnicity, culture, gender, class)
- Statements of the positive contributions diversity makes to the situation, workplace, etc.
- Statements about 'continual learning' and seeking knowledge
- Sense that the person is comfortable and enthusiastic about diversity

If we were to interview three people you worked well with, what would they say about you?

[A vignette re "Ability and Willingness to be Purposeful" to get at willingness to try to use tolls and skills that are unfamiliar and ability to report descriptively on behavior, thoughts, and feelings while doing so.]

Part II: Read the following vignette to the Candidate:

You have been preparing for an important meeting with three people who will make decisions regarding their participation in the project with which you are involved. Their decisions will significantly impact the direction the project will take. You are accustomed to leading but in this case your goal is to assure each person is able to make a decision that is informed and based on individual choice.

1. How would you approach this meeting?

2. Describe how you might find / use tools and skills that are new to you.

3. Once the meeting has occurred what would you want to include in a report to your project team (e.g. behaviors, thoughts, feelings, etc)?

Rating: ___

What we are looking for:

- Willingness to try to use tools and skills that are unfamiliar
- Ability to report descriptively on behavior, thoughts and feelings while engaged in novel or unfamiliar tasks
- Sees value in "reporting" back to the team

Behavior Rehearsal

The purpose of this behavior rehearsal is to assess the applicant's:

- Skills and comfort related to providing constructive or critical feedback to others as an indicator of ability and willingness to deal with conflict
- The ability to accept positive feedback from a member of the interview panel
- The ability to accept constructive suggestions from the interview panel.
- The ability and willingness to act on suggestions during a re-practice

The interview lead should explain that the panel would like to get a feel for the applicant's interaction style and has a few behavior rehearsal scenes to go through. One of the interviewers should use the feedback checklist below and after the practice should offer positive feedback on a few items, then make one or two suggestions for improvement and ask the person to re-practice that portion of the behavior rehearsal. Set up the re-practice by telling either the applicant or the "community person" what to say to start the re-practice (e.g. "Okay, let's start by having you say…").

Post Meeting Feedback Scenario

Applicant Role

Background

You are chairing a community planning group. One of the group members represents Juvenile Probation Services. The purpose of the community planning group is to bring together different service sectors (e.g., children's mental health, education, child welfare, juvenile justice) to better coordinate service and improve service access for children with mental health issues. Juvenile Justice is critical to the planning effort. However, the representative, who is a senior probation officer, is consistently late in arriving and spends most of the meeting doodling on the agenda, leaving the room to take cell phone calls, and generally leaves the meetings early. As the chair, you notice that other group members' nonverbal behavior indicates that they "disapprove" of this person's behavior. You know from individual conversations with the probation officer that he/she really cares about the youth in the community and has worked with youth who have substance abuse and mental health problems. In your role as a System Coach, you have decided to talk to the person after the meeting about his/her engagement in the process.

Community Member Role

Background

You are a member of a community planning group. You represent the Juvenile Probation Services. The purpose of the community planning group is to bring together different service sectors (e.g., children's mental health, education, child welfare, juvenile justice) to better coordinate service and improve service access for children with mental health issues. You did not volunteer to attend and do not have the power or the avenues to the power to make the kinds of decisions that the group needs to make. You feel uncomfortable in the group. You are consistently late in arriving and spend most of the meeting doodling on your paper, leaving the room to take cell phone calls, and you try to leave early. You do buy into the need for the planning and the goals of the group. You really care about the youth in the community and have worked with youth who have substance abuse and mental health problems. But you just feel like you are not the right person to represent juvenile justice and you feel a little embarrassed that you can't come to the table with the authority needed.

Situation

During the behavior rehearsal the applicant will play the role of a "systems coach", who is facilitating the meetings and generally helping the community with their planning processes. The goal of the scene is to allow the applicant the opportunity to provide feedback to you and explore why you are not engaged with the group. The scene takes place after one of these meetings. The applicant will approach you to explore your feelings and provide some feedback and observations about your behavior. Generally be pleasant and cooperative, but a bit embarrassed during the interaction.

If the applicant mentions one or two of your behaviors as he/she talks with you, you should acknowledge the behavior and apologize. However, if the applicant uses judgmental or non-behavioral descriptions of your behavior (e.g. you seem bored, disengaged) and does not mention any of your behaviors specifically (e.g. doodling, arriving late, leaving early) you should not acknowledge your behavior as problematic. Instead, you should just look puzzled and say something like, "I don't think I understand what the problem is." or something similar.

If the applicant asks you if you have any feedback for her/him or if he/she is doing anything to make you uncomfortable just say, No, you think she/he is doing a good job leading the group. At some point in response to a query (hopefully) you can reveal that you do not think you are the right person and that someone with more authority should be at the table. And if asked, yes, you do have a recommendation and will help make that happen.

Candidate:____Date: ___________________________

Rater: ____

Giving Feedback – Checklist for Behavior Rehearsal

Use a 1 to 7 rating scale for each question as follows, along with comments:

1 = Very Dissatisfied
2 = Dissatisfied
3 = Slightly Dissatisfied
4 = Neutral – Neither Satisfied nor Dissatisfied
5 = Slightly Satisfied
6 = Satisfied
7 = Very Satisfied

___ 1. Begins interaction with empathy or supportive statement (e.g. "Thanks for making time for these meetings", "I realize it's difficult for you to spend this kind of time").

___ 2. Is behaviorally specific about the behavior observed.

___ 3. Does not use "judgmental" terms (e.g. you seem bored, you are disruptive, you are not helpful) but instead states observations and asks what is going on for the probation officer (e.g. I've noticed that you often arrive late and leave early.).

___ 4. Asks for feedback on own behavior?

___ 5. Offers rationales for the community process or benefits of having everyone engaged in the meeting.

___ 6. Makes reference to the "good intentions" of the probation officer (e.g. caring, works hard on behalf of youth)

___ 7. Asks person to participate in coming up with ideas for a "solution" to the problem at hand or to commit to increased engagement

___ 8. Does NOT mention that the person is making other people uncomfortable.

___9. Good quality components (e.g. voice tone, eye contact)

___ 10. Overall Rating related to Giving Feedback (NOT an average of the above)

Other observations:

Candidate:____Date: ____________________________

Rater: ____

Receiving Feedback – Checklist for Behavior Rehearsal

Use a 1 to 7 rating scale for each question as follows, along with comments:

1 = Very Dissatisfied
2 = Dissatisfied
3 = Slightly Dissatisfied
4 = Neutral – Neither Satisfied nor Dissatisfied
5 = Slightly Satisfied
6 = Satisfied
7 = Very Satisfied

___ 1. Accepts positive feedback comfortably from the interviewer (e.g. says thank you, doesn't deny strengths)

___ 2. Accepts suggestions for improvement (e.g. asks for clarification if needed, verbally and/or nonverbally indicates understanding of feedback, does not "argue" about the merits of the feedback).

___3. Thanks feedback giver for suggestions.

___ 4. Willing to re-practice if asked to do so.

___ 5. Able to incorporate suggestions into the repractice.

___ 6. Overall Rating related to Receptivity to Feedback (NOT an average of the above)

Other Observations:

The STAR analytic principles are:

S = Situation: Please describe the specific situation and your role.

T = Task: The tasks that were associated with the situation.

A = Action: The actions you took to address the situation.

R = Results: The results of your actions.

Appendix D. Systems Coaching Reporting Form

AHCA Project
Systems Coach Reporting Form

Systems Coach:

Date of report submission:

Person(s) contacted:

Date of Visit/Contact:

Type of Contact: ( ) Telephone ( ) Group Meeting ( ) Individual Meeting

( ) Other ____

Length of Contact:

Preparation before each contact

What is my purpose?

What do I want to accomplish or what is my specific goal?

What do I need to know?

1. Is there information I want to review?

(ex. Read "Stakeholder Analysis")

2. Is there something I need from someone else (NIRN Team) to prepare (consultation, practice or role play, etc.)?

After contact (Debrief)

Goal Area(s):

What did I accomplish and was it what I intended?

Rating (1 low to 7 high): ________

(Type in a number from 1-7 indicating how satisfied you are that you accomplished what you set out to do. 1=Very Dissatisfied and 7= Very Satisfied)

Activities / Observations:

What happened? What were your observations?

Next Action Steps:

Self-Reflection

Based on the entire visit, please analyze your preparation, behavior, thought processes, perceptions and discoveries about your role as a systems coach including what was learned about implementation

Significant Program/ Staff Changes:

Describe any changes to the district or program. Include staff changes, program changes, extraordinary events, contract changes, etc.

Skills

- Observing and Describing Behavior
- Providing Rationales
- Providing Recognition
- Accepting Positive Feedback
- Accepting a Concern
- Raising a Concern
- SCOCS
- Ladder of Inference
- Asking for Advice
- Listening
- Checking Perceptions
- Providing Conceptual Feedback or Review
- Using Conceptual Format to Plan and/or Prepare
- Active Modeling of the use of tool

Tools

- Stakeholder Analysis
- Problem and Situational Analysis
- Visioning
- Logical Frameworks
- Risk Analysis
- Participatory Methodologies and Management
- Teamworking
- Building Partnerships
- Conflict Resolution
- Theory of Change
- Implementation Stages
- Implementation Drivers
- Knowledge of "purveyors" and IPO's
- Monitoring, Reviewing, and Evaluation

Add to this list based on what you are training (skills and tools)

Appendix E. Systems Coach Training Evaluation

Systems Coach

Training Evaluation Form

Date:

Section:

Presenter(s):

Name: (optional):

Please use a 1 to 7 rating scale when ratings are requested:

7 = Very Satisfied
6 = Satisfied
5 = Slightly Satisfied
4 = Neutral
3 = Slightly Dissatisfied
2 = Dissatisfied
1 = Very Dissatisfied

1. How satisfied are you that the material in this section is relevant to the roles and responsibilities of a Systems Coach? Rating: ___

Comments:

2. How satisfied are you that the material was clearly presented? Rating: ____

Comments:

3. How satisfied are you that the training methods used facilitated learning? Rating: ___

Comments:

4. Please rate the material presented in this section in terms of level of complexity on scale of 1 to 7 where 1 = Elementary and 7 = Advanced. Rating: ____

Comments:

5. How satisfied are you that the amount of time spent on the topic was sufficient to gain a moderate level of expertise or understanding of the skills and/or tools presented? Rating: ____

Comments:

6. What did you learn that you think will be most helpful to a Systems Coach?

7. What was least helpful?

8. What could be done differently in subsequent presentations of this material to future Systems Coaches?

9. Other comments?

Appendix F. Depression

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Behavior Therapy		No named program referenced	6 - 18	Not specified	With substance abuse
C-Care/CAST	Students at risk of suicide (school based)	http://www.sprc.org/featured_resources/ebpp/pdf/ccare_cast.pdf	14- 18	multiple	Not referenced
CBT Group for Depression	Can be used with delinquent youth and depressed parents	http://www.kpchr.org/public/acwd/acwd.html	13 – 18 and their parents	Not specified	Not referenced
Cognitive Behavioral Therapy (CBT)		www.kpchr.org/public/acwd/acwd.html	Not specified	Not specified	With substance abuse
Interpersonal Psychotherapy for Depressed Adolescents	This therapy is better suited for adolescents who are motivated to be in treatment and agree that one or more interpersonal problems exist.	Guilford Press - (800) 365-7006; info@guilford.com Manual entitled "Interpersonal Psychotherapy for Depressed Adolescents" No TA available	12 - 18	49% Puerto Rican, 41% Hispanic, 10% Caucasian	Not referenced
Primary and Secondary Control Enhancement Training for Youth Depression PASCET (3-6 years)		Dr. John R. Weisz UCLA Department of Psychology (310) 206-7620 weisz@psych.ucla.edu TA available	3-6	Not specified	Not referenced
Relaxation	School based group sessions	Center for Mindfulness mindfulness@umassmed.edu www.umassmed.edu/cfm	11 - 15	Not specified	Not specified
Self Control		Manual and workbook available through Workbook Publishing at www.workbookpublishing.com; TA - Kevin Stark University of Texas at Austin (512) 471-0267	Not specified	Not specified	Not specified

Appendix G. Anxiety (including avoidant behaviors and phobias)

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Cognitive Behavioral Therapy (CBT)		www.kpchr.org/public/acwd/acwd.html	Not specified	Not specified	With substance abuse
CBT plus CBT for Parents		No contact information	3 - 18	Not specified	Not specified
Client-Centered and Play Therapy-Adolescent Portable		Hawley, Kristin M. (PhD, University of California, Los Angeles) Assistant Professor (Clinical) 204C McAlester Hall (573) 882-2533 hawleyk@missouri.edu		African-American; Hispanic	Not specified
Coping Cat (CBT)		Philip C. Kendall (Possible TA); Temple University (215) 204-1558 philip.kendall@temple.edu; http://www.workbookpublishing.com/anxiety.htm	8 - 13	Not specified	Not specified
Exposure		Manual is available Edna B. Foa, Ph.D. (215) 746-3327 foa@mail.med.upenn.edu	Not specified	Not specified	Not specified
Friends Program		Alan E. Kazdin Alan.Kazdin@yale.edu , 203-432-9993	7-11 or 12-16	Not specified	Not specified
Modeling Live Modeling Filmed Modeling Participant Modeling Symbolic Modeling		Barbara J Burns (919) 687-4676 x 243 bjb@geri.duke.edu	Not specified	Not specified	Not specified
Parent-Child Interaction Training	Home-based	Joseph Strayhorn, Ph.D. Early Childhood Behavior Disorders Clinic 1 Allegheny Square Suite 414 Pittsburgh, PA 15212	5 - 6	Not specified	Not specified
Queensland Early Intervention And Prevention Of Anxiety Project (QEIPAP)		http://www.personal.psu.edu/dept/prevention/QEIPAP.htm	7 - 14	Not specified	Not specified
Reinforced Practice		Thomas Ollendick, Ph.D. 460 Turner Street, Suite 207 (540)231-6451; tho@vt.edu	4 - 12	Not specified	Not specified
Relaxation	School based group sessions	Center for Mindfulness (508) 856-2656 mindfulness@umassmed.edu www.umassmed.edu/cfm TA available	11 - 15	Not specified	Not specified
Self Control		www.workbookpublishing.com TA: Kevin Stark University of Texas at Austin (512) 471-0267	Not specified	Not specified	Not specified
Systematic Desensitization Imaginal Desensitization In Vivo Desensitization		Barbara J Burns (919) 687 4676 x 243 bjb@geri.duke.edu	Not specified	Not specified	Not specified

Appendix H. Anger/Aggressive behavior

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
AC-SIT	School based	Dr. John Lochman (Technical Assistance), University of Alabama, (205) 348-7678 jlochman@gp.as.ua.edu Video available; contact Dr. Jim Larson at larsonj@mail.uww.edu	Not specified	Not specified	Not specified
Aggression Replacement Training Program		Arnold Goldstein, Ph.D. Center for Research on Aggression, Syracuse University 805 South Crouse Avenue Syracuse, NY 13244 (315) 443-9641	5 – 18 (K-12th grade)	Not specified	Not specified
Anger Control for Aggressive Youth		http://cavershambooksellers.com/searchresults.php?query=1572306831 (book site)	3 - 18	Not specified	Not specified
Anger Coping Program	For boys; School-based group intervention	John E. Lochman, Ph.D. University of Alabama, Dept. of Psychology, P.O. Box 870348 Tuscaloosa, AL 35487 205.348.7678 jlochman@gp.as.ua.edu	9-12	Not specified	Not specified
BrainPower		Cynthia Hudley, Ph.D. MC 0031, University of Southern California, Rossier School of Education, 3470 Trousdale Parkway, Waite Phillips Hall 1001D, Los Angeles, 90089-0031 (213) 740-3473 hudley@usc.edu	7-11	Not specified	Not specified
Capital and Serious Violent Offender Program	Incarcerated youth; Residential setting	Dr. Corrine Alvarez–Sanders, Assistant Deputy Executive Director of Rehabilitation Services, Texas Youth Commission, P.O. Box 4260, Austin, TX 78765, 512-424-6152, tyc@tyc.state.tx.us http://www.tyc.state.tx.us/programs/special_treat.html	16 - 20	Not specified	Not specified
C-Care/CAST	School-Based	Program Developer/Evaluator Elaine Thompson, PhD, RN Reconnecting Youth Prevention Research Program Psychosocial and Community Health Campus Box 357263 University of Washington School of Nursing Seattle, WA 98195-7263 Phone: (206) 543-8555 elainet@u.washington.edu	14 - 18	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Child-Parent Psychotherapy for Family Violence (CPP-FV)		Early Trauma Treatment Network, Psychiatry Department, University of California-San Francisco Alicia Lieberman, PhD (alicial@itsa.ucsf.edu), or Patricia Van Horn, PhD (pjv@itsa.ucsf.edu)	0 - 5	Latin American Immigrants; other immigrant populations	Not specified
Dialectical Behavior Therapy Program for Incarcerated Female Juvenile Offenders	Incarcerated female youth; residential setting	Brad Beach Echo Glen Children's Center 33010 Southeast 99th Street Snoqualmie, WA 98065 4258312500 beachbr@dshs.wa.gov	9-20	African - American, White, American Indian / Alaskan, Hispanic	Not specified
Earlscourt Social Skills Group Programme (ESSGP)	School based	No contact information	6 - 12	Not specified	Not specified
Families and Schools Together (FAST Track)		The Conduct Problems Prevention Group 110 Henderson Building South University Park, PA 16802-6504 (814) 863-0112	Not specified	various	Not specified
First Step	Classroom based with in-home visits	Hill M Walker Human Development Center on Human Development 351 CSB 5252 University of Oregon Eugene, OR 97403-5252 (541) 346-3591 hwalker@uoregon.edu	Not specified	Not specified	Not specified
First Step to Success		Sopris West 4093 Specialty Place Longmont, CO 80504 (800) 547-6747 www.sopriswest.com	5 - 6	93% White	Not specified
Incredible Years	School based, with parental involvement	Lisa St. George Administrative Director The Incredible Years 1411 8th Avenue West Seattle, WA 98119 (206) 285-7565 Toll-free Phone and Fax: (888) 506-3562 incredibleyears@seanet.com http://www.incredibleyears.com/	2 - 8	Hispanic, Asian-American, African-American	Not specified
Linking the Interests of Families and Teachers (LIFT)	School Based with parental involvement	John Reid, Ph.D., Senior Scientist Oregon Social Learning Center 160 East 4th Avenue, Eugene, OR 97401, (541) 485-2711	5 - 11	Not specified	Not specified
Parent-Child Interaction Training	Home-based	Joseph Strayhorn, Ph.D. Early Childhood Behavior Disorders Clinic 1 Allegheny Square Suite 414 Pittsburgh, PA 15212	5 - 6	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Peer Coping Skills	Group based, school intervention	No contact information	6 - 8	Not specified	Not specified
SCARE Program		D. Scott Herrmann, Ph.D. Juvenile Probation / Superior Court of Arizona, 3125 West Durango, Phoenix, AZ 85009 (602) 506-7143 donher@juvenile.maricopa.gov To Order: Don Burks, Kendall/ Hunt Publishing Company, PO Box 1840, Dubuque, IA 52004-1840, 800/542-6657, ext. 1124	11 - 13	Not specified	Not specified
Student-Mediated Conflict Resolution Program	School based	Materials and TA: Collaborative Student Mediated Team, McMaster University Hamilton, Ontario, Canada 905-521-2100 x 77307 cunningh@mcmaster.ca	10 – 11 (5th grade)	Not specified	Not specified
Think First	School based	Jim Larson, Coordinator University of Wisconsin—Whitewater Department of Psychology Whitewater, WI 53190 (262) 4725412 larsonj@uww.edu	10-18	African - American, White, and Hispanic	Not specified
Treatment Recommendations for the use of Antipsychotics for Aggressive Youth (TRAAY)		James C. MacIntyre, M.D. Bureau of Children & Families New York State Office of Mental Health 44 Holland Avenue - 8th floor Albany, NY 12229 (518) 473-6902 cocfjcm@omh.state.ny.us	Not specified	Not specified	Not specified

Appendix I. PTSD/Trauma

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Child-Parent Psychotherapy for Family Violence (CPP-FV)		Early Trauma Treatment Network, Psychiatry Department, University of California-San Francisco Alicia Lieberman, PhD (alicial@itsa.ucsf.edu), or Patricia Van Horn, PhD (pjv@itsa.ucsf.edu)	0 - 5	Latin American Immigrants; other immigrant populations	Not specified
Cognitive Behavioral Intervention for Trauma in Schools	School based	For more information on the CBITS model, contact Marleen Wong (marleen.wong@lausd.net) at the LAUSD Community Practice Site, Lisa Jaycox (jaycox@rand.org) or Bradley Stein (stein@rand.org) at the RAND Corporation, or Sheryl Kataoka (skataoka@ucla.edu) at UCLA. Copies of the treatment manual can be ordered from Sopris West Educational Services (800) 547-6747 www.sopriswest.com	10 - 15	various, including Native American children and recent immigrants who speak primary languages other than English, such as Spanish, Russian, Korean, and Western Armenian	Not specified
Cognitive Behavioral Therapy for Child and Adolescent Traumatic Stress		Judith A. Cohen, M.D. Center for Traumatic Stress in Children & Adolescents Allegheny Gen. Hospital Four Allegheny Center, Room 859 Pittsburgh, PA 15212 412-330-4321 JCohen1@wpahs.org	3 - 18	Hispanic, American Indian / Alaskan, Asian / Pacific Islander, White, and African-American; some assessment tools are available in Spanish	Not specified
Cognitive-Behavioral Therapy for Child Sexual Abuse (CBT-CSA)	Group based	Esther Deblinger, Ph.D. New Jersey School of Osteopathic Medicine 42 East Laurel Road, Suite 1100B Stratford, NJ 08084 (856) 566-7036 deblines@umdnj.edu www.hope4families.com	3 - 18	Not specified	Not specified
Integrated Cognitive-Behavior Therapy for Traumatic Stress Symptoms		Barbara J Burns Box 3454 Med Center Durham, NC 27710 919-687-4676 x 243 bjb@geri.duke	Is being developed for children	Not specified	Tailored for Co-occurring PTSD and substance abuse
Prolonged Exposure Therapy for Posttraumatic Stress		Center for the Treatment and Study of Anxiety Department of Psychiatry University of Pennsylvania 3535 Market Street, 600 N Philadelphia, PA 19104 csta@mail.med.upenn.edu http://www.med.upenn.edu/ctsa/	"Case reports have indicated that PE is useful with children whose PTSD is related to accidents and disasters."	Not specified	Not specified
The Sexual Abuse, Family Education and Treatment (SAFE–T) Program	Trauma related to sexual abuse	Barbara Rodgers, Director SAFE–T Program Thistletown Regional Centre for Children and Adolescents 51 Panorama Court Toronto, Ontario M9V 4L8 416-326-0647 barbara.rodgers@css.gov.on.ca	12 - 19	Not specified	Not specified

Appendix J. ADHD

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Behavior Therapy		No named program referenced	6 - 18	Not specified	With substance abuse
Cognitive Behavioral Training for Parents of Children with AD/HD		Child Conduct Clinic, Northwestern University 203-432-9993	Not specified	Not specified	Not specified
Parent-Child Interaction Training	Home-based	Joseph Strayhorn, Ph.D. Early Childhood Behavior Disorders Clinic 1 Allegheny Square, Suite 414 Pittsburgh, PA 15212	5 - 6	Not specified	Not specified
Relaxation	School based group sessions	Center for Mindfulness 508-856-2656 mindfulness@umassmed.edu www.umassmed.edu/cfm TA available	11 - 15	Not specified	Not specified

Appendix K. Conduct Disorder and Oppositional Defiant Disorder (including disruptive behaviors, antisocial behaviors, serious criminal behavior, negative behaviors)

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
AC-SIT	School based	Dr. John Lochman (Technical Assistance) University of Alabama 205-348-7678 jlochman@gp.as.ua.edu Video available; contact Dr. Jim Larson at larsonj@mail.uww.edu	Not specified	Not specified	Not specified
Adolescent Transitions Program	School based, family centered	Ann Simas Child and Family Center University of Oregon 195 West 12th Avenue Eugene, OR 97401-3408 541-134-1983 asimas@uoregon.edu http://cfc.uoregon.edu	11 - 18	Not specified	Not specified
Aggression Replacement Training Program		Arnold Goldstein, Ph.D. Center for Research on Aggression Syracuse University 805 South Crouse Avenue Syracuse, NY 13244 Tel: (315) 443-9641	5 - 18 (K-12th grade)	Not specified	Not specified
Anger Control for Aggressive Youth		http://cavershambooksellers.com/searchresults.php?query=1572306831 (book site)	3 - 18	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Anger Coping Program	For boys; School-based group intervention	John E. Lochman, Ph.D. University of Alabama, Dept. of Psychology P.O. Box 870348 Tuscaloosa, AL 35487 205-348-7678 jlochman@gp.as.ua.edu	9-12	Not specified	Not specified
Assertiveness Training		Manuals available by multiple authors	Not specified	Not specified	Not specified
Behavior Therapy		No named program referenced	6 - 18	Not specified	With substance abuse
Bethesda Day Treatment Center		Jerilyn Keen, M.A., President Bethesda Day Treatment Center P.O. Box 270 Central Oak Heights West Milton, PA 17886 570-568-1131 jerilyn@bdtcpa.org http://www.bdtcpa.org	12 - 18	African - American, White, Asian, American Indian / Alaskan, and Hispanic	With substance abuse
Brief Strategic Family Therapy (BSFT)		Jose Szapocznik, Ph.D. (Contact) Carleen Robinson-Batista 1425 NW 10th Avenue, Third Floor Miami, Florida 33136 305-243-2226 Fax: 305-243-5577	6 - 17	Hispanic; African-American	With substance abuse
CBT plus CBT for Parents		No contact information	3 - 18	Not specified	Not specified
Child-Parent Psychotherapy for Family Violence (CPP-FV)		Early Trauma Treatment Network, Psychiatry Department, University of California-San Francisco Alicia Lieberman, PhD (alicial@itsa.ucsf.edu), or Patricia Van Horn, PhD (pjv@itsa.ucsf.edu)	0 - 5	Latin American Immigrants; other immigrant populations	Not specified
Client-Centered and Play Therapy-Adolescent Portable		Hawley, Kristin M. (PhD, University of California, Los Angeles) Assistant Professor (Clinical) 204C McAlester Hall (573) 882-2533 E-mail: hawleyk@missouri.edu	adolescent	African-American; Hispanic	Not specified
Cognitive Behavioral Therapy (CBT)		www.kpchr.org/public/acwd/acwd.html	Not specified	Not specified	With substance abuse
Contingencies for Learning Academic and Social Skills (CLASS)	School based	Hops, H., & Walker, H.M. (1988). CLASS: Contingencies for Learning Academic and Social Skills manual. Seattle, WA: Educational Achievement Systems	Not specified	Not specified	Not specified
CSF Buxmont Academy	Adjudicated youth; day treatment setting	Ted Wachtel, Community Service Foundation & Buxmont Academy P.O. Box 283 Pipersville, PA 18947 215-766-7443 tedwachtel@enter.net	8-18	African - American, White, Hispanic	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Dialectical Behavior Therapy Program for Incarcerated Female Juvenile Offenders	Incarcerated female youth; residential setting	Brad Beach Echo Glen Children's Center 33010 Southeast 99th Street Snoqualmie, WA 98065 425-831-2500 beachbr@dshs.wa.gov	9 - 20	African - American, White, American Indian / Alaskan, Hispanic	Not specified
Earlscourt Social Skills Group Programme (ESSGP)	School based	No contact information	6 - 12	Not specified	Not specified
Early Offender Program	High risk recidivist with two or more police contacts	No contact information	Up to age 13	African - American, Asian / Pacific Islander, White , American Indian / Alaskan Hispanic	Not specified
Families and Schools Together (FAST Track)		The Conduct Problems Prevention Group 110 Henderson Building South University Park, PA 16802-6504; (814) 863-0112	Not specified	various	Not specified
First Step to Success	Kindergarten classrooms	Sopris West 4093 Specialty Place Longmont, CO 80504 800-547-6747 www.sopriswest.com	5 - 6	93% White	Not specified
Florida Environmental Institute	Adjudicated youth; serious offenders	Jimmy Davis, Executive Director, Florida Environmental Institute 122 Ranch Road P.O. Box 506, Venus, FL 33960 863-699-3785 fei-bm@ami-fl.org	15 - 18	Not specified	Not specified
Functional Family Therapy	Family-based	Holly deMaranville, Communications Coordinator Functional Family Therapy, LLC 2538 57th Avenue, SW Seattle, WA 98116 206-369-5894 hollyfft@attbi.com	11 - 18	Not specified	With substance abuse
G.R.O.W.T.H.	Post-release aftercare services in either residential or day treatment setting for female youth	Kaye Harris, Director The Boys & Girls Clubs of South Alabama, Inc. 1102 Government Street Mobile, AL 36604 251-479-7011 kharris@bgcsouthal.org www.bgcsouthal.org/	13 - 17	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, Hispanic	Not specified
Helping the Noncompliant Child	Intervention with parents	Rex Forehand, Ph.D. University of Vermont Department of Psychology 230 Dewey Hall 2 Colechester Avenue Burlington, VT 05405 802-656-8674	3 - 8	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Incredible Years	School based, with parental involvement	Lisa St. George Administrative Director The Incredible Years 1411 8th Avenue West Seattle, WA 98119 Phone and Fax: (206) 285-7565 Toll-free Phone and Fax: (888) 506-3562 Email: incredibleyears@seanet.com http://www.incredibleyears.com/	2 - 8	Hispanic, Asian-American, African-American	Not specified
Leadership and Resiliency Program (LRP)		Laura Yager, M.Ed., LPC, CPP-ATOD Alcohol and Drug Services Fairfax-Falls Church Community Services Board 3900 Jermantown Road, Suite 200 Fairfax, VA 22030 703-934-5476 Email: Laura.Yager@fairfaxcounty.gov	14 - 19	Not specified	Not specified
Linking the Interests of Families and Teachers (LIFT)	School Based with parental involvement	John Reid, Ph.D. Senior Scientist Oregon Social Learning Center 160 East 4th Avenue Eugene, OR 97401 541-485-2711	5 - 11	Not specified	Not specified
Living with Children (parent training)		Material: Research Press, Inc. 800-519-2707 rp@researchpress.com	3 - 12	Not specified	Not specified
Lucas County Intensive Supervision Unit	only nonviolent felony offenders committed for the first time	Sandy Strong Lucas County Intensive Supervision Unit 429 North Michigan Avenue Toledo, OH 43624 (419) 213-6663 sstron@co.lucas.oh.us	13 - 18	Not specified	Not specified
Montreal Longitudinal Study/Preventive Treatment Program	Boys	Richard E. Tremblay University de Montreal Faculte des Arts et des Sciences GRIP 3050 Boulevard Eduoard-Monpetit, C.P. 6128 Montreal, Quebec, Canada H3C 317 514-343-6963	Not specified	Not specified	Not specified
Multidimensional Treatment Foster Care (MTFC)	Teenagers with histories of chronic and severe criminal behavior at risk of incarceration	Patricia Chamberlain, Ph.D. Principal Investigator Clinic Director Oregon Social Learning Center 207 East 5th Street, Suite 202 Eugene, OR 97401 541-485-2711	Not specified	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, and Hispanic	Not specified
Multisystemic Therapy	Home based	Scott W. Henggeler, Ph.D. Director, Family Services Research Center Medical University of South Carolina Department of Psychiatry and Behavioral Sciences 171 Ashley Avenue, Annex III Charleston, SC 29425-0742 843-876-1800	12 - 17	Not specified	With substance abuse

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
North Carolina Intensive Protection Supervision Project	designed for status offenders deemed at high risk of becoming serious, violent, and chronic offenders	Thomas Danek Organization: North Carolina Intensive Services Division P.O. Box 2448 Raleigh, NC 27602 919-662-4738 Fax: 919-662-431	0 - 14	African - American, and White	Not specified
Orange County Repeat Offender Prevention Program	first-time offenders no older than 15½ who exhibit at least three risk factors	Shirley Hunt, Ph.D. Orange County Probation Department P.O. Box 10260 Santa Ana, CA 92711 714-569-2174 shirley.hunt@ocgov.com	8-15 years	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, and Hispanic	Not specified
Oregon Social Learning Center (OSLC) Multidimensional Treatment Foster Care (TFC) Program		Mark Eddy Oregon Social Learning Center 160 E. 4th Avenue Eugene, OR 97401 541-485-2711 marke@oslc.org	13 - 19	Not specified	Not specified
P	Foster Care Setting	http://oslc.org	0 - 12	Not specified	Not specified
Parent Child Interaction Therapy		Network sites where PCIT training is currently being provided: 1. Lisa Connelly, MA, (Frank Putnam, MD, PI) Trauma Treatment Replication Center, Cincinnati Children's Hospital Medical Center (513) 636-0041 Lisa.Connelly@cchmc.org 2. Dolores Subia Bigfoot, PhD, Indian Country Child Trauma Center, University of Oklahoma Health Sciences Center, (405) 271-6824, ext. 45138. dee-bigfoot@ouhsc.edu. Website: www.pcit.org (Sheila Eyberg, PhD, at the Child Study Lab, Department of Clinical and Health Psychology, University of Florida)	2 - 7	Spanish, currently being adapted for use with Native American families.	Not specified
Parent Management Training-Oregon	Parents and children	Patricia Chamberlain, Ph.D., Oregon Social Learning Center 160 East 4th Street Eugene, OR 97401 541-485-2711 pattic@oslc.org www.oslc.org	Not specified	Not specified	Not specified
Parent Training	Parents and children	Sheila M. Eyberg University of Florida seyberg@hp.ufl.edu	Not specified	Not specified	Not specified
Parent-Child Interaction Training	Home-based	Joseph Strayhorn, Ph.D. Early Childhood Behavior Disorders Clinic 1 Allegheny Square, Suite 414 Pittsburgh, PA 15212	5 - 6	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Problem Solving Skills Training (also combined with Parent Management Training)		Alan E. Kazdin, John M. Musser Professor of Psychology, Institute of Social & Policy Studies, Director of Child Conduct Clinic, Director of Child Study Center; Ph.D., 1970, Northwestern University. Primary area = Clinical Departmental Information, Lab Page Alan.Kazdin@yale.edu, 203-432-9993, Office = K 210	Not specified	Not specified	Not specified
Rational Emotive Therapy		Materials and TA: Albert Ellis Institute 45 East 65th Street New York, NY 10021 800-323-4738 or 212-535-0822 Resource materials are available	13 - 18	Not specified	Not specified
Reinforced Practice		Thomas Ollendick, Ph.D. 460 Turner Street, Suite 207 540-231-6451; tho@vt.edu	4 - 12	Not specified	Not specified
Structural Family Therapy		Jose Szapocznik, Ph.D. (Contact for general program information) Victoria Mitrani, Ph.D. (Contact for general program information) Center for Family Studies 1425 Northwest 10th Avenue 3rd Floor Miami, FL 33136 305-243-4592 vmitrani@mednet.med.miami.edu	Not specified	Hispanic families	behavioral and alcohol or drug problems Time-out Plus Signal Seat
Treatment Foster Care		Patricia Chamberlain, Ph.D., Director Oregon Social Learning Center 160 East Fourth Street Eugene, OR 97401 541-485-2711 Pattic@oslc.org http://www.oslc.org	11 - 18	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, and Hispanic	Not specified
Videotaped Modeling Parent Training	Child and parents	Materials, TA and Training (888) 506-3562 www.incredibleyears.com Materials and training provided by the developers of the Incredible Years. Many different programs and associated materials are listed on the website.	9 - 18	Not specified	Not specified

Appendix L. Substance Abuse

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Adolescent Portable Therapy		Jean Callahan, Director APT Organization: Vera Institute of Justice 233 Broadway, New York, NY 10279 212-376-3035 jcallahan@vera.org http://www.vera.org	0 - 16	Not specified	Not specified
Aftercare Services		No named program referenced	0 - 14	Not specified	Not specified
Behavior Therapy		No named program referenced	6 - 18	Not specified	Co-occurring with Mental Health
Brief Strategic Family Therapy (BSFT)		Jose Szapocznik, Ph.D. (Contact) Carleen Robinson-Batista 1425 NW 10th Avenue, Third Floor Miami, Florida 33136 305-243-2226 Fax: 305-243-5577	6 - 17	Hispanic; African-American	Co-occurring with Mental Health
Cognitive Behavioral Therapy (CBT)		www.kpchr.org/public/acwd/acwd.html	Not specified	Not specified	Co-occurring with Mental Health
Family Systems		Stacy Kong (808) 973-1112 stacy.kong@fhsd.health.state.hi.us	Not specified	Not specified	Not specified
Functional Family Therapy	Family-based	Holly deMaranville, Communications Coordinator Functional Family Therapy, LLC 2538 57th Avenue, SW Seattle, WA 98116 206-369-5894 hollyfft@attbi.com	11 - 18	Not specified	Co-occurring with Mental Health
Integrated Cognitive-Behavior Therapy for Traumatic Stress Symptoms	Simultaneous treatment of PTSD and substance abuse	Barbara J Burns Box 3454 Med Center Durham, NC 27710 919-687-4676 x 243 bjb@geri.duke	Is being developed for children	Not specified	Tailored for Co-occurring PTSD and substance abuse
Maine Juvenile Drug Treatment Court	Post plea, but pre-final description	Hon. Keith A. Powers Maine District Court P.O. Box 412 Portland, ME 04112 207-822-4269 ruth.harris@maine.gov http://www.courts.state.me.us/mainecourts/drugcourt/juvenile.html	13 - 18	Not specified	Not specified
Maricopa County Juvenile Drug Court		Steve Carpenter Maricopa County Juvenile Courts 3125 West Durango Phoenix, AZ 85009 602-506-2528 602-506-3627 stevecar@juvenile.maricopa.gov	13 - 17	Hispanic, White	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Multidimensional Family Therapy	Family-based	Howard A. Liddle, Ed.D. Center for Treatment Research on Adolescent Drug Abuse University of Miami School of Medicine 1400 N. W. 10th Avenue, Suite 1108 P.O. Box 019132 Miami , FL 33101 305-243-6434 hliddle@med.miami.edu	11-18	African - American, White, and Hispanic	Co-occurring with Mental Health
Multimodal Substance Abuse Prevention	Males in residential placement or education setting	Alfred Friedman, Ph.D. Belmont Center 4200 Monument Road Philadelphia, PA 19131 215-877-6408 friedman@aehn.einstein.edu	13-18	74% African-American, 15% White, 8% Puerto Rican, and 2% Asian	Not specified
Multisystemic Therapy for Juvenile Offenders	Home based	Marshall E. Swenson, MSW, MBA Manager of Program Development, MST Services 710 J. Dodds Blvd. Mt. Pleasant, SC 29464 marshall.swenson@mstservices.com 843-856-8226 http://www.mstservices.com/	Not specified	Not specified	Not specified
Orange County Juvenile Substance Abuse Treatment Court		Robert Hudson, Presiding Judge Orange County Probation Department 341 The City Drive Santa Ana, CA 92868-3209 714-935-7000 lmorfin@occourts.org	0 - 18	Not specified	Not specified
Structural Family Therapy		Jose Szapocznik, Ph.D. (Contact for general program information) Victoria Mitrani, Ph.D. (Contact for general program information) Center for Family Studies 1425 Northwest 10th Avenue, 3rd Floor Miami, FL 33136 305-243-4592 vmitrani@mednet.med.miami.edu	Not specified	Hispanic families	with behavioral and alcohol or drug problems
Treatment Foster Care		Patricia Chamberlain, Ph.D., Director Oregon Social Learning Center 160 East Fourth Street Eugene, OR 97401 541-485-2711 Pattic@oslc.org http://www.oslc.org	11 - 18	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, and Hispanic	Not specified

Appendix M. Autism

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Functional Communication Training (FCT) and Applied Behavior Analysis (ABA)	Implemented in school	FCT Materials and TA: Guilford Press 800-365-7006 info@guilford.com Book available on website entitled "Severe Behavior Problems: A Functional Communication Training Approach" TA: Dr. Mark Durand 727-553-4814 ABA Materials and TA: Institute for Applied Behavior Analysis 310-649-0499 www.iaba.com Books and videos available through website; TA also available through website	2 - 15	Not specified	Not specified
Pivotal Response Training	Parent Education	autism@education.ucsb.edu UCSB Koegel Autism Center Graduate School of Education UC Santa Barbara Santa Barbara, CA 93106 805-893-2049	0 - 8	Not specified	Not specified
TEACCH (pre-school age)	School and home based	Materials and TA: Division TEACCH Dr. Gary B. Mesibov Gary_Mesibov@unc.edu www.teacch.com Materials in the form of videos, journal articles, teaching kits, and assessments available through the website; TA also available through the website http://www.teacch.com/mainpage.htm	"pre-school age"	Not specified	Not specified
The PLAY Project (2 -6 years)		Materials and TA: The P.L.A.Y Project The Ann Arbor Center for Developmental and Behavioral Pediatrics 734-997-9088 www.playproject.org CD Rom workshop including seminars, workshops, and techniques available through website; TA also available through website.	1.5 - 6	Not specified	Not specified
UCLA Young Autism Project (YAP) (under 4 years)		UCLA 310-825-2961 310-840-5983 lovaas@psych.sscnet.ucla.edu	0 - 4	Not specified	Not specified

Appendix N. Emotional and Behavioral Disorders (including SED and miscellaneous)

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Children in the Middle	Children's reaction to divorce (Adjustment Disorder)	Donald A. Gordon, Ph.D Center for Divorce Education 1005 East State Street, Suite G P.O. Box 5900 Athens, OH 45701 740-593-9505 Toll-free: (866) 234-WISE (9473) gordon@mind.net www.divorce-education.com/ Family Works Inc., West 583 Prim Street Ashland, OR 97520 familyworks@familyworksinc.com http://www.divorce-education.com/ http://www.childreninthemiddle.com/index.htm	3 - 15	Not specified	Not specified
Dialectical Behavior Therapy Program for Incarcerated Female Juvenile Offenders	Incarcerated female youth; residential setting (Borderline Personality)	Brad Beach Echo Glen Children's Center 33010 Southeast 99th Street Snoqualmie, WA 98065 425-831-2500 beachbr@dshs.wa.gov	9 - 20	African - American, White, American Indian / Alaskan, Hispanic	Not specified
Family Therapy This is a generic strategy. If you are interested in reviewing a program that includes family therapy as a strategy, please review the following programs: * Brief Strategic Family Therapy * Functional Family Therapy Program * Home-Based Behavioral Systems Family Therapy * Multisystemic Therapy	(Emotional disturbed children)	Order a copy of CSAP's Family Centered Approaches from National Technical Information Systems, (800) 553-6847. The practitioners guide is $29.50, order #PB 98159692. The reference guide is $58.00, order #PB 99101800	Not specified	Not specified	With substance abuse
Filial (Play) Therapy	Parents and children (Emotionally disturbed children)	Filial (Play) Therapy Landrety, G.L. (2002) Play therapy: The art of the relationship (2nd ed.) New York: Brunner Routledge.	Not specified	Not specified	Not specified
Intensive/ Regular Case Management	(non-specific diagnosis)	No one manual exists for case management. A variety of studies have outlined four program requirements, but more evaluation is needed to understand more fully what form these components should take. The four components are: Organizational arrangements; identification of the target population; selection, preparation, and support of case managers, resource requirements.	Not specified	Not specified	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Mentoring	(Severe emotional Disorder)	Big Brothers, Big Sisters is an organization that trains mentors before they work with a child. Big Brothers Big Sisters National Office 230 North 13th St. Philadelphia, Pa 19107 www.bbbsa.org 215-567-7000 Information about becoming a mentor available through website	10 - 16	"50% minority"	
Multidimensional Family Therapy	Family-based	Howard A. Liddle, Ed.D. Center for Treatment Research on Adolescent Drug Abuse University of Miami School of Medicine 1400 N. W. 10th Avenue, Suite 1108 P.O. Box 019132 Miami , FL 33101 305-243-6434 hliddle@med.miami.edu	11-18	African - American, White, and Hispanic	With substance abuse
Multisystemic Therapy	Home based (Sexual Offenders)	Marshall E. Swenson, MSW, MBA Manager of Program Development, MST Services 710 J. Dodds Blvd. Mt. Pleasant, SC 29464 marshall.swenson@mstservices.com 843-856-8226 http://www.mstservices.com/	Not specified	Not specified	Not specified
Structural Family Therapy		Jose Szapocznik, Ph.D. (Contact for general program information) Victoria Mitrani, Ph.D. (Contact for general program information) Center for Family Studies 1425 Northwest 10th Avenue 3rd Floor Miami, FL 33136 305-243-4592 Fax: 305-243-5577 Email: vmitrani@mednet.med.miami.edu	Not specified	Hispanic families	with behavioral and alcohol or drug problems
Think Time Strategy	School Based (seriously emotionally disturbed (SED) students)	J. Ron Nelson Ph.D. Research Professor University of Nebraska, Lincoln Center for At-Risk Children Services Barkley Center Lincoln NE 68583-0738 402-472-0283 Fax: 402-472-7697 E-mail:rnelson8@unl.edu	5 - 14	Not specified	Not specified
Treatment Foster Care		Patricia Chamberlain, Ph.D., Director Oregon Social Learning Center 160 East Fourth Street Eugene, OR 97401 541-485-2711 Pattic@oslc.org http://www.oslc.org	11 - 18	African - American, Asian / Pacific Islander, White, American Indian / Alaskan, and Hispanic	Not specified

Name of Program or Practice	Specific population/ setting	Program Availability (contact info.)	Age group	Ethnic populations	Co-occurring populations
Wrap Around	(Emotional and Behavioral Disorders)	No one manual exists for wraparound, but ten essential elements and ten requirements for practice have been outlined by wraparound leaders and advocates. Three training approaches have been developed. The first is the PEN-PAL affiliated with East Carolina University is for agency staff and is manualized. A higher education training program at the Program in Community Mental Health at Trinity College in Vermont. The third, in which states are heavily relying, is a train the trainer model with a manual and videotapes.	0 - 18	Not specified	Not specified
Wrap Around Foster Care	Out-of-home setting (Emotional and Behavioral Problems)	Seraaj Family Homes, Inc. Corporate Office P. O. Box 230550 400 Cotton Gin Rd Montgomery, Al 36117 334-271-2402 info@seraajfh.com http://www.seraajfh.com/contact.htm	0 - 18	Not specified	Not specified
Wraparound Milwaukee	(Serious emotional disturbances)	Bruce Kamradt - Director 9201 Watertown Plank Road Milwaukee, WI 53226 414-257-7611	Not specified	African-American, Asian/Pacific Islander, White, Hispanic	Not specified

Appendix O. Family Case Management Survey

Family Perspectives on Service Coordination

Hello! This survey is about practices that help families with children or youth who have a serious mental health challenge to get access to coordinated services. These practices are known by many different names. These names include: care coordination, service coordination, case management, care management. All these services share the goal of providing a full range of coordinated services for a child or youth. This survey is being conducted by the Department of Children and Families at the University of South Florida's Louis de la Parte Florida Mental Health Institute.

We want to identify promising practices in service coordination for children with serious mental health challenges. To do that, we are distributing surveys both locally (in Florida) and nationally. We value your knowledge as a family member affected by how services are provided. The goal of this effort is to identify the core elements of effective service coordination practice. We will then develop a coaching intervention. This coaching intervention will help service providers use these principles in their service system.

You have been identified as a family member of a child/youth with a serious mental health challenge. That is why you are being asked to take this survey.

This survey should take no longer than thirty minutes.

Survey Information and Informed Consent

Before you can take this survey, we need to have your informed consent. The statements below describe this study and how its data will be stored, analyzed, and used. By responding yes to the statements below, you are giving your informed consent to participate.

1. Survey Participation:

- ☐ I understand that I am being asked to take a short survey. This survey is about my family's experiences with case management.
- ☐ I understand that I will not be paid for my participation in this survey.
- ☐ I understand that this study will provide new information about case management. The results will be used to find effective ways of providing services for families
- ☐ I understand that there are no known risks involved in my participation.
- ☐ I understand that my participation is my choice. I understand that I may leave the study at any time.
- ☐ I understand that if I withdraw or choose not to participate that there will be no penalty or loss of benefits that I am entitled to receive.

2. Data Management:

- ☐ I understand that these research records will be kept confidential to the extent of the law.
- ☐ I understand that reports and articles are expected to be written as a result of this study. In these reports, individual participants will NOT be identified.
- ☐ I understand that only the research team at the Louis de la Parte Florida Mental Health Institute will have access to the data. Certain persons may inspect the data. These people are: authorized research personnel, agents of the Department of Health and Human Services, and the USF Institutional Review Board.
- ☐ I understand that the survey data will be stored in secure, locked filing cabinets at the University of South Florida, Florida Mental Health Institute.

3. Additional Information:

- ☐ If I have any questions about this research study, I may contact the Principal Investigator or Research Coordinator. Robert Friedman, Ph.D. is the Principal Investigator. Melissa Van Dyke is the Research Coordinator. They may be reached at 813-974-8807.
- ☐ If I have questions about my rights as a person who is taking part in a research study, I may contact the University of South Florida, Division of Research Compliance at (813) 974-5638.

4. Consent to Take Part in this Research Study

I freely give my consent to take part in this study. I understand that this is research. I have received a copy of this consent form.

☐ Yes ☐ No

______________________________	______________________________	____________
Signature of person taking part in study	Printed Name of person taking part in study	Datte

Statement of Person Obtaining Informed Consent

I have carefully explained to the person taking part in the study what he or she can expect. The person who is giving consent to take part in this study

- Understands the language that is used.
- Reads well enough to understand this form. Or is able to hear and understand when the form is read to him or her.
- Does not have any problems that could make it hard to understand what it means to take part in this study.
- Is not taking drugs that make it hard to understand what is being explained.

To the best of my knowledge, when this person signs this form, he or she understands:

- What the study is about.
- What needs to be done.
- What the potential benefits might be.
- What the known risks might be.
- That taking part in the study is voluntary.

______________________________	______________________________	____________
Signature of Investigator	Printed Name of Investigator	Datte

Service Experience

On the next pages, we will ask you several questions. These questions are about your experiences and preferences with service coordination / case coordination / case management.

The person who is supposed to help your family find and coordinate services has many titles. In some agencies, this person is called the "Case Manager." In other agencies, this person is called the "Service Coordinator." Other agencies use other titles (System Navigator, Case Coordinator). In this survey, we will call this person the "service coordinator."

What that person does has also been called by different names. Some agencies call it "case management." Others call it "service coordination." Still others call it other names (system navigation, case coordination). In this survey, we will use the same name for all of those services. We will call all of them "service coordination."

1. Have you ever had service coordination/case coordination/case management services for your child or youth?

☐ Yes ☐ No *If "No," turn the page. If "Yes," go to page 14.*

Service Experiences and Desired Services

You have indicated that you have never had service coordination services for your child or youth with a serious mental health challenge.

The questions on this page ask about the types of service experiences you feel would be helpful to your child or youth.

1. Would you like to have a person to help you access and coordinate services for your child/youth?

☐ Yes ☐ No *If "No," turn the page. If "Yes," go to page 9.*

1. What kinds of assistance would be helpful in terms of getting the supports that you need for your child / youth?

____

____

____

2. If you were to receive help from a mental health service provider, how important would it be for the provider to:

Note: For each of these questions, you may select the "N/A" (Not Applicable) box if you feel you cannot answer the question.

	Very Unimportant	**Unimportant**	**Neutral**	**Important**	**Very Important**	**N/A**
Understand my culture	☐	☐	☐	☐	☐	☐
Speak my language	☐	☐	☐	☐	☐	☐
Respect my beliefs	☐	☐	☐	☐	☐	☐
Treat me and my child/youth with respect	☐	☐	☐	☐	☐	☐
Respect my wishes to keep certain information private	☐	☐	☐	☐	☐	☐
Be available 24 hours a day	☐	☐	☐	☐	☐	☐
Be able to meet with me face-to-face	☐	☐	☐	☐	☐	☐
Be the same Provider over time (low job turnover)	☐	☐	☐	☐	☐	☐
Help me understand my child/youth's difficulties	☐	☐	☐	☐	☐	☐
Let me set service plan goals for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get services for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get desired crisis services	☐	☐	☐	☐	☐	☐
Attend meetings with me when I am uncomfortable going alone	☐	☐	☐	☐	☐	☐
Be able to explain my child / youth's needs to other professionals	☐	☐	☐	☐	☐	☐

Go to NOMINATION AND FEEDBACK page 24!

Participant Would Like a Service Coordinator: Follows From Page 6.

1. Who would you be most comfortable talking to and working with to find and access services:

   Choose One:

   - ☐ A professional from the Mental Health system
   - ☐ Another parent who has a child with similar needs
   - ☐ A team of professionals from several disciplines
   - ☐ A team consisting of one parent and one professional
   - ☐ Other (Please explain):______________________________

2. How important would it be for the Service Coordinator (whether that is another family member, service professional, or team) to:

	Very Unimportant	Unimportant	Neutral	Important	Very Important	N/A
Understand my culture	☐	☐	☐	☐	☐	☐
Speak my language	☐	☐	☐	☐	☐	☐
Respect my beliefs	☐	☐	☐	☐	☐	☐
Treat me and my child/youth with respect	☐	☐	☐	☐	☐	☐
Respect my wishes to keep certain information private	☐	☐	☐	☐	☐	☐
Be available 24 hours a day	☐	☐	☐	☐	☐	☐
Be able to meet with me face-to-face	☐	☐	☐	☐	☐	☐
Be the same Provider over time (low job turnover)	☐	☐	☐	☐	☐	☐
Help me understand my child/youth's difficulties	☐	☐	☐	☐	☐	☐
Let me set service plan goals for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get services for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get desired crisis services	☐	☐	☐	☐	☐	☐
Attend meetings with me when I am uncomfortable going alone	☐	☐	☐	☐	☐	☐
Be able to explain my child / youth's needs to other professionals	☐	☐	☐	☐	☐	☐

3. What are the best times for you to meet with a service coordinator? (Choose One)

   - ☐ Morning hours (between 7 and 10 AM)
   - ☐ Late Morning and Early Afternoon (10 AM to 2 PM)
   - ☐ Afternoon (2 PM to 5 PM)
   - ☐ Evening (5 PM to 9 PM)
   - ☐ After 9 PM
   - ☐ Varies

4. What else should a service coordinator know before they begin to work with a family?

____

____

____

5. What should agencies and agency staff do to make sure that your choices are the true focus of services? (By 'your choices' we mean the services and outcomes you desire).

____

____

____

6. What have been the most frustrating things about receiving services for your child/youth?

____

____

____

7. What have been the most frustrating things about receiving services for your child/youth?

____

____

____

8. What have been the most helpful actions persons / professionals have taken to assist your child or youth?

____

____

____

Go to NOMINATION AND FEEDBACK page 24.

Parents Who Have Received Case Managemenet Services:

1. Have you received service coordination services in the past two years?

   ☐ Yes ☐ No

2. How were you first referred for service coordination services? Through:

   ☐ School
   ☐ Florida Department of Children and Families
   ☐ Juvenile Justice
   ☐ Local Community Mental Health Agency
   ☐ Other: ________________________________

3. Who provided service coordination services:

   ☐ A professional from the Mental Health system
   ☐ Another parent who has a child with similar needs
   ☐ A team of professionals from several disciplines
   ☐ A team consisting of one parent and one professional
   ☐ Other: ________________________________

4. Where would you most prefer to meet with a service coordinator?

   ☐ At home
   ☐ At Child / Youth's School
   ☐ Community setting (i.e., church or community center)
   ☐ At the Mental Health agency
   ☐ Other: ________________________________

5. What are the best times for you to meet with a service coordinator? (Choose One)

   ☐ Morning hours (between 7 and 10 AM)
   ☐ Late Morning and Early Afternoon (10 AM to 2 PM)
   ☐ Afternoon (2 PM to 5 PM)
   ☐ Evening (5 PM to 9 PM)
   ☐ After 9 PM
   ☐ Varies

6. What qualities are most important in a service coordinator?

   ____

   ____

   ____

   ____

   ____

   ____

Service Ratings

These next questions ask you to rate the types of services you may have received, as well as how they were delivered.

PLEASE READ ALL ANSWER CHOICES CAREFULLY BEFORE ANSWERING: THE ANSWER CHOICES YOU ARE GIVEN CHANGE WITH EACH SET OF QUESTIONS.

Note: you may select the "N/A" (Not Applicable) box if you did not receive the service or feel you cannot answer the question.

1. **Rate how much you agree or disagree with each statement about your experience with your child / youth's service coordinator(s):**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Consistently available, easy to contact	☐	☐	☐	☐	☐	☐
Available in times of crisis	☐	☐	☐	☐	☐	☐
Easy to talk to	☐	☐	☐	☐	☐	☐
Held meetings at convenient times	☐	☐	☐	☐	☐	☐
Made sure I was able to attend meetings	☐	☐	☐	☐	☐	☐

2. **Please rate how much you agree or disagree with each statement about your child / youth's service coordinator(s):**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Treated me and my child/youth with respect	☐	☐	☐	☐	☐	☐
Showed respect for my family's religious beliefs	☐	☐	☐	☐	☐	☐
Showed he/she really cared for my child / youth	☐	☐	☐	☐	☐	☐

3. **My child / youth's service coordinator(s):**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Helped me better understand my child's behavior or diagnosis	☐	☐	☐	☐	☐	☐
Gave me a sense of hope about my child / youth	☐	☐	☐	☐	☐	☐
Let me choose services and direct treatment plan	☐	☐	☐	☐	☐	☐

4. **My child / youth's service coordinator(s):**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Helped me communicate with school staff	☐	☐	☐	☐	☐	☐
Obtained needed classroom/school supports	☐	☐	☐	☐	☐	☐
Helped me communicate with mental health professionals	☐	☐	☐	☐	☐	☐
Helped communicate with other service system staff about my child's support needs	☐	☐	☐	☐	☐	☐

5. **My child / youth's service coordinator(s):**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
Found a local mentor or role model for my child / youth	☐	☐	☐	☐	☐	☐
Found positive community activities for my child / youth	☐	☐	☐	☐	☐	☐
Was creative in finding services for my child / youth	☐	☐	☐	☐	☐	☐

6. **Please rate the importance of each service component:**

	Very Unimportant	Unimportant	Neutral	Important	Very Important	N/A
Understand my culture	☐	☐	☐	☐	☐	☐
Speak my language	☐	☐	☐	☐	☐	☐
Respect my beliefs	☐	☐	☐	☐	☐	☐
Treat me and my child/youth with respect	☐	☐	☐	☐	☐	☐
Respect my wishes to keep certain information private	☐	☐	☐	☐	☐	☐
Be available 24 hours a day	☐	☐	☐	☐	☐	☐
Be able to meet with me face-to-face	☐	☐	☐	☐	☐	☐
Be the same Provider over time (low job turnover)	☐	☐	☐	☐	☐	☐
Help me understand my child/youth's difficulties	☐	☐	☐	☐	☐	☐
Let me set service plan goals for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get services for my child / youth	☐	☐	☐	☐	☐	☐
Be able to get desired crisis services	☐	☐	☐	☐	☐	☐
Attend meetings with me when I am uncomfortable going alone	☐	☐	☐	☐	☐	☐
Be able to explain my child / youth's needs to other professionals	☐	☐	☐	☐	☐	☐

1. What should agencies and agency staff do to make sure that your choices (the services and outcomes you desire) are the true focus of services?

____

____

2. What have been the most frustrating things about receiving services for your child/youth?

____

____

3. What have been the most helpful actions of your child / youth's service coordinator(s)?

____

____

4. Was there ever a time you needed a specific service for your child / youth, and it was not available?
   - ☐ Never
   - ☐ Almost Never
   - ☐ Sometimes
   - ☐ Very Often
   - ☐ Always
5. What else should a supports coordinator know before they begin to work with a family?

   ____

   ____

   ____

Nomination and Feedback

Here you have a chance to list programs that you think are doing particularly good work. These should be programs that help children or youth with mental health challenges.

We also give you the opportunity to give us feedback about this survey.

1. Please list programs that you know of that are doing a great job of helping children and youth with serious mental health challenges. These are programs that you would feel good about referring another family to for help. Please list the program name. Please also list where it is located.

   Program#1:______________________________________

   Location of Program #1:__________________________

   Program #2:_____________________________________

   Location of Program #2:__________________________

   Program #3:_____________________________________

   Location of Program #3__________________________

2. Is there any important information that you would like to share that was not covered in the survey?

   ____

   ____

   ____

Thank You!

We greatly appreciate the time you took and the feedback you have provided.

If you would like to receive a copy of our findings, please contact Melissa Van Dyke, Project Coordinator. You can reach her by telephone at (813) 974-8807, or by email at: VanDyke@fmhi.usf.edu

Appendix P. Importance of Specific Qualities of Care Coordinator

QUALITY OF CARE COORDINATOR	AVERAGE IMPORTANCE[a]
Coordinator understands my culture	3.8
Coordinator speaks my language	4.8
Coordinator respects my beliefs	4.2
Coordinator treats me and my child/youth with respect	4.6
Coordinator respects my wishes to keep certain information private	4.6
Coordinator available 24 hours a day	3.8
Coordinator able to meet with me face-to-face	3.8
Same Coordinator over time (low job turnover)	4.4
Coordinator helps me understand my child/youth's difficulties	4.3
Coordinator lets me set service plan goals for my child / youth	4.2
Coordinator able to obtain services for my child / youth	4.4
Coordinator able to obtain desired crisis service	4.3
Coordinator attends meetings with me when I am uncomfortable going alone	4.8
Coordinator able to communicate my child / youth's needs to other professionals	4.8
AVERAGE	4.3

[a] The Average Importance is rated on a five point scale in which 1 = Very Unimportant, 3 = Neutral, and 5= Very Important.

Appendix Q. Recent Case Management Service Experiences

DOMAIN	AVERAGE AGREEMENT[a]
INVOLVEMENT AND AVAILABILITY	
Consistently available, easy to contact:	3.4
Available in times of crisis	3.4
Easy to talk to	4
Held meetings at convenient times	4.1
Made sure I was able to attend meetings	3.9
RESPECT	
Treated me and my child / youth with respect	3.5
Showed respect for my family's religious beliefs	4
Showed he/she really cared for my child / youth	3.2
HOPE/CONTROL	
Helped me better understand my child's behavior or diagnosis	3.8
Gave me a sense of hope about my child / youth	3.4
Let me choose services and direct treatment plan	3.3
COMMUNICATION	
Helped me communicate with school staff	3.4
Obtained needed classroom/school supports	3.1
Helped me communicate with mental health professionals	3.2
Obtained needed mental health supports	3.3
Helped communicate with other service system staff about my child's support needs	3.1
INFORMAL SERVICES	
Found a local mentor or role model for my child / youth	3
Found positive community activities for my child / youth	3.1
Was creative in finding services for my child / youth	3

[a] The Average Agreement is rated on a five point scale in which 1 = Strongly Disagree, 3 = Neutral, and 5= Strongly Agree.

Appendix R. Case Management and CAFAS-Eight Scale Functioning

Program	Time Point	Outcome	Sample Size	Comparison Group
Hamilton Co., OH Hamilton County Mosaic Project	Discharge [a]	-60 points [b]	106	None
Hawaii Child and Adolescent Mental Health Division	Discharge [c]	-37 points	1,644	None
Indiana DAWN Project	24 months	-20 points	Not stated	None
Massachusetts Coordinated Family Focused Care	9 months [d]	- 41.2 points	138	None
Massachusetts Mental Health Service Program for Youth-Massachusetts	18 months	- 30 points	48	None
Milwaukee, WI Wraparound Milwaukee	12 months [e]	See Footnote [f]	439	None
Nebraska Region III Professional Partners Program [g]	Discharge [h]	-51.10 points -45.9 points	44 246 (MST)	None
Nevada Wraparound in Nevada	18 months	-35 points - 2 points	33 Wraparound Case Management 32 Services-as-usual	Services-as-usual group
Pennsylvania Intensive Mental Health Program	Discharge [i]	-60 points	50	None

[a] The Hamilton County Indicators Report indicates that average enrollment time is 12-15 months (p. 24), however, the average length of service receipt for this group is unknown.

[b] This represents the Median change score for this sample, from enrollment to discharge, for youth with at least nine months of service receipt. The attrition rate previous to nine months is unknown.

[c] The assessment of change compares two distinct populations: children / youth entering services and children / youth exiting services. Thus the data do not describe intra-individual change. Additional analyses of intra-individual change (N = 193) demonstrated change scores in the range of -19 to -43 points across different levels of care (Daleiden & Tolman, 2005, p. 27).

[d] Data are from Taub, Banks, Smith & Breault (2006, p. 346).

[e] Data analyses from Milwaukee do not account for attrition from the program over time; it is unclear if or how substantially attrition would affect these findings.

[f] The Milwaukee system reports a 22-point drop in CAFAS-rated dysfunction over time. However, these data are from the 5-scale CAFAS; results using the 8-scale CAFAS would indicate larger reductions,in dysfunction, similar in size to reductions seen in the Massachusetts and Nebraska systems.

[g] All data from the most recent report of the Professional Partners Program, August, 2005.

[h] Average length of service in the Professional Partner Program is 13.19 months (2004 Annual Report, p. 6).

[i] The average discharge date is 12.61 months (Puddy, 2005 p. 42)