Children’s Mental Health: Service Array, Evidence-Based Practices, and Quality Improvement

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Executive Summary

Background and Methodology

The purpose of this study was to gather information that is practical and helpful for the state of Florida and for communities within Florida in improving their systems, services, and, most importantly, outcomes for children with mental health challenges and their families. Florida’s Agency for Health Care Administration (AHCA) was interested in three major research questions:

1. What is the current service array in Florida, and what should it be?
2. How can we develop an effective and feasible performance measurement/quality improvement (PM/QI) system?
3. How can we promote the implementation of best practices and Evidence-based Practices (EBP’s)?

To answer these questions, an online survey was administered to leadership from the 25 AHCA and Department of Children and Family (DCF) offices with follow up interviews with each of the 25 offices. These offices nominated providers in their Districts or Areas whom they felt were innovative, used Evidence-based Practices (EBP’s), or provided high-quality services. Thirty-three of the providers completed an online survey. The initial findings were summarized and presented to a parent focus group, a Hispanic parent focus group, a Florida Mental Health Institute (FMHI) Expert focus group, national experts and directors of exemplary communities and programs, and a state-wide stakeholders key informant group for their feedback. We were particularly interested in how the Florida results compared to the national picture.

Service Array and Access

There is a wide array of services in Florida. However, accessibility varies considerably depending on the type of service and population needing service. The more accessible services were well funded by Medicaid and had multiple sources of funding. These tended to be at the two ends of the continuum; outpatient therapy services and residential/out-of-home services. Less accessible services had less Medicaid funding as well as other sources of funding. These tended to be community-based services (e.g., family/care-giver support, mentoring, services to prevent out-of-home placement) or services related to populations of concern. Some well-funded services (Therapeutic group homes, crises services) were still viewed as less accessible.

Several populations were identified by many respondents as being very difficult to serve. They included: dual-diagnosis (developmental disabilities with borderline IQ/mental health issues), co-occurring substance abuse and mental health, serious behavior problems; sexual problems (perpetration, reactivity), very young children with behavioral issues, and youth labeled as having reactive attachment disorder.
Parents described a number of problems with the system from their perspective, describing the system as “fragmented,” and emphasizing a need for better coordination and communication between departments (e.g., Mental Health, Substance Abuse, Developmental Disabilities, and Education), providers, and families. Parents also reported that the waiting list for Developmental Services waiver eligibility and services was excessively long; and that funders needed to have a longer-term view of services. The medical model tends to think of short-term services and “cures,” while many children require extensive long-term services. Transitions from hospitals and residential settings to the family and community were viewed as problematic. The family members also identified major shortages both in qualified child psychiatrists and in service providers for non-traditional services (e.g., respite, recreation, tutors, and mentors) who understood the special needs of children with mental health challenges. Finally, parents wanted better access to Behavior Analysts and family support services.

Many of the issues parents raised were also cited by other respondents as barriers to service accessibility. In addition, they cited risk and liability issues, particularly for the harder to serve populations; the need for additional specialty training and expertise among providers; inadequate funding for specific services; and stigma. There was agreement on the existence of a vicious circle: Without more funding for an accessible array of community services there was a need for more intensive (and costly) restrictive settings, particularly for the more difficult-to-serve populations. Yet this consumed a large proportion of funds that could not then be allocated to the community services. Secondly, the provider need for billable hours dictated the service array. For instance, many home-based services, particularly in rural areas, negatively impacted agency funds because they could not bill for travel time.

According to the national experts, these same issues are typical for the rest of the nation. In fact, Florida has a better Medicaid plan and list of options than many states, as well as an excellent working relationship between AHCA and children’s mental health agencies. Consequently, there is a good foundation already in place in this state for improving the service array. These experts also presented a list of strategies to facilitate better service arrays and access:

- Strong interagency relationships and partnerships
- Inclusive planning
- Strong family organizations
- Systems that encourage a wide array of services so families actually have choice
- Evaluation data that is functional for decision-making and available to families
- State, District and local commitment and strong state leadership
- Redeployment from higher cost to lower cost services
- Pooled, flexible funding

Overall, data collected on the service array indicate that while there is a broad array of services being provided in Florida, there is a significant discrepancy between degree of need and capacity of the system to provide services. This is
particularly the case with home and community-based services that are more intensive than office-based outpatient services, and have the potential to maintain children in their families and communities. It is also the case with child and adolescent psychiatric services, family support services such as respite care and mentoring, and applied behavior analysis. It is recommended that a major thrust of efforts to improve the service array be focused on increasing accessibility to effective home and community-based services.

**Performance Measurement/Quality Improvement (PM/QI)**

There was universal agreement among the AHCA/DCF respondents that most data collection by Florida state officials is used for eligibility, accountability, monitoring, and billing purposes. Furthermore, Florida’s management information system is new and still has problems; so that the data are not yet “trusted” by many in the field. Most data collection by providers relates to the mandatory requirements of accreditation and licensing authorities. The outcome measures collected seem to be quite limited to measures such as “Children’s Functional Assessment Rating Scale (CFARS)” and “days in the community.” Similarly, little or no system outcome data are collected or used for purposes other than the monitoring of providers. Feedback was not given to providers, especially clinicians, in a timely manner and in a format they could readily use and understand to make decisions.

There are a number of barriers to achieving a good PM/QI system. There is a lack of training on how to use the current systems and PM/QI in general. It was seen by many to be something “somebody else” does. The lack of time was seen as a major barrier since staff at all levels perceived themselves to be over-burdened and perceived that the paper work was already onerous. This was complicated by the fact that it would take non-billable time to address PM/QI issues and providers were under heavy pressure to meet productivity standards. Since many staff had never received what they perceived to be useful information, there was no buy in by some stakeholders. The final major barrier was the lack of funding for the infrastructure, support, and staff to implement and maintain a good PM/QI system.

National experts agreed that the Florida case is typical in that very few states collected data that was used for PM/QI purposes. Hawaii and Michigan were the notable exceptions for states, and Wraparound Milwaukee, Family Central in Nebraska, and the Dawn Project in Indianapolis were programs that had exemplary PM/QI systems. One recommendation stemming from this study is that the state, District/Area and local entities should maximize the use of the current data system by collaborating on processes to access useful information. This information can then be used by programs and systems to compare their performance to other programs and systems as well as to the state as a whole.

The single most important conclusion is that effective PM/QI procedures, while they require an investment of money and human resources, can have a tremendously positive payoff in strengthening systems and services while improving outcomes for children with mental health challenges and their
families. It is highly recommended that Florida devote the resources and attention to the development and implementation of such a system, recognizing that it must be multi-faceted, and involve both the state and local levels. Characteristics of PM/QI systems that serve as effective decision support systems include

- Multiple measures that are relevant to the population of concern;
- Timely feedback presented in a format that is easy to understand and use;
- Collaborative development and monitoring by key stakeholders, including families and children served by the system;
- The ability to benchmark clinician and agency performance to others and the state as a whole;
- Feedback including detailed information on the progress of individual children and families in multiple domains, processes and structures;
- Data aggregated by clinician, program, agency, District and the state as a whole;
- Holding regular meetings with all stakeholders to share and discuss the data to identify problems and develop solutions;
- Public access to the data through publication and websites to foster accountability for performance;
- Using the information to develop individual, program and system capacity, not for punishment;
- Supporting the infrastructure necessary to develop and maintain the system; and
- Having a flexible data system so it can produce the information in the type of format suitable for the questions being asked (e.g., outcomes for different populations, by setting).

**Evidence-Based Practices and Programs in Florida**

National reviews by the U.S. Surgeon General, President’s New Freedom Commission on Mental Health, and the Institute of Medicine have recommended the increased use of Evidence-based Practices (EBP’s) and programs to help improve the overall quality of care nationally. In the survey of AHCA and children’s mental health program District personnel (N = 25), the respondents noted that the most prevalent children’s mental health EBP’s and programs in use in Florida are: stimulant medication for ADHD (identified by 59% of the respondents); anti-depressant medication for mood disorders (59%); cognitive behavior therapy (55%); life skills training (55%); behavioral parent training (52%); dialectical behavior therapy (30%); bullying prevention in the schools (30%); functional family therapy (30%); and positive behavior support in the schools (30%). Furthermore, respondents reported that state employees, providers and families all lacked adequate knowledge about EBP’s. Providers said that the greatest pressures to adopt EBP’s came from funding and oversight agencies, program supervisors and managers, accreditation and licensing authorities, as well as staff members themselves.
Mental health program staff reported that the lack of funding for services, start-up costs and ongoing infrastructure was a major barrier to greater use of EBP’s. In addition, there was a lack of awareness of the potential benefits, and either a lack of motivation or resistance to change. Finally, staff turnover was cited as a major obstacle. Providers agreed on the lack of funding for planning and technical assistance and the resistance to change as implementation barriers. They also felt the poor fit between program requirements and Medicaid reimbursement rules made the ongoing support of EBP’s a major challenge. Equally important was the lack of qualified staff and program-specific training for staff. Finally, the lack of staff time and buy in were seen as barriers.

The providers surveyed were nominated by the District/region staff as exemplary and these providers seemed to be well-informed of factors important to implementation of EBP’s and programs. Providers also indicated that their supervision ratios were available to support EBP’s, and that they had weekly supervision, often based on direct observation of the practitioner. On the other hand, there was little use of data to inform supervision or practice.

As with the other two areas of concern, national experts indicated that the situation in Florida is common to most states. The EBP’s that are used are generally adopted independently by programs and providers with few state-organized examples. States that have begun statewide efforts include Michigan, New Mexico, Ohio, Oklahoma, Oregon, and Washington.

One can conclude from the study that EBP’s could be used to provide services to the underserved populations noted in the survey. Another advantage is that EBP’s come equipped with fidelity measures that are useful in establishing good PM/QI Systems. Finally, EBP’s could be used to replace some areas of poor quality and to provide treatment to the most challenging populations. However, if the use of EBP’s is to be broad and systemic, and to go beyond the individual efforts of particular providers, there is a need for an infrastructure and support system to assist state staff and providers in determining the appropriate use of EBP’s, and then to implement them.

Conclusion

The data collected for this study both from within and outside of Florida clearly indicate, as is noted at the end of the section on service array, that it is possible to serve children more effectively and in less restrictive environments than their current settings. This can be accomplished with better outcomes and at less cost. However, to do so requires building community capacity for cross-system planning and collaboration, providing supports for community leaders, an infrastructure to support evidence-based interventions, and the creation of a data-based culture in which data on system performance are regularly collected and used to strengthen the system. If significant improvements are to be made system-wide, then it is important that the state undertake a comprehensive, multi-systemic effort to bring together key stakeholders, including families, at both the state and local level, to provide direction to such efforts. Although it is possible to make improvements in each of the areas studied here by focusing on them separately, the greatest gain
would be to move away from isolated efforts at change to a more comprehensive, multi-year effort and commitment to improve services and outcomes for children with mental health challenges and their families. Such an effort could start within one or two Districts, should include ongoing consultation and coaching, should focus on the service array, the performance measurement system, and the use of EBP’s, and should be combined with the development of a resource center to support the planning and service delivery efforts of communities throughout the state.
Background

Florida, like most states across the country, has been striving for the past 20 years to develop a network of effective community-based systems of care for children with emotional disturbances and their families (Stroul & Friedman, 1986). The Children's Workgroup of the Florida Commission on Mental Health and Substance Abuse, in its 2001 report, emphasized the importance of this, and indicated that, “the social and emotional well-being of children is the foundation for success in school, for positive peer relations, for constructive community involvement and community service, and, ultimately, for becoming productive, contributing, healthy adults” (Children's Workgroup, 2001, p. 23).

The Workgroup found that Florida, like most states (Friedman, 2004), was finding that the implementation of effective systems of care was much more challenging than the creation of a vision for such systems (Children's Workgroup Report, 2001). It found that despite progress that had been made, and the outstanding effort by many people, there remained a significant absence of integrated, coordinated efforts to plan on behalf of children with emotional or substance abuse disorders or both, and a high level of unmet need.

Consistent with the effort to develop and implement effective systems, Florida’s Agency for Health Care Administration (AHCA), with input from the Department of Children and Families (DCF), asked for research to be conducted on three important dimensions of effective systems:

1. The array of services and supports that should be provided;
2. The type of performance measurement/quality improvement system that could strengthen the overall system; and
3. The infrastructure and strategies that would support the implementation of EBP’s and programs.

These three critical areas of concern have been identified by many as being important for effective systems (Bickman & Noser, 1999; Fixsen and Blase, 1993; Friedman, 2004; Kamradt, 2000; and Research and Training Center for Children's Mental Health [RTTCMH], 2004). In fact, a recent model of factors that are related to implementation of effective systems of care developed by the Research and Training Center for Children’s Mental Health (RTTCMH, 2004) includes each of these items, along with a number of other variables.

The RTTCMH’s model emphasizes as well that other variables such as a strong value base, a clear definition of and understanding of the population of concern, an implementation plan, strong family voice, collaborations across service sectors, and culturally competent services and pathways to care are all important factors, for example. Perhaps most important, the RTTCMH’s model emphasizes that each of these factors are inter-related and inter-connected, and that development
of an effective system requires a comprehensive approach in which each of these seemingly separate factors are in fact integrated into a cohesive goal-centered whole. Although the focus of this particular study is on three factors in particular, it is done with an understanding both that they are not the only important factors and that there is a need for a comprehensive, systemic approach to improving access to care and effectiveness of care.

**Purpose of Study**

The purpose of the study was to gather information that is practical and helpful for the state of Florida and for communities within Florida in improving their systems, services, and, most importantly, outcomes for children with mental health challenges and their families. The information should directly lead to a further examination of the present service array, to determine if it should be modified in any way. The information also should be used to examine the present Performance Measurement/Quality Improvement (PM/QI) procedures, and the infrastructure that exists to promote the effective implementation of Evidence-based Practices (EBP’s). It is hoped that the information gathered will be translated into policies that will strengthen the system of care for children with mental health challenges and their families.

**Methods**

This study takes a policy analysis approach to examine children’s mental health practices in Florida. The method involves a 4-step approach:

1. Examination of the existing services and practices in Florida;
2. Comparison with the existing body of knowledge in the field;
3. Input from key stakeholders within Florida; and
4. Development of policy recommendations based on the findings.

Within this approach, the three *areas of concern* were studied:

1. Service array, accessibility, and funding;
2. Performance measurement and quality improvement (PM/QI); and
3. Implementation of (EBP’s).

The research team conducted a review of published and unpublished literature about practices and policies related to the three areas of concern. This included an identification of communities outside of Florida that have high-quality service arrays, strong performance measurement or quality improvement systems, or successful implementation of EBP’s.

To determine the present status of the Florida system with regard to the three issues of concern, a variety of data collection efforts were undertaken. First, an online survey was developed using *SurveyMonkey* software. The *State Leadership Survey* included 19 questions. Types of questions included check boxes, numerical ratings, and open-ended essay responses. The survey topics included
• Types of services available;
• Satisfaction ratings of accessibility of services;
• Services that are lacking and need to be added to the array;
• Checklists of EBP’s currently available in Florida;
• Identification of providers that use EBPs;
• Satisfaction ratings of the quality of services;
• Checklists of types of data collected by providers;
• Satisfaction ratings of quality of out-of-District services;
• Checklists of system performance indicators;
• Need for other system performance indicators;
• Checklists of funding sources; and
• Information on under-funded and over-funded services.

This online survey was administered to Florida state officials from AHCA and the Department of Children and Families/Children’s Mental Health (DCF). In most cases, the respondents were either the Area AHCA Program Administrator or the District DCF Children’s Program Specialist, with some offices also utilizing their Mental Health Supervisors and “Data Liaisons” for some or all of the questions. There were a total of 25 responses to this survey, representing 14 DCF District offices and 11 AHCA Area offices. In order to encourage the respondents to be candid, all responses were anonymous and the researchers could not identify whether the online responses came from an AHCA or DCF Children’s Mental Health office.

After completion and analysis of the online survey data, a follow-up interview by telephone was conducted with each of the 11 AHCA offices and 14 DCF offices. In most cases, the people who responded to the online survey were the individuals interviewed; however, many AHCA Program Administrators included other specialists, clinical staff, or data/QA personnel in the interview. Follow-up interview questions and probes focused on
• Populations that are underserved, not served, or very difficult to serve;
• Use of and knowledge about evidence-based services;
• Incentives, motivation, and reasons for implementing evidence-based services;
• Ratings of knowledge about EBP’s on the part of providers, families, and state leadership;
• Description of EBPs in their area;
• Facilitators and barriers to implementation of EBPs
• Evidence of goals, strategies, and a “Theory of Change”;
• Descriptions of data collection efforts;
• Assessment of clinical or child outcomes;
• Assessment of system outcomes;
- Ratings of the quality of their PM/QI system; and
- Descriptions of their PM/QI system and use of data.

The respondents were then asked to nominate any provider agencies from their Area or District that were using EBPs or some innovative practices. If no providers were nominated, they were asked to name a few providers that did high quality work. Sixty-four providers were nominated based on the above criteria. All providers were contacted by phone to determine the appropriate respondents to another survey and contact information was obtained.

Next, the online Provider Survey was conducted. This survey was sent to the sixty-four nominated providers and consisted of 22 questions in a variety of formats. Responses were anonymous and most often the respondents were the Program Directors, CEO’s, or Clinical Directors. Thirty-three of the 64 providers responded to the survey. Questions for the nominated providers included
- Definitions of “success” regarding EBPs;
- Reasons for implementing EBPs;
- Ratings of importance of implementation factors regarding EBPs;
- EBPs that were discontinued and reasons why;
- Questions regarding training and supervision practices;
- Questions regarding caseloads and wait lists;
- Motivation for adopting EBPs;
- Facilitators and barriers to implementation of EBPs;
- Ratings of the quality of their PM/QI system;
- Description of their PM/QI system;
- Motivation to have QI programs; and
- Facilitators and barriers to implementation of PM/QI systems.

The results of the 25 State Leadership Surveys, the 33 Provider Surveys, and the 25 Follow-up Interviews were summarized and sorted according to the three areas of concern. This allowed for a more meaningful qualitative and quantitative analysis of the data. Brief overviews of the findings were written, including some additional probing questions. These briefs were used to facilitate discussion and elicit recommendations from the following focus groups.

**Florida Parent Focus Group (Mixed Ethnicity)**

Seven parents from Winter Park, West Palm Beach, Tampa, Delray Beach, Orlando, and Jacksonville took part in a focus group via a telephone conference call. Parents were asked about
- Rating the quality of Florida’s mental health services for children and families;
- Rating their knowledge about EBPs;
- Services that are inadequate or need improvement;
- Barriers to good quality mental health services;
• Roles that parents and families can play in improving mental health services; and
• Relationships between populations identified by others as needing improvement and parent’s perceptions of service needs in Florida.

Florida Parent Focus Group (Hispanic)
Five Spanish-speaking parents from the Tampa area responded to the same questions in written format administered by a Spanish-speaking surveyor. The results were translated and shared with the research team by this surveyor.

Florida Mental Health Institute (FMHI) Expert Focus Group
Eight FMHI staff reviewed and analyzed the preliminary findings and shared their views based on their knowledge of children’s mental health efforts in Florida and nationally. Based on these findings, suggestions were made regarding possible national experts and successful community leaders to interview that might have significance for Florida’s needs.

Key Informant Roundtable Discussion
Twenty-two Florida key informants took part in an all-day meeting to discuss the preliminary findings, recommendations, and to share their insights. The group consisted of five AHCA representatives, three DCF representatives, three Provider representatives, three Parent representatives (two of whom were involved in the Parent Focus Group), selected FMHI consultants, and the research team. Material was distributed prior to the meeting and the findings were presented in PowerPoint format during the morning session. The remainder of the day involved receiving feedback from the group on the preliminary findings, perceived value of the practices and policies that were identified, the feasibility of implementing some of the proposed recommendations, and a consensus on future steps in the study.

National Expert Interviews
Conference calls were made to various national experts to get input on the Florida findings, the areas of concern, and their relationship to national trends that may have direct relevance to Florida. Participants included
• Barbara Burns, Duke University;
• Sheila Pires, Human Service Collaborative;
• Ivor Groves, Human Systems & Outcomes, Inc.;
• Jeanne Rivard, National Association of State Mental Health Program Directors; and
• Brigitte Manteuffel, Opinion Research Corporation-Macro International, Inc (ORC-MACRO).
Successful Community Director Interviews

Conference calls were made to various Directors of successful communities or programs with a focus on the Florida findings, the *areas of concern*, “lessons learned” and implementation strategies that could possibly benefit Florida. Some interviews took part in conjunction with other research projects but covered much of the same topic areas. Participants included:

- Bruce Kamradt, Wraparound Milwaukee;
- Tina Donkervoet/Bruce Chorpita, Hawaii System of Care;
- Knute Rotto, Dawn Project (Indianapolis);
- Myra Alfreds, Westchester County, New York;
- Beth Baxter, Nebraska Family Central; and
- Patrick Kanary, Ohio Center for Innovative Practices.

Summary of Data Sources

- Online Survey of 25 AHCA/DCF Offices
- Follow-up interviews of all 11 AHCA Area Offices
- Follow-up interviews of all 14 DCF District Offices
- Online Survey of 33 Nominated Provider Agencies
- Feedback from mixed ethnicity Parent Focus Group (conference call)
- Feedback from Hispanic Parent Group (questionnaire)
- Feedback from FMHI Expert Focus Group
- Feedback from Florida Key Informant Roundtable Discussion
- Feedback from National Experts
- Feedback from Directors of Successful Communities/Programs

The next sections summarize the findings for each of the three main areas covered in this study.
Service Array, Accessibility and Funding

Background

Meeting the mental health needs of children relies, in part, upon the existence of an adequate array of services and the ability of children and their families to access services within that array when they are needed. In addition, services must be effective in addressing the presenting problems of children and adolescents with mental health challenges. This section of the report provides information and perspectives on the current range, accessibility, funding, and perceived quality of children's mental health services in Florida. Data sources were described above.

AHCA and Children's Mental Health Assessment of Array, Access, and Funding

The 25 respondents to the Internet survey had the opportunity to review a list of 32 possible types of services (e.g., therapeutic foster care, respite for families, individual therapy) and to offer the following information for each service related to range, access and funding:

- Identification of services that exist in the Area or in the District;
- Identification of services that exist out of Area or out of the District;
- Rating of how satisfied they were with accessibility to the service on a 4-point rating scale;
- Detailing of issues that created access problems;
- Recommendations for services that need to be added to the array to improve mental health services for children;
- Percent of funding provided by Medicaid for each type of service; and
- Other funding sources for each type of service (e.g., Block grant, Temporary Assistance for Needy Families (TANF), private insurance, charitable funding).

In addition to the Internet Survey, AHCA Area Office staff and DCF staff from Children's Mental Health offices in each District participated in a telephone interview with the research team. During the interview, these respondents had the opportunity to further discuss needed services, access issues, and funding strengths and challenges. The following results summarize the responses from AHCA Area Offices and DCF Children’s Mental Health Specialists at the District level.

Array of Services

Data from the Internet Survey were analyzed with respect to whether or not each of the 32 services listed were available in or out of the District, or both. The percent of responses detailed below is based on the total number of individuals who responded to a given question. Not all of the 25 respondents answered all questions. For example, if a total of 18 people responded to a listed type of service and 15 said “Yes, this service exists in District,” then it would be noted that 83% (15/18) of the respondents replied “Yes.”
Overall, 28 of the 32 listed services were marked as “available in District” by 89% to 100% of the respondents. It should be noted that of the 28 listed services that were checked by 89% to 100% of the respondents as “available in District,” there were three services for which there were 13 or fewer respondents of the 25 possible respondents. This lower response rate may indicate that respondents did not have the knowledge base to answer the question about availability. These services were

- Respite Services for Families;
- Transition Services (child to adult mental health system); and
- Therapeutic Preschool or Nursery.

Four of the 32 listed services were marked by 75% to 83% of the respondents as available in District. The four services were

- Therapeutic Community-Based Group Homes;
- Residential Treatment Centers;
- Partial Hospitalization; and
- Residential or Group Care for Sex Offenders.

In general, these data indicate that a wide range of services exist in the Districts across Florida with a minority of service only available outside the District.

**Access to Services**

While the above data indicate that a wide range of services exist, there was considerable variability when it came to the respondents’ impressions of how accessible each of the services is in relation to meeting child and family needs. Respondents rated their satisfaction with accessibility on a 1 to 4 scale as follows:

- 1 = Very Satisfied with Accessibility
- 2 = Satisfied with Accessibility
- 3 = Unsatisfied with Accessibility
- 4 = Very unsatisfied with Accessibility

Each service was assigned a Level of Accessibility based on the percent of respondents who placed the service in the collapsed category of Very Satisfied or Satisfied with Accessibility (Ratings of 1 or 2 on the scale above). For example, if 80% to 100% of the raters indicated they were Very Satisfied or Satisfied with Accessibility (e.g., a 1 or 2 rating on the scale) then the service was assigned to the “highly accessible” listing, and so on as detailed in the table below.

**Table 1: Levels of Accessibility**

<table>
<thead>
<tr>
<th>% Of Respondents Who Were Very Satisfied or Satisfied with Accessibility</th>
<th>Level of Accessibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>80 – 100% rated it a 1 or 2</td>
<td>Highly Accessible</td>
</tr>
<tr>
<td>60 – 79% rated it a 1 or 2</td>
<td>Accessible</td>
</tr>
<tr>
<td>40 – 59% rated it a 1 or 2</td>
<td>Much Less Accessible</td>
</tr>
<tr>
<td>0 – 39% rated it a 1 or 2</td>
<td>Significantly Less Accessible</td>
</tr>
</tbody>
</table>
The services listed within each of the four Levels of Accessibility are detailed below.

**Services Classified as Highly Accessible (80% - 100% Satisfied or Very Satisfied)**
- Case Management
- Individual Child Therapy
- Group Therapy
- Psychotropic Medication Management
- Family Therapy
- Assessment and Diagnostic Evaluation
- School-Based Mental Health Services
- Crisis Stabilization (immediate, short-term residential or inpatient)
- Substance Abuse Services

**Services Classified as Accessible (60% - 79% Satisfied or Very Satisfied)**
- Therapeutic Foster Care
- Early Intervention Services (Birth to 5)
- Residential Treatment Centers
- Psychiatric In-Patient Services
- Wraparound Services
- Trauma Services after personal or community traumatic event
- Prevention Services

**Services Classified as Less Accessible (40% - 59% Satisfied or Very Satisfied)**
- Therapeutic Community-Based Group Homes
- Day Treatment (partial or full)
- Crisis Services (no removal of child)
- Home-based services (to prevent out-of-home placements)
- Home-based services (for reunification)
- Behavioral/Therapeutic Aides
- Family Support Services (advocacy parent support groups)
- Respite for Foster Families

**Services Classified as Significantly Less Accessible (0% - 39% Satisfied or Very Satisfied)**
- Residential or Group Care for Sex Offenders
- Transition Services (child to adult mental health systems)
- Partial Hospitalization
- Therapeutic Nursery/Preschool
- Respite Services for Families
- Family Education
- Mentors
- Tutors
Funding

All respondents were asked to estimate the percent of funding provided by Medicaid for each service that exists in their District. Nineteen of the 25 respondents rated the Medicaid coverage. They did this by rating the level of Medicaid funding on a 5-point rating scale below. The lower the rating the higher the Medicaid funding level.

1 = 76% – 100% covered by Medicaid
2 = 51% – 75% covered by Medicaid
3 = 26% – 50% covered by Medicaid
4 = 0% - 25% covered by Medicaid
5 = Medicaid does not cover this service

They also were asked to check off other sources of funding for each service from a list of eight possible funding sources. However, they were not asked to estimate the contribution of each of these eight additional sources of funding. A range of 2 to 13 respondents answered these funding questions depending on the service (e.g., Case Management N = 13, Partial Hospitalization N = 2) with most of the services receiving responses from 9 to 13 respondents. This significant decrease in respondents (from 25 in the Medicaid funding question) is perhaps due to the fact that the AHCA Area office staff indicated during interviews that they were not familiar with particular services and saw their responsibilities related primarily to client eligibility, documentation, and monitoring related to Medicaid funding. Therefore, it may be that the respondents to this question were primarily from the pool of 14 Children’s Mental Health Specialists who were invited to participate.

The eight non-Medicaid funding sources were

- Mental Health Funding – Non Medicaid;
- Block Grant;
- TANF;
- State Children’s Health Insurance Program (SCHIP);
- County Tax Base;
- Other Child-Serving Sectors (Juvenile Justice, Education, Developmental Disabilities, Child Welfare);
- Private Insurance/Client Fees; and
- Charitable Funding.

A look at the funding data for services available in Districts combined with the accessibility data helps tell a more complete story about the accessibility of the array of services for children and their families and the role that diverse funding sources may play in supporting that array. The four tables below (Tables 2, 3, 4, and 5) detail the funding level from Medicaid and the number of other sources of funding for each service within the four accessibility clusters. For one of the eight non-Medicaid funding sources listed above to be recorded in the last column, five or more respondents had to list that source. This criterion was imposed to provide a better sense of common non-Medicaid funding sources across the state.
### Table 2: Services Rated as Highly Accessible

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid Funding Level</th>
<th>Other Listed Funding Sources (5 or more respondents checked the funding source – Actual number listed in parentheses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>1.18</td>
<td>Mental Health – non-Medicaid (11) Block Grant (6) TANF (5) Private Insurance/Client Fees (5)</td>
</tr>
<tr>
<td>Individual Child Therapy</td>
<td>1.18</td>
<td>Mental Health – non-Medicaid (8) TANF (5) Private Insurance/Client Fees (9)</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>1.19</td>
<td>Mental Health – non-Medicaid (7) Block Grant (6) TANF (6) Private Insurance/Client Fees (9)</td>
</tr>
<tr>
<td>Psychotropic Medication Management</td>
<td>1.35</td>
<td>Private Insurance/Client Fees (9) Mental Health – non-Medicaid (8) Other Service Sectors (5)</td>
</tr>
<tr>
<td>Family Therapy</td>
<td>1.44</td>
<td>Mental Health – non-Medicaid (7) TANF (6) Private Insurance/Client Fees (9)</td>
</tr>
<tr>
<td>Assessment and Diagnostic Evaluation</td>
<td>1.47</td>
<td>Private Insurance/Client Fees (11) Mental Health – non-Medicaid (12) Other Service Sectors (9) Block Grant Funding (7)</td>
</tr>
<tr>
<td>School-Based Mental Health Services</td>
<td>1.76</td>
<td>Mental Health – non-Medicaid (5)</td>
</tr>
<tr>
<td>Crisis Stabilization (immediate, short-term Residential or inpatient)</td>
<td>2.13</td>
<td>Mental Health – non-Medicaid (10) Private Insurance/Client Fees (5)</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>2.33</td>
<td>Mental Health – non-Medicaid (5) Block Grant (6) TANF (6) Private Insurance/Client Fees (7)</td>
</tr>
</tbody>
</table>

### Table 3: Services Rated as Accessible

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid Funding Level</th>
<th>Other Listed Funding Sources (5 or more respondents checked the funding source – Actual number listed in parentheses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Foster Care</td>
<td>1.12</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Early Intervention Services (Birth to 5)</td>
<td>1.44</td>
<td>Mental Health – non-Medicaid (7) Block Grant (5)</td>
</tr>
<tr>
<td>Residential Treatment Centers</td>
<td>1.56</td>
<td>Mental Health – non-Medicaid (8) Other Service Sectors (6)</td>
</tr>
<tr>
<td>Psychiatric In-Patient Services</td>
<td>1.88</td>
<td>Mental Health – non-Medicaid (7)</td>
</tr>
<tr>
<td>Wraparound Services</td>
<td>2.18</td>
<td>Mental Health – non-Medicaid (8)</td>
</tr>
<tr>
<td>Trauma Services after personal or community traumatic event</td>
<td>3.71</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Prevention Services</td>
<td>4.15</td>
<td>Mental Health – non-Medicaid (7)</td>
</tr>
</tbody>
</table>
Table 4: Services Rated as Less Accessible

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid Funding Level</th>
<th>Other Listed Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Community-Based Group Homes</td>
<td>1.25</td>
<td>Mental Health – non-Medicaid (8)</td>
</tr>
<tr>
<td>Day Treatment (partial or full)</td>
<td>2.13</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Crisis Services (no removal of child)</td>
<td>2.50</td>
<td>Mental Health – non-Medicaid (6)</td>
</tr>
<tr>
<td>Home-based services (to prevent out-of-home placements)</td>
<td>2.53</td>
<td>Mental Health – non-Medicaid (5) Other Service Sectors (5)</td>
</tr>
<tr>
<td>Home-based services (for reunification)</td>
<td>2.67</td>
<td>Mental Health – non-Medicaid (5) Other Service Sectors (6)</td>
</tr>
<tr>
<td>Behavioral/Therapeutic Aides</td>
<td>3.29</td>
<td>Other Service Sectors (3)</td>
</tr>
<tr>
<td>Family Support Services (advocacy parent support groups)</td>
<td>4.44</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Respite for Foster Families</td>
<td>4.58</td>
<td>Mental Health – non-Medicaid (5) Other Service Sectors (5)</td>
</tr>
</tbody>
</table>

Table 5: Services Rated as Significantly Less Accessible

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicaid Funding Level</th>
<th>Other Listed Funding Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential or Group Care for Sex Offenders</td>
<td>2.21</td>
<td>Mental Health – non-Medicaid (5)</td>
</tr>
<tr>
<td>Transition Services (child to adult mental health systems)</td>
<td>3.50</td>
<td>Mental Health – non-Medicaid (5)</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>4.08</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Therapeutic Nursery/Preschool</td>
<td>4.43</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Respite Services for Families</td>
<td>4.58</td>
<td>Mental Health – non-Medicaid (5)</td>
</tr>
<tr>
<td>Family Education</td>
<td>4.75</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Mentors</td>
<td>4.88</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
<tr>
<td>Tutors</td>
<td>4.94</td>
<td>No other funding sources with 5+ respondents</td>
</tr>
</tbody>
</table>

Not surprisingly, a review of the above data indicates that accessibility levels are highly correlated with both higher levels of Medicaid funding and with more respondents indicating that other sources of non-Medicaid funding also support the highly accessible service listing. After the Highly Accessible grouping of services, there is a drop-off in the indication that other sources of funding contribute significantly to service provision. When other sources are mentioned, Mental Health (non-Medicaid) funding is the most frequently cited resource.
There were several instances where the level of service accessibility was not well aligned with the funding data. For example, two services rated as Accessible but with low Medicaid funding levels, were Trauma Services after personal or community traumatic events and Prevention Services. In addition, these services had few respondents naming non-Medicaid sources of funding support. It may be that trauma services are readily mobilized at the time of a crisis for an individual, child, or family; and these services are not a day-to-day service need for large numbers of children and their families, and are therefore seen as accessible. Similarly, Prevention Services are designed to deal with the precursors (risk and protective factors) to more serious problems; therefore, accessibility may be more difficult to judge or may be seen as satisfactory in the absence of community data related to the effectiveness of preventive efforts.

Lack of alignment of funding data with accessibility also occurred for services that were seen as having high levels of Medicaid funding but were still seen as Less Accessible or Significantly Less Accessible. These services were Therapeutic Community-Based Group Homes, which received a high Medicaid Funding rating of 1.25 but an accessibility classification of Less Accessible. Similarly, Day Treatment (partial or full) received a fairly high Medicaid funding rating of 2.13 but also was classified as Less Accessible. And finally, Residential or Group Care for Sex Offenders received a relatively high Medicaid funding rating of 2.21 but was classified as Significantly Less Accessible. While these three services had high or reasonably high levels of Medicaid funding, they also had fewer sources of other funding. Mental Health non-Medicaid funding was the only additional source of funding listed frequently by respondents.

There is some indication of multi-system funding for children's mental health services as noted in the data regarding funding of services by Other Service Sectors for children and their families. Funding by Other Service Sectors was listed by five or more respondents for the following service areas:

- Psychotropic Medication Management;
- Assessment and Diagnostic Evaluation;
- Substance Abuse Services;
- Residential Treatment Centers;
- Home-based services (to prevent out-of-home placements);
- Home-based services (for reunification);
- Respite for Foster Families; and
- Behavioral/Therapeutic Aides.

**Recommendations for the Service Array in Districts**

Twenty AHCA and DCF respondents made 63 service recommendations via the Internet Survey. They responded to an open-ended question, “What services need to be added to the array in your District in order to improve children’s mental health services?” (e.g., specific populations, presenting problems, diagnoses, service locations).
Table 5 summarizes the types of recommendations made. The data from the chart suggest that respondents are not familiar with specific treatments for specific populations. Given the higher proportion of recommendations that were location-specific and restrictiveness-specific for broad populations (e.g., seriously emotionally disturbed (SED), young females, under age 10), it may mean that staff attributes more intensive treatment to more restrictive and more costly levels of intervention. Intensive interventions also can be delivered in a variety of settings (e.g., therapeutic group homes, outpatient therapy, in-home services, therapeutic foster care) and can be delivered intensively in community and family settings as well (e.g., Multi-Systemic Therapy (MST), Multidimensional Treatment Foster Care).

**Table 6: Recommendations for Additional Services**

<table>
<thead>
<tr>
<th>% of Total Recommendations</th>
<th>Types of Recommendations</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% N = 19</td>
<td>Physical setting or broad therapeutic recommendation in combination with a population</td>
<td>-Residential treatment for youth with conduct disorders&lt;br&gt;-After school for SED&lt;br&gt;-Therapeutic Group Care (TGC) for young females&lt;br&gt;-Therapeutic day care for under age 10</td>
</tr>
<tr>
<td>17% N = 11</td>
<td>Treatment for specific disorders but not a specific type of therapy (e.g., borderline personality but not dialectical behavior therapy for borderline personality) or location</td>
<td>-Therapy for reactive attachment disorder&lt;br&gt;-Eating disorders&lt;br&gt;-Borderline personality disorders&lt;br&gt;-Sex offenders</td>
</tr>
<tr>
<td>14% N = 9</td>
<td>A broad category of children</td>
<td>-Physically, emotionally abused&lt;br&gt;-Sexual victims&lt;br&gt;-Developmental Disabilities/Mental Health (DD/MH)&lt;br&gt;-Behavior problems due to neurological damage&lt;br&gt;-Ages Birth - 5</td>
</tr>
<tr>
<td>11% N = 7</td>
<td>A broad category of services</td>
<td>-Prevention&lt;br&gt;-More outpatient access&lt;br&gt;-Crisis service&lt;br&gt;-Reunification services</td>
</tr>
<tr>
<td>10% N = 6</td>
<td>Specific practices or programs but no specific population</td>
<td>-Grief counseling&lt;br&gt;-Wraparound&lt;br&gt;-Anger management&lt;br&gt;-Certified Behavior Analysts (CBA)&lt;br&gt;-Targeted Mentors</td>
</tr>
<tr>
<td>10% N = 6</td>
<td>Non therapeutic services for families and caregivers</td>
<td>-Family supports&lt;br&gt;-Respite for families&lt;br&gt;-Respite for foster parents</td>
</tr>
<tr>
<td>5% N = 3</td>
<td>Location of service only</td>
<td>-Residential in District&lt;br&gt;-Local TGC</td>
</tr>
<tr>
<td>3% N = 2</td>
<td>Payment by disorder or issue</td>
<td>-Mental health for Medicaid&lt;br&gt;-Medicaid $ for eating disorders</td>
</tr>
</tbody>
</table>
The 63 specific recommendations varied greatly. The following are the recommendations that garnered three or more recommendations:

- Treatment for youth who have committed sexual offenses (6);
- Transitional services for teens with Mental Health issues (4);
- Respite for families (4);
- Children with developmental disabilities and mental health issues (3); and
- Prevention (3).

It should be noted that 10 of the 63 recommendations were for more restrictive congregate care settings (e.g., residential treatment, therapeutic group homes) and 20 recommendations were for more community-based, family-oriented and outpatient services.

Further Improving the Service Array: Population or Groups of Children who are Difficult to Serve

During interviews with DCF Children’s Mental Health staff and AHCA staff, we asked both groups to respond to the following question, “Is there a population or group of children who are difficult to serve or not served well at this point?” “Why?” “What are the barriers to service?” Specifically asking about population-based needs, unlike the Internet question that asked about services needed, resulted in more population-specific recommendations. Table 6 details the categories of child and adolescent problems that were perceived as needing attention, along with associated barriers to service development and provision.

### Table 7: Populations in Need of Services and Associated Barriers

<table>
<thead>
<tr>
<th>Populations in Need of Services</th>
<th>DCF N = 14</th>
<th>AHCA N = 11</th>
<th>Associated Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MH Dual Diagnoses Borderline IQ may not meet MH or DD requirements</td>
<td>29% (4)</td>
<td>55% (6)</td>
<td>Medical model funding does not suit this population since symptom reduction models are not functional for persons with developmental disabilities. Time-limited managed care funding does not work well for this population.</td>
</tr>
<tr>
<td>Other Dual Diagnoses and Systems Mix (e.g., Substance Abuse/Mental Health, Child Welfare/Mental Health, Juvenile Justice/Mental Health)</td>
<td>29% (4)</td>
<td>0%</td>
<td>Expertise and training, as well as cross system issues, were seen as problematic.</td>
</tr>
<tr>
<td>Sexually Reactive/sexually acting out/Sexual offenders/female sexual offenders</td>
<td>43% (6)</td>
<td>27% (3)</td>
<td>Often only more restrictive setting available and not enough step-down services in the community. Issues of expertise, training, liability and funding/</td>
</tr>
<tr>
<td>Serious Behavior Problems</td>
<td>57% (8)</td>
<td>27% (3)</td>
<td>Expertise, training, liability and funding were all of concern.</td>
</tr>
<tr>
<td>• Violent teens, Oppositional Defiant Disorder (ODD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Runaways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Borderline Personality Disorders (self-harm issues)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Acting too severely for foster care</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Barriers to the Provision of Services to Populations in Need

The following themes emerged related to barriers listed briefly in Table 6 above. Each theme related to barriers to service provision is briefly discussed below.
These themes were
1. Risk and Liability Issues;
2. Expertise and Training;
3. Inability to match funding criteria with children’s needs;
4. Lack of funding for the services needed; and
5. Recognition that high cost services consume resources.

1. Risk and Liability Issues

Associated with lack of training and expertise are the inherent risks and liability concerns that limit the number and types of providers who are willing and able to serve more challenging populations of children. In particular, several AHCA respondents noted that Treatment Foster Care is not a viable option for sexually acting-out children for two reasons. First, there are inherent risk factors related to accusations against the foster parents and second, there is a financial disincentive since these children cannot reside with a second child in placement, thus limiting the financial incentives for foster parents to work with these more challenging children. These disincentives combined with lack of specialized training for foster parents serve as significant barriers to utilizing specialized foster care.

Similar risk and liability issues were cited with regard to working with children who display psychosis for fear of false allegations due to delusional thinking and other mental health symptoms.

An ancillary challenge then emerges which results in children residing in crisis settings for prolonged periods of time due to cost of service, lack of expertise, and liability concerns. Again, both AHCA and DCF respondents mentioned barriers associated with risk and liability.
2. Need for Expertise and Training

Both AHCA and DCF respondents mentioned issues related to lack of expertise and need for more training to provide necessary services. In working with some of these populations of concern, issues mentioned included the use of less skilled staff and inadequate (e.g., some home-based services, foster care). When less-skilled individuals deliver services, their lack of training and expertise can be problematic. In some other cases, the expertise to provide services to specific populations overall was cited as problematic (e.g., sexually reactive and perpetrators, developmental disabilities, aggressive children). While training is clearly a necessary condition for improving expertise and changing practices, a recent review of the implementation research literature indicates that training alone, no matter how well done, is unlikely to improve practices. Attention to factors such as staff selection; coaching and supervision; and staff and program evaluation are also required for new expertise to be implemented with fidelity and positive outcomes (Fixsen, Naoom, Blase, Friedman & Wallace, 2005). Given the theme of “expertise and training” as a barrier for five of the seven populations mentioned in the chart above, the introduction of Evidence-based Programs and Practices for these youth, if available, would be one way to address this barrier.

3. Inability to Match Funding Criteria with Children’s Needs

Several DCF respondents mentioned concerns in meeting the needs of children who are not eligible for Medicaid funding. Associated information from one provider from the Internet survey also mentioned that more limited services are provided to children who rely on private insurance. In addition to Medicaid eligibility concerns, one respondent mentioned the challenge of getting SSI funding in a timely fashion.

DCF respondents also noted that for children with developmental disabilities and mental health problems, the medical model of funding treatment in a time-limited fashion and gearing treatment to ‘symptom reduction’ really does not work for this population since their problems are ongoing (e.g., IQ is not amenable to symptom reduction). There also were concerns about funding and service transitions for teens with mental health problems (and sometimes with developmental disabilities as well) transitioning to the adult system.

A final “inability to match funding with needs” issue related to the challenge of funding children in rural areas where transportation for the provider or the family or both results in families being unable to reach treatment settings or providers being unwilling to travel. It was noted that since travel time is not billable this might be a disincentive for providers to work in rural areas and a disincentive for home-based services. In an effort to manage resources, the result may be that more acute and expensive admissions come into the system that could have been prevented through home-based interventions.

4. Lack of Funding for Needed Services

Not surprisingly, respondents from DCF and AHCA saw funding generally as a barrier and felt that more funding was needed for mental health services. In
particular, funding was seen as a barrier in providing services such as specialized foster care homes that serve only one foster child, intensive home based services, step down services from Statewide Inpatient Psychiatric Programs (SIPP), early intervention services, resources for evidence-based programs that work for various populations, and funding for additional residential and group care placements to reduce wait lists.

5. Recognition that High Cost Services Consume Resources

Interestingly, there was a “push-pull” noted in the comments. On the one hand, there were numerous statements about the wait lists or lack of availability of residential, group home, and treatment foster care spaces. On the other hand, there was also recognition that these services are costly and funding levels for high-end services may not facilitate the development of a broader array of services. Comments reflecting this sentiment included: “Most money went to SIPP or TFC so there is nothing left;” “The group homes are expensive,” and “no resources, need more low-end services.”

Parent Perspectives on Service Array, Accessibility and Funding

Perspectives of parents whose children need mental health services and who have directly accessed or attempted to access services are important in rounding out the information on array and accessibility. Twelve parents provided the research team with information. Seven parents of diverse ethnicity from across the state participated in a focus group through a conference call and five parents of Hispanic origin in the Tampa area completed a written response to the similar questions asked of the focus group. The questionnaire was translated into Spanish and responses were interpreted for the research team by a researcher fluent in Spanish.

The seven parents who participated in a focus group via a conference call were asked to rate the overall quality of mental health services for children in Florida on a 5-point rating scale with 5 representing the most positive rating. The average rating across the seven parents was 1.5. In discussion, it became clear that this quality rating was related to the quality of existing services and to the availability and access to needed services. The Hispanic parents provided a similar rating when asked to rate the quality of mental health services in Florida with an average rating of 2.0.

The parents were also asked what services are lacking, inadequate, or need improvement in Florida. For the focus group, there were a number of themes that emerged in discussing the service array, quality and access. First was the limited access to Behavior Analysts and the cost for the services of Behavior Analysts, who were seen as highly valuable in helping parents and children. Some of the examples cited were related to children with multiple needs that crossed departmental jurisdictions (e.g., health, developmental disabilities, mental health, and education). Longer-term access to a Behavior Analyst was seen as crucial and highly supportive of families continuing to care for their children at home. Accessibility issues arose concerning the cost of privately paying for this service.
There was a long waiting list for service access through the Developmental Services Waiver and private insurance would not pay for this service. Parents commented that there were 5,000 children and adolescents on the waiting lists. Subsequent discussions with developmental disabilities staff and AHCA staff indicated that the wait list number is closer to 15,000. It is interesting to note that neither the AHCA nor DCF staff noted a shortage or barriers related to access to Behavior Analysts.

Generally, the parents in the focus group did not think that developmental disabilities and mental health worked well together to benefit the child. In addition, they also did not feel that children who had developmental disabilities and mental health concerns were served well by the school system.

Parents also noted that the crisis units and in-patient or residential services were really not accessible to families. Parents said that there were only two specialty children’s crisis units in the state. The typical response to a crisis was described as accessing the crisis unit for a 48- to 72-hour intervention, with a medication change as the typical intervention, and then referral back to the local psychiatrist. When pursuing more intensive services (e.g., residential) parents are told there are many other children in worse shape who need these placements. While the parents did not explicitly note the ability to utilize adult crisis units for children, one might infer that their dissatisfaction was related to the lack of children’s crisis units and not the lack of a crisis unit per se.

There was a theme in the parent focus group related to severity thresholds that indicated that families were caught in the middle. On the one hand, parents are informed that resources are scarce and are told that their child’s problems are not severe enough to access the service they are seeking. On the other hand, their children are being rejected by the very agencies that are supposed to be treating them because their behavior problems were too severe. One parent noted that this happened with two agencies that were specifically funded to provide services to children who had problems or diagnoses like her child’s. Parents also noted that it seemed that only middle-of-the-road children could access services in other domains (e.g., specialized medical services, school services). Behavioral problems that were likely to manifest themselves in the community environment (e.g., school, health settings, after school activities) often resulted in exclusion from the entire setting or parts of the setting (e.g., youth can’t go to the school cafeteria, schooled in a portable classroom, no extracurricular activities).

Another issue that was identified by parents in the focus group that also was echoed by the Children’s Mental Health Specialists was that many of the problems and challenges faced by children with multiple conditions are not amenable to current funding structures. That is, there will not be a short-term course of “treatment” for their child that results in a “cure” for the condition. Many children need consistent and often one-on-one help that is ongoing. In particular this spoke to the needs of children with both developmental disabilities and mental health issues.

Another area of need was the need for nontraditional, community-based services to engage bright and creative children when they return from
hospitalization or otherwise re-enter the community. These services include extracurricular and after school activities such as athletics, art and computer classes, as well as activities with mentors and tutors. Such services can build on a child’s strengths and help keep children engaged productively in the community. Parents also commented that community-based service providers should be trained to work with children who have behavioral problems and mental health issues. One of the parents talked about “Jeff Industries” in Broward County that provides training for nontraditional service providers (e.g., Scoutmasters, coaches, mentors, tutors, after school recreation assistants) so that they are better equipped to help children with mental health problems participate in these settings.

Child psychiatrists and adolescent psychiatrists who were viewed as “qualified” by the parents were also viewed as in short supply by parents in the focus group. Parents indicated that even when a competent professional is found the wait for services could be four to five months. This wait time was particularly problematic when children were in crisis. With respect to quality and competence, parents often felt that they were the experts: They had done the research, tried out strategies and arrived at approaches that fit for their child. Psychiatrists often would ask them what they were currently doing, and if it had worked in the past the psychiatrist advised them to continue that strategy. On the whole, this particular group of parents did not feel that helpful strategies and interventions for use at home or in the community were forthcoming from the medical community.

Family members in the focus group also felt that qualified respite was desperately needed. With the exception of Systems of Care sites funded with federal dollars, there was no funding for this service. Qualified respite often had to be provided by therapists or trained aides from the school who were already working with the child. The cost for this respite is high since professional rates are charged to the families. Not only was there a need for qualified respite, but there was also a need for consistent respite providers over time. Parents talked about the fact that the teenager down the block is not a suitable respite provider, and that even when a professional or mature adult is employed their skill level may not be adequate.

When parents who participated in the focus group were asked to discuss the most significant barriers to the provision of quality mental health services to children in Florida they cited a number of issues including:

- **Stigma.** They felt that many parents don’t speak up about their children’s needs because they do not want to label the child and they do not trust medication because it has not been tested for children. They are fearful that the label will result in their child’s exclusion from settings and services. Parents said that once a child has problems in school they are treated more like a criminal than a person with an illness and the child’s world and community participation becomes increasingly restricted (e.g., can’t attend certain activities or be in certain settings);

- **Cultural incompetence.** Providers and schools do not take a family’s culture into consideration, including such cultural issues as religion and language;
• Lack of nontraditional services. Services that are “out of the box” such as behavior intervention, parenting classes, arts, recreation, etc., are not given credence and validity;

• Fragmentation. There is no seamless system of care as children move from setting to setting or access different systems or transition in various ways (e.g., back to family from residential, to adult services, to independence, in and out of juvenile justice or child welfare). There is no central point for systems to come together, especially when children are in crisis. Parents feel they are left on their own to try to figure things out. Parents felt like schools would be a natural place to help families find pathways to service;

• Lack of funding;

• Lack of qualified providers;

• High caseloads of psychiatrists and case managers;

• Wait lists for services;

• Lack of quality family case management;

• Providing support for the entire family, especially caregivers;

• Lack of qualified, affordable respite;

• Medical personnel and facilities that are not trained to meet the needs of the children and do not recognize there is an impact on the entire family;

• Need for parent support groups and “buddy systems” so families will not feel they are alone; and

• Overall, the parents that were knowledgeable about or involved with Systems of Care sites saw many advantages to everything from better coordination to family supports to family voice.

The responses of the Hispanic family members with respect to access, needed services, and barriers reflected the cultural challenges facing the community. Issues and barriers cited included

• Language barriers and the need for more bilingual personnel for
  o Orientation materials at mental health clinics;
  o Clinicians and physicians; and
  o General information related to service availability.

• Like the focus group respondents, these families also saw the lack of health insurance as a barrier.

• Specific service needs included
  o Crisis and emergency services;
  o Prevention services;
  o Family support services;
  o More clinics in parts of the community that are accessible to families (e.g., transportation needs); and
  o In general not enough personnel who are bilingual.

• Additional challenges included
  o Lack of continuity of service provision over time;
Need for parent education about the system and how to access services;
Lack of importance given to the needs of children with mental health issues;
Impact of immigration and having to learn an entirely new system; and
General concerns about the confidentiality of medical records.

National Experts Perspectives on Service Array, Accessibility and Funding

Five national experts in children's mental health participated in individual telephone interviews with various members of the research team. These experts were provided with a summary of the Florida data together with questions to be addressed during the telephone call. In addition, an expert panel from the Louis de la Parte Florida Mental Health Institute also reacted to the preliminary findings during a focus group meeting.

With respect to array of services and accessibility, national experts noted that the accessibility and funding pattern for Florida was fairly typical of the patterns seen across the nation. Like Florida respondents, they indicated that there is a lack of accessibility and affordability of mental health services for children not eligible for Medicaid. The other accessibility and funding pattern was that traditional therapy (e.g., individual, group, and family) and more costly residential services seem to predominate, as they did in the Florida survey, with less accessibility and funding for a range of community-based service options (e.g., home-based services, family supports, respite for caregivers). Reasons for these patterns were explored with the national experts.

With respect to lack of accessibility and affordability of mental health services for children not eligible for Medicaid, respondents, experts and parents noted that many families lack private insurance. And even when families have private insurance, many valued and needed services are either not funded by the insurer (e.g., Behavioral Aides or Certified Behavior Analysts) or the course of funded treatment is too short and families find they are unable to afford the additional treatment needed for their children.

With respect to the lack of accessibility and funding for mid-range community-based services, a key national expert on funding indicated that historically, there has not been a good understanding of the promise and function of these mid-range, community-based services by Medicaid. The national expert also noted that in costing out such services, Medicaid often makes assumptions that services are used sequentially by everyone rather than understanding that children and families use only what they need and that community-based services can be an alternative to more costly services. This “sequential, everyone uses everything” thinking, can lead Medicaid to assume that these services would add great cost to the financing structure. The national expert also did note that the system still requires careful management, or it indeed, can become prohibitively expensive.

An overall challenge with Medicaid funding is that it is a medical model perspective (medical eligibility, time-limited, ‘cure’ oriented) and therefore does not understand the value of services in the array that are not provided by
“licensed” professionals (e.g., value of family education and support, behavior management skills training that is often done by paraprofessionals, intensive case management). While there is a push federally from the President’s New Freedom Commission on Mental Health to be more flexible, there is simultaneously a push back from Medicaid, especially on case management. The view is sometimes that Juvenile Justice and Child Welfare already have case management so why should Medicaid pay for it? When in point of fact systems case management is very different in terms of functions and goals.

Another problem with accessibility and funding of these mid-range services is that rates are often set too low; therefore providers don’t offer the service. Another related problem that then emerges is that providers of these mid-range services don’t necessarily know how to effectively provide services, and may not be able to do so at the rates set. For example, the home and community rehabilitation option can be used to fund home-based services. However, effective home-based services are not just a location but also require competent professionals who deliver effective treatment and services. Overall, case rates can work well for Evidence-based Programs and practices and community-based services but an adequate rate needs to be negotiated. States find that the pace of negotiating with Medicaid can be frustratingly slow. When there are capitated managed care plans, there can be more flexibility in how funding is allocated. However, if it is an “acute care only” capitated system, there can be real problems with access to an appropriate array.

Across systems (e.g., Juvenile Justice, Child Welfare) national experts noted that there is a strong residential services lobby in most states that promotes the use of residential services. Part of the strength of the lobby arises because youth and children from these other systems have their costs defrayed by entering residential settings that are paid for by Medicaid. An example of this is the state of Maryland, where Medicaid pays for virtually all residential treatment. When child welfare and juvenile justice-involved children are placed in residential treatment facilities, those systems do not pay for their care. Medicaid and the Department of Mental Hygiene pay for treatment. This creates an incentive for child welfare and juvenile justice systems to put youth into residential treatment centers.

The national expert also noted that some states, such as Maryland, developed funding structures that created incentives for the use of residential treatment through their Medicaid payment plans. For example, Maryland uses the “Family of One” designation, which allows waiver of income requirements to qualify for Medicaid for funding of residential services but not for community-based services. Maryland currently spends $50-$70 million dollars annually for about 700 children in residential placement.

The national expert also noted that states too often think they need to apply for a federal waiver, which is often time-consuming and less successful, rather than building the Medicaid funding for evidence-based or new approaches through a broad state rehabilitation services option benefit that is managed. Also, states can use the 1115 waiver for demonstration and pilot programs to test the feasibility and impact of broadening the array of services or providing services differently.
With respect to funding and access, another expert noted that states have employed the strategy of redeploying funding from high cost services in order to fund more community-based and less costly services.

The national experts within and outside of Florida mentioned that Florida has several strengths related to Medicaid funding and operations. These include the following:

- Florida’s state Medicaid plan is one of the best in the country. It includes funding categories for most of the home and community based services listed on the survey and viewed as desirable by parents. Given the breadth of services allowed through the home and community waiver, there may be opportunities to support less traditional services and improve the array of community-based services;
- One expert noted that the inclusion of Therapeutic or Treatment Foster Care in the funding structure was enviable, with many states clamoring for more treatment foster care and not having the funding mechanism available; and
- AHCA and the DCF Children’s Mental Health offices have a collaborative working relationship at the state level and at the District levels. Area and District staff universally characterized their relationships as cooperative, collaborative and facilitated by frequent, open communication. This level of cooperation and communication is a strength in system planning and oversight.

It should be noted that with the transition to a capitated system, HMO’s and other managed care entities (e.g., pre-paid mental health plans) would have an increasing influence related to service development, selection and provision. Area 1, which includes Escambia, Okaloosa, Santa Rosa and Walton counties, currently operates on a capitated system. Interview responses from both DCF Children’s Mental Health and the Area AHCA office indicated that they did not have concerns, generally, about lack of service or the inability to get service for particular populations. However, they did comment on disincentives in the structure for home-based service (inability to bill for travel time) and the challenge of providing services in a rural area (e.g., transportation issues for families).

**National Experts Perspectives on Populations of Concern**

National experts noted that, nationally, populations of concern were similar to those listed by AHCA and DCF Children’s Mental Health respondents in Florida and included:

- Children and youth with a variety of sexual problems (e.g., sexual offenders, sexually reactive);
- Children and adolescents with developmental disabilities (borderline IQ) and mental health problems;
- Children and youth with severe behavior problems (e.g., aggression, self-harm, running away); and
- Adolescents with mental health problems or with developmental disabilities and mental health problems transitioning to the adult service system.

Nationally, there is generally a mindset that children and youth with more challenging behavior problems need to be excluded from communities and sent to...
residential treatment settings. Also, there is a general tendency to equate intensity of service delivery with residential settings and a general lack of understanding that intensity of service is related to the type and frequency of intervention and not the location of the service. For example, the intensity of service in a home-based intervention can be equal to or greater than the intensity of service in a residential setting. The national experts concurred with the Florida respondents that issues related to liability, training, expertise, and funding all contributed to the lack of intensive community-based services for these populations. In addition, parents in the focus group cited stigma as an additional factor resulting in parents being fearful of advocating for services and having their child labeled or excluded from the community.

For some populations of concern, the issues relate to the challenges of working across domains. Florida respondents and national experts noted the challenges of serving children with developmental disabilities and mental health issues. In many states developmental disabilities departments rely heavily on special education to meet the needs of these children and adolescents. However, school settings are often challenged in meeting the needs of this dually diagnosed population. Furthermore, the challenges increase as adolescents age out of child welfare, children’s mental health, and public education systems. As these young people transition to adulthood and adult services, the service systems for adult mental health and adult developmental disabilities do not meet their needs. These service systems tend to be geared toward persons with severe mental illness or persons with more severe developmental disabilities. One unfortunate result is that many of these youth then end up incarcerated or homeless.

Despite these tendencies to treat children and adolescents with challenging behavior and diagnoses in residential settings, or the failure of systems to work well together, there are some excellent examples of communities that have taken on the challenge of creating more effective, intensive community-based services for these children and youth. In particular the following communities were cited as exemplary:

- The Dawn Project in Indianapolis, Indiana;
- The Westchester County System of Care in Westchester, New York;
- Fulton County, Georgia;
- Milwaukee Wraparound Project;
- Monroe County, Rochester, New York; and
- Massachusetts Mental Health Services Program for Youth.

**Exemplary Approaches to System and Practice Change**

When national experts were asked to detail the factors and strategies that facilitate accessibility, the development of an appropriate range of services and adequate funding, they cited the following processes and components:

- Inclusive planning and input of stakeholders at all levels;
- Interagency relationships and partnerships;
• On-going training;
• State support from the Governor’s Office and from heads of departments;
• Partnering among children’s services at the state level to increase the profile of children’s mental health and to improve funding;
• Reallocation of existing funding from high cost restrictive services to lower cost community-based services;
• Strong partnerships between children’s mental health and the state Medicaid office;
• Development of flexible funding mechanisms for wraparound approaches;
• District and local commitment and involvement;
• Evaluation data that can guide decision making and are widely available and understood by families, communities, providers and state departments;
• Infusion of the System of Care into the larger systems;
• Cultivation of multiple champions and leaders;
• Strong family organizations; and
• Constituents who advocate for change.

To better illustrate the influence of these factors and the implementation of these strategies, we interviewed lead professionals at two sites: the Milwaukee Wraparound Project and the Westchester County System of Care in Westchester, New York. Both sites were recommended by several of the national experts as providing good systems of care and effective services for very challenging populations. These sites were also selected because the challenging populations they serve were the populations cited by Florida DCF and AHCA respondents as not well served or needing more service in Florida. These populations include sexually reactive children and youth, youth who have committed sexual offenses, dually diagnosed adolescents with developmental disabilities and mental health issues, and youth who present serious risk to the community (e.g., juvenile fire setters).

Milwaukee and Westchester both engaged in similar processes to develop effective, less costly, and more community-based services for these populations of concern. These processes are as instructive as the resulting service approaches and arrays.

Milwaukee likened their planning and execution process to a “mini-system of care” approach to the populations of concern while Westchester consistently referred to utilizing a Theory of Change approach (Hernandez and Hodges, 2003). Both planning and execution processes involved the following common components:

• **Initial identification of the population** – Leadership in the community identified a population of children and adolescents that was not being served well or was being served primarily in residential placements outside the community. In Milwaukee the impetus to address the population was the recognition by the program leadership that the combined children’s service system would be asked to serve children and adolescents with challenging needs in the community. With its combined service system, Milwaukee
essentially operates on a no-refusal policy. In the case of Westchester County, the leadership came from the family advocacy organization that has a strong commitment to serving these children and youth in the most community-based and least restrictive setting possible.

- **Cross system collaboration and planning** – Both efforts involved broad-based collaboration among stakeholders and careful planning. For example, the efforts in Milwaukee related to sexually offending and reactive youth brought representatives of the courts together, including judges and District attorneys, law enforcement including sensitive crimes unit, child welfare, victims’ advocates, mental health providers, probation officers, and others. In Westchester, for the same population, a similar cross-system committee focused on these youth, with funding for the committee provided by the state.

- **Data collection and analyses** – In both communities the committees carefully studied the population of concern by collecting and reviewing the data from their community that was related to these children and adolescents. For example, the Milwaukee committee reviewed every case on a monthly basis beginning in January 2000, including demographics of the child or youth, the victim, the circumstance related to the offense, legal proceedings, length of time to get mental health services, and outcome data in terms of recidivism. This process built joint ownership for the population and helped create a real understanding of the range of problems and issues.

- **Seeking out evidence-based assessments and treatment approaches** – Both communities sought out the best evidence related to valid risk assessments and treatment approaches. Both national and local experts were sought out and the committees reviewed the information. In both communities the committee development, data analyses and seeking out of evidence was a protracted process over a year.

- **Exposure of the community to the issues and the best evidence** – In both communities, experts educated the community (e.g., parents, providers, agency personnel) about what was known regarding risk assessments and treatment approaches. This was accomplished in a variety of ways including presentations by national and local experts and by visiting exemplary programs.

- **Building community capacity** – Federal grants, state funding and community initiatives helped build the capacity of psychologists and providers. In both communities psychologists were trained, supervised and mentored in providing high quality risk assessments using validated instruments. In both communities there was a shift from nearly exclusive residential treatment primarily or exclusively for adjudicated youngsters, to a range of services with the majority of children being served while residing with their families or with foster families. Service delivery is through intensive wraparound approaches with a strong emphasis on safety planning, supervision, and offense specific individual, group, and family therapy. As with any wraparound approach, each treatment plan is highly individualized.

   Community capacity building involves training across systems about the needs and services required for and available to this population. For example, the Westchester effort involves training of all providers throughout the system on effective safety and intervention strategies, since these children are likely to be served in a variety of settings. This embedding of knowledge and skill throughout the community is seen as an effective approach.
Maintaining and using data systems – In both communities, the broad collaborative committee continues to collect and review data about the outcomes at the child and system level. For example, in Milwaukee, recidivism prior to the wraparound approach was 16% and decreased to 10% after the decreased use of residential services and increased use of community-based services. On a population basis, Milwaukee serves about 130 children and youth at any given time who have committed sexual offenses or who are sexually reactive. At the time of the interview, only 17 were being served in residential treatment settings and they envisioned only about 3 of those 17 children needing longer-term residential treatment. Another 40 are served in group homes and foster homes, primarily due to the nature of their offenses (e.g., incest) and the care that needs to be taken related to family safety. However, even for these youths, the goal is a relatively short out-of-home placement with a return to family. The remaining children and youth are all served in their own families with wraparound plans. Average cost for serving these youth in the community is about $4,000 per child per month, including costs for treating the victims and the family using a case rate-funding model. This compares favorably to the cost of residential treatment for these youth at about $9,000 per child per month. It should be noted that these residential treatment costs are very similar to the Statewide Inpatient Psychiatric Program (SIPP) costs per child per month in Florida. The cost savings accrued in Milwaukee are more likely when youth being served are very challenging and have primarily been accessing more costly residential services and are then afforded the opportunity to utilize evidence-based, intensive community-based services that are more flexibly funded through a case rate model.

Both Westchester and Milwaukee noted that their approaches have garnered the confidence and support of judges, law enforcement officials and probation officers due to the valid risk assessments and the careful attention to and implementation of individual plans of care.

For juveniles who have set fires and for dually diagnosed adolescents with borderline IQ's and developmental disabilities, Westchester County went through a planning process with the same steps as those detailed above.

In Milwaukee, the use of Individual Plans of Care (wraparound approaches) for dually diagnosed children has been adequate to serve the needs of the population. However, Milwaukee has been through years of system development, pooled funding approaches, the development of an extensive data system to evaluate outcomes and family satisfaction, and the fostering of a diverse and effective provider network.

In addition to the routine and effective use of Individual Plans of Care, Milwaukee offers families and their children a “true” choice as they access service. This choice is possible because an extensive provider network has been developed over the years. Families have access to consumer satisfaction data and outcome data for services in the network. Because it is a fee for service system, providers remain highly responsive to families and are likely to use outcome data to improve services and inform parents about their service. It also should be noted that system management and monitoring in Milwaukee occurs through a non-profit,
publicly managed care entity and that blended funding among child welfare, mental health and juvenile justice fund the service array.

With respect to children with developmental disabilities and mental health concerns, there were still challenges experienced by both Westchester and Milwaukee that included the following issues.

• Near total lack of communication between the departments that deal with developmental disabilities and those that deal with mental health in Westchester.

• Westchester had funding challenges because the Medicaid Waiver funding structure was a state structure rather than a county structure. The strict gatekeeping, inflexible rules and eligibility criteria make it a difficult system to work with in New York for this population.

• Milwaukee noted the challenges related to family-based services when the parents also have developmental disabilities or mental health issues or both.

• As in Florida, Wraparound Milwaukee and Westchester also expressed concern about the challenge of transition to adult services for this group. However, Westchester County noted that there is a great deal of attention being given to this population at the federal level. Recently, there was a federal summit led by the Department of Health and Human Services to bring the various federal departments together around the needs of these youth.

Summary and Recommendations for Array and Access

Challenging populations can be effectively served in less restrictive environments. However, multi-year efforts are required and must include careful attention to cross-system planning and collaboration, attention to evidence-based assessments and interventions, ongoing community and provider capacity-building as well as regular performance improvement and functional data systems. There is no simple or rapid solution to the problem of developing and implementing a high quality and effective array of services. The best solution appears to be a community needs assessment and planning process that takes into account funding issues, family perspectives, training and coaching needs, the needs of diverse populations, and performance measurement.

There may be increased opportunity to creatively and flexibly fund a broader array of services in Florida. Within the state of Florida, the expansion of managed behavioral health care through HMO’s and carve outs will occur in the next 12 months in Broward and Duval Counties. With this expansion, there will be an opportunity to replicate the apparently successful development of an adequate and accessible array of services as reported in District 1 by both AHCA and DCF respondents. We recommend tracking the flexible and creative use of resources to improve the service array in the managed care environment as this approach expands across the state. It also will be important for AHCA and DCF to continue to work closely together to analyze the adequacy of the procedure codes as well as the possibility of developing new codes for nontraditional services. It may be that the expansion of this funding strategy will allow for system improvements in array, access and quality.
We also recommend exploration of service expansion within communities and Districts and to foster more statewide nontraditional services (e.g., respite, family support); improve access to Certified Behavior Analysts; improve the competence of staff in service sectors designed to service all children (e.g., after school activities, recreation programs, Medical services); and investigate the availability of and access to qualified child and adolescent psychiatrists. The expansion of these services were recommended by the parent focus groups and, given the size of the groups, it may be wise to encourage individual communities and Districts to analyze family needs in their areas. With respect to the availability of child and adolescent psychiatrists, it may be helpful for the state to further investigate and define the degree of need that exists, as well as the barriers to attracting and keeping qualified child psychiatrists engaged with the populations of concern. If there is a lack of qualified psychiatrists, it may be that funding rates are too low or that their services are viewed as too expensive, or both, which may restrict their role to medication management only. This may not be professionally satisfying for these physicians. While the number of parents in the focus groups was small, they felt strongly about this issue and, therefore, it may warrant further study.
Performance Measurement and Quality Improvement (PM/QI)

Background

For years, the management literature has extolled the benefits of systematic approaches to the collection of useful information that can drive data based decision-making, support quality assurance and guide program improvement efforts. Such performance measurement and quality improvement (PM/QI) systems are viewed as providing organizations with a competitive edge. Starting with Management by Objectives (MBO) (Drucker, 1974) and Performance Based Budgeting Systems (PBBS) (Wildavsky, 1984), these efforts evolved into Quality Circles and Continuous Quality Improvement (Deming, 1982; Crocker, Charney & Leung Chiu, 1984). All of these systems had several characteristics in common. First, they all required a shared, clear organizational mission and goals from which all organizational activities flowed. Second, the information to be collected to shape organizational performance was jointly determined by frontline staff, supervisors, and managers and collected and fed back to each person, starting at the lowest level. These data were then aggregated for top managers into a minimal set of performance indicators that covered all aspects of the operations. Finally, line workers and supervisors were empowered to use the information to derive local solutions to problems and to innovate ways to improve the operations. The role of the data was not to punish, but rather to motivate self-monitoring and correction. Today such efforts are commonly referred to as decision support systems. However, to implement all of these different systems requires organizational commitment at all levels and wide-scale organizational change.

While Performance Measurement and Quality Improvement are extremely important and very common organizational activities, the unfortunate reality is they are often vaguely defined and poorly implemented. Most organizational leaders are in favor of PM/QI systems, but few seem to agree on exactly what they are, the amount and kind of resources that should be devoted to them, and the specific results that are expected from them.

Not surprisingly, with escalating Medicaid budgets, this was an area of interest to AHCA. In this part of the study three different areas were addressed:

- What is the current state of PM/QI in Florida?
- How does this compare to what is happening in the rest of the nation?
- What are some exemplary PM/QI efforts at both state and program levels?

PM/QI in Florida

The information in this section came from the two online surveys and from interviews with Area AHCA and District DCF respondents. In conducting the interviews and analyzing the data, we were very cognizant of the very different roles of AHCA and DCF and how that affected their view of PM/QI. AHCA's
main responsibility is to ensure that the Medicaid dollars are spent in accordance with federal regulations and the state Medicaid plan. They are responsible for maintaining accurate eligibility roles, ensuring that services paid for are Medicaid eligible, and that all of the appropriate documentation and justifications are in place so that the state will not be liable for any paybacks in a federal audit. DCF, on the other hand, is responsible for program content and monitoring the quantity and quality of mental health services delivered. In general, at the local level this oversight function is carried out through the contracting process and subsequent monitoring of those contracts. As a result, the responsibility for overall planning and system design is very diffuse.

Since PM/QI efforts should be related to the organization's overall goals, we asked the District and Area offices what they saw as their goals. Most respondents described their goals as the mandated outcome measurement of 1) number of days the child spent in the community, 2) the child's functional scores on the CFARS, and to a lesser degree, 3) system decreases in high-end residential placements and re-admissions. It was also mentioned that the Legislature sets the performance measures. Other goals mentioned by respondents related to service provision or contracting such as: “implement Wraparound,” “have a better continuum of care,” “provide more in-home service,” “serve rural areas better,” and “use performance-based budgeting.” Two respondents also mentioned treatment plans in the context of goals and expressed the need for children's treatment goals to be individualized and quantifiable.

When asked to describe their performance measurement or quality improvement systems, 50% of the AHCA respondents had no information or opinion about the subject. Clearly this was an area that was not within the scope of responsibilities for the Area offices. Most stated, “Tallahassee takes care of that.” There appeared to be a distinct disconnect between the state headquarters and the Area offices with regard to PM/QI. There was a perception that PM/QI is “someone else's job” or that there were no job positions (or funding) to perform these tasks. When asked to rate the quality of the PM/QI system in their Area/District on a 5-point scale (5 being the best quality), AHCA respondents had a higher average rating (3.1) than DCF respondents (2.7), even though they had little information about it or responsibility for it. System performance was a topic that was misunderstood by many respondents and AHCA/DCF respondents only referred to contract monitoring or possibly provider meetings to address the performance of the “system” as opposed to the use of data to evaluate the functioning and quality of the continuum of services in an Area or District.

The select group of providers (33 providers from throughout the Florida, nominated by AHCA and DCF as providing high-quality work) in this study rated their PM/QI systems as “excellent” or “good” in 85% of the responses with no provider rating their PM/QI system as “poor.” When the providers were asked to describe where the motivation (or pressure) to have QI programs comes from, they reported that the major source of pressure came from (in order of greatest...
influence) accreditation or licensing authorities, funding and oversight agencies, program supervisors or managers, and board members. Family members and consumers were seen as providing the least amount of pressure.

AHCA respondents reported that systematic data collection is not a responsibility of the Area offices other than data collection that occurs during the monitoring of service providers. All respondents agreed that the major indicators used were: number of children served, demographics, costs (per child served and services), and out-of-home placements. Most DCF respondents report that they also track child/family satisfaction, timely access to services, service utilization (mental health, child welfare, and juvenile justice), outcomes, and consumer complaints. When they receive information indicating there is a pressing issue, a meeting is convened with all relevant parties to try to come up with a solution before the problem escalates. All providers (n = 33) agreed that their agency routinely collected and reported overall program data and 96% said they used these data for program improvement. Most providers (93%) also reported that they collect and report outcome data, but only 52% said clinicians used data regularly in treatment planning. Some of the concerns regarding data collection were: the lack of good indicators, problems with the new management information system (MIS), and the fact that data are submitted monthly to the “data warehouse,” where many reportedly lost any meaningful use of the data. When asked how data are used, AHCA deferred that responsibility to Tallahassee, but mentioned that “sometimes they share it.” Most DCF respondents described a data information feedback loop at all levels of the organization, but were quick to admit that there wasn’t a lot of “trust” in the data yet because of the new-ness of the MIS. Many thought the system would be improved once the “bugs” were worked out of the new MIS. These responses seem to indicate that providers, for a variety of reasons including the fact that they go through licensing and accreditation processes, seem to have much better developed PM/QI procedures than do state agencies.

When asked about clinical or child outcomes, all AHCA respondents reported that this was not their responsibility. Most respondents reported that the CFARS was the main (or only) clinical outcome measure used. DCF respondents reported two other methods of assessing child outcomes: provider treatment reports and first-hand knowledge from attending meetings or observing the clients, or both. Non-traditional services data (e.g., family support, family education, preschool, mentors, and tutors) are less likely to be collected and reported routinely on an individual basis, although they are more likely to be collected and reported routinely on a program level. Most traditional services data tend to be collected and reported routinely on the individual level but less so at the program level, according to DCF respondents.

Almost all of the providers reported that the strongest facilitator to implement a PM/QI system came from the funding and accrediting bodies. Other facilitators included: desire on the part of boards and senior management to improve, desire to demonstrate the effectiveness of the agency and improve its stature and reputation in the community, motivation on the part of staff and management to
help clients by providing better services, enthusiastic leadership, and inclusion of staff in the QI process by providing useful feedback to them so they can improve their services.

Providers most often cited “lack of funding” and “lack of time” as the most significant barriers to implementation of a PM/QI system. The lack of time was seen as a result of staff being overextended and burdened with excessive paperwork. Staff-related barriers included lack of QI positions or dedicated staff, proper training, lack of interest or resistance of staff at all levels to change or to be held accountable, and staff turnover. Infrastructure barriers included the need for updated MIS equipment and lack of technical assistance. Another barrier was described as the difficulty in establishing quality outcome measures that are simple and efficient to use.

When providers were asked about barriers to PM/QI implementation as it relates to the therapists, many mentioned the fact that PM/QI activities are rarely “billable” and in many fee-for-service agencies with high productivity standards, PM/QI conflicts with meeting these standards. Excessive paperwork that results in considerable “unpaid overtime” is seen as a significant barrier to implementation of QI systems. Other reported barriers for therapists included: lack of training, lack of understanding the importance of the PM/QI process and how it fits into the agency performance as a whole, lack of meaningful and timely feedback loops to clinicians, lack of interest (buy in), not seeing the value of it compared to the time it takes away from direct service with an increasingly difficult client population, resistance to change, and the fact that the PM/QI procedures are often unclear or inefficient.

In the parent focus groups, parents were asked about PM/QI and indicated that they were not sure they knew what information was collected or what would be useful to them. They did feel that a report card on agencies and services would be helpful to them in understanding what choices to make among the options available. One type of information they felt would be particularly useful would be the prognosis for children who had a serious emotional disturbance who were making a transition either from one level of school to another or from one type of program to another. In particular they were interested in what the experiences of other families were as their children made these transitions. Parents felt this would help them know what to expect and perhaps enable them to take some action to prevent problems.

In the discussion with state stakeholders it was pointed out that under the new DCF leadership they were starting to use the key performance measures set by the Legislature on a regular basis but were limited in that the Legislature sets their performance measures. For children’s Mental Health, the differences in CFARS scores were noted. They all agreed on the importance of using data in a timely manner to make informed decisions about services.

Thus, currently in Florida most data collection by state officials is used for eligibility, accountability, monitoring, and billing purposes. Most data collection by providers relates to the mandatory requirements of accrediting or licensing authorities. Child outcome measures seem to be limited to “CFARS” and days
in the community. Little or no system outcome data are collected or used for purposes other than the monitoring of providers. Barriers to achieving a good PM/QI system in the state are the lack of training, lack of time because of an overabundance of paperwork, lack of buy in of some stakeholders; the “non-billable” time required to address these issues and a lack of funding for support, resources and staff.

When asked to rate the quality of services in their Area or District, both AHCA and DCF respondents were most satisfied with substance abuse, school-based mental health, and trauma services. They were least satisfied with programs for sex offenders, transition services, preschool services, family education, mentors, tutors, and therapeutic aid services. The low satisfaction could relate to the quality of the existing service, or in many cases, the lack of these services.

With regard to out-of-District services, 50% of the AHCA/DCF respondents reported they were satisfied, and 50% reported that they were unsatisfied or very unsatisfied. However, most do not send their children and families out of the District for services and those that reluctantly have to send them out of the District, are not happy with the quality or outcomes of the services. AHCA respondents reported that information regarding the quality of mental health services is not provided to the Area offices. Most perceptions of particular service quality seemed to be based on anecdotal information.

The National Perspective

All of the national experts agreed that Florida is not unique in its approaches to PM/QI, and that very few states collected data that were used for performance measurement or quality improvement. Functional outcomes did not seem to be captured in any systematic and useful way as a part of a PM/QI system. States basically have a billing process and an MIS process that are separate systems (like Florida). If outcomes are used, it is generally for a time-limited evaluation effort of a particular program or project, not as an ongoing process that regularly informs decision-making. States generally do not have good data systems that can be linked back to programs and specific children to use in a quality improvement system. Usually the data are far removed from the human element and states don’t have the right people in place to collect and interpret the data they do have. The 2003 Health Care Tracking Reform Project (Stroul, Pires & Armstrong, 2004) indicates that only a very small percentage of states track and use functional clinical outcomes to inform decision-making at any level. Most of the quality measures collected by the managed care systems focused on cost, service utilization, and penetration rates. While 95% of carve-out managed care systems were measuring clinical and functional outcomes as were 74% of the integrated systems (overall 86%), their outcome measurement systems were considered to be at an early stage with only 29% of carve-outs and 9% of integrated systems (22% total) reporting that their information systems were implemented and they were getting results in 2003 (Stroul, Pires & Armstrong, 2004). There is no information, however, on whether they were using these data for quality improvement purposes.
Ironically, there are frequently data available in the community. But what that data is, how reliable it is, who enters the data, and what is entered in the billing system are at issue. People do not have a firm grasp of what data are routinely available and the reliability and validity of the data. In addition, the MIS has a greater capacity to handle information but only the fields for billing are being filled in. Hence, there is a lack of both the culture and infrastructure to collect and make good use of data.

There was also agreement on some of the challenges to developing functional PM/QI systems. There is a lack of understanding that for data to be useful the results need to be fed back to decision makers in a timely and user-friendly format. As a result, there is a lack of a functional infrastructure to produce timely information. States and localities don’t have the decision-makers, clinicians, program directors and consumers looking at and using the data. Because of past experience, most persons do not see data as something useful and therefore do not see any value in collecting data in a thorough, accurate, and rigorous way. Furthermore, even if they did value it, as was noted in the Florida survey, under the current fiscal systems, few have the time to devote to this effort.

The experts pointed out that communities need to be encouraged to find their local data but with the caveat that they need to be sure that the data systems that exist are helpful and reliable and that they can actually use the data. Others encouraged some form of service testing or system of care practice review to supplement data systems. Service testing and system of care practice review involves selecting a random sample of cases and then interviewing everyone involved with the case according to a carefully developed protocol (Improvement Concepts Inc., 1995; Hernandez, Worthington & Davis, 2005; Hernandez, Worthington & Davis, 2005). Florida DCF has already conducted some pilot tests of this process in the child welfare system. This process provides an in-depth view of individual cases which can give a much more realistic picture of the treatment process, collaboration among organizations, problems and successes that can supplement the data system as well as highlight areas for further study. Consequently, a comprehensive PM/QI approach should not only collect aggregate data but should systematically collect data at the child and family level to see how the system is actually operating.

**Exemplary State and Program PM/QI Efforts**

There was a consensus among national experts about exemplary programs. Michigan and Hawaii were cited as the two states that were most advanced in their PM/QI systems. On a program level, Kearney Nebraska, Wraparound Milwaukee, and the Dawn Project in Indianapolis, Indiana were three that were repeatedly mentioned as having good data systems that were regularly used to guide decision-making at both the system, program and clinician level.

In looking at the two states it is important to remember their contexts differ considerably from the situation in Florida. Hawaii is a much smaller state, which developed its PM/QI system as part of a consent decree to settle a lawsuit brought against the Departments of Mental Health and Education. Michigan has a much
better resourced central office and contracts with local mental health authorities, who then sub-contract with private non-profit providers. There is strong county government and local taxing authority as well. So while these are exemplary systems, their approaches would have to be adapted to fit the realities of the Florida context.

**Michigan:** In 1996, The Michigan Department of Community Health (MDCH) established the Level of Functioning Project (LOF), a partnership between MDCH, Eastern Michigan University (EMU) and the Community Mental Health Service Programs (CMHSP’s). The project involves using the Child and Adolescent Functional Assessment Scale (CAFAS, Hodges, 2000) to determine the effectiveness of treatment as usual on children under the care of the public mental health system. The CAFAS data collection effort was in addition to the already existing state MIS system that as described above, was mainly used for quality assurance purposes and was not able to provide timely and therefore, useful feedback to programs and clinicians (Hodges, 2003). This project was developed to provide a voluntary system for providers to receive feedback that would be useful for decision-making. A unique feature of this program was that each CMHSP was held harmless, that is, there was a firm commitment that information would not be used to punish any agency. Another important feature was that the project was not expected to be implemented overnight, but was allowed to evolve in a planned and collaborative manner such that there were not only considerable improvements but also ownership among the partners (Hodges & Wotring, 2004).

The LOF staff worked hard to develop a format for the data that was user-friendly for the programs. Currently, most of the state participates in the project and programs submit client outcomes using CAFAS as well as selected demographic and service utilization information. The CAFAS measures the level of functioning of a child in eight domains (school or work, home, community, behavior toward others, moods and emotions, self-harmful behavior, substance use, and thinking). The LOF staff produces a monthly report for each program that it can use for clinical management. They also receive statewide information on the same indicators. This allows programs to benchmark themselves in comparison to other programs. The CAFAS software also allows agencies to produce individual client assessment reports and treatment plans so that the progress of individual children can be monitored in all of the domains over time. The data are shared with all participants semi-annually at a statewide meeting where participants discuss the data, share innovative ways of using it, and how they are working with particular types of clients.

In order to determine how well programs were doing and to identify exemplary programs, it is important to be able to control for differences in the populations served by the programs and to track the outcomes of children with different types of problems. The LOF program used a statistical analysis procedure called propensity scoring, which allows one to compare different populations.
and to match sub-populations across programs. Secondly, subgroups of youth being served were identified via cluster analysis (Hodges & Wotring, 2000) so that outcomes could be determined by client type. This allowed a CMHSP to determine the effectiveness of different programs within its agency for different types of clients served. Fortunately, every participating CMHSP program did better than the state average for some type of client. Therefore, each agency was able to take pride in some aspect of its performance. This helped acceptance of the program enormously.

The program followed a logical evolution. First, the task was to come up with a data feedback system that provided useful information in a timely manner. Secondly, the importance of distinguishing among different types of presenting problems was recognized and a useful method was developed for breaking out the data by type of client presenting problem. This gave a good picture of the effectiveness of treatment as usual for children in the public mental health system. The data was then used to identify exemplary programs in the state. The programs were examined more carefully using a case study methodology by a team from the University of South Florida. The case studies helped determine processes these programs were using which contributed to their success, so that these treatment and care approaches could be shared with other programs. In the next phase, the data was analyzed to determine the patterns of outcomes for children with different presenting problems. The rate of successful outcomes for these youths varied from 38% to 58% depending on the outcome indicator used and the subgroup. Once the outcomes had been determined and fed back to the agencies on how well they were doing with the different sub-groups, the agencies also were given material on the EBP’s, which might be useful for the different types of problems. A statewide planning group helped determine which EBP’s should be rolled out on a statewide level (Hodges & Wotring, 2004).

The two case studies of the exemplary sites revealed the power of data in stimulating changes in practice and changing the culture of an agency to one of continuous quality improvement. In both sites, supervisors strongly supported the use of the data for treatment planning in a non-punitive way. Supervisors built on the helpful strategies that were positively impacting child outcomes and teams suggested new strategies to address continuing concerns. This strength-based problem-solving approach emphasized clinician responsibility. The supervisor and teams used the program data to identify problematic domains and therefore, more systemic service delivery issues. The data were also shared with partners both to improve coordination and to leverage changes when improvement depended on complementary services. Both sites also cited the importance of strong support from agency leadership in the use of the data and the development of a PM/QI system.

In short, Michigan, through the use of a collaborative partnership, was able to use timely data from one single instrument to make significant advances in understanding the children being served in the public mental health system and in developing strategies that encouraged a culture of PM/QI. This approach has led to improvements in outcomes and initiatives to implement evidence-based
practice statewide. (See Appendix A for a detailed presentation of a site-specific example report for a Michigan agency.)

**Hawaii:** Hawaii presents a completely different example. In contrast to Michigan, the mental health system is state-run, with intensive case management being provided by the state and the majority of direct services being provided by private agencies, and it was the state management information system (MIS) that was turned into a comprehensive performance management system. The impetus for the transformation was a consent decree. Nevertheless, the changes that were made have been sustained and utilized effectively for establishing a PM/QI system. While the initial force for the change was external, the development of the system was a collaborative process involving all major stakeholder groups so that the system has evolved to be consumer-driven and very user-friendly. While participation in the PM/QI system was not voluntary, just as in Michigan the culture was established that data would not be used for punishment. Rather, data would be used to create a quality improvement process that was helpful and not threatening to either management or clinicians.

There are 27 performance measures in Hawaii’s system. These measures cover a wide variety of areas including

- Management functions (e.g., have sufficient personnel to serve eligible populations, maintaining sufficient fiscal allocation to sustain services, timely payment to providers);
- Service responsiveness and access (e.g., community based services in least restrictive setting, timely access to full array of services);
- The treatment planning process (e.g., families engaged as partners, individualized child-centered process); and
- Improvements in child outcomes (e.g., Improved CAFAS or Child Behavior Check List [CBCL] scores).

Each measure has a clear percentage assigned to it against which performance is measured. Each state “family guidance center” is required to submit a comprehensive quarterly performance and sustainability report for their respective Districts (based on school districts as opposed to counties). This report includes information from Children’s Mental Health, Department of Education, and Early Childhood Division (ages Birth -5). The report shows the quarterly performance of the various Districts and the state overall and it also explains the reasons for specific trends and outcomes.

Reports on individual client progress on all sub-scores for the CAFAS, CBCL and Child and Adolescent Level of Care Utilization System (CALOCUS) are particularly useful. The supervisors receive a report that allows them to look at a care coordinator’s entire caseload at a glance (referred to as the “Dashboard”) and highlight areas of improvement, decreases in performance, levels of care and caseload acuity for each child in a color-coded graphic format. Caseload acuity takes into consideration the difficulty and anticipated time needed to adequately coordinate services for individual children and their families. This is important
for balancing caseloads (e.g., a care coordinator can handle a larger caseload if the clients are lower acuity). Supervisors then use this data to work with the care coordinators and providers on improvement. The data for each entity is transparent. It is published and shared along with statewide averages much as in the Michigan system. Family satisfaction data is also collected and internal reviews of treatment plans and coordinated service plans (involving multiple agencies) are also monitored and tracked. Thus, the extent to which probation officers, school or child welfare personnel participate is monitored, as are plan characteristics such as individualization, use of informal supports, EBP’s, contingency and crises plans. Hawaii also uses service testing, where a sample of cases is chosen and all parties are interviewed using a standardized protocol (Improvement Concepts Inc., 1995). This is seen not only as a supplementary type of quality assurance but, more importantly, as a tool for improving practice. The service testers are comprised of teams of state employees, family advocates (parent partners), providers, and contracted employees. Finally, as is discussed in the EBP section, Hawaii has conducted an elaborate examination of EBP’s and has a web-based database of resources that can be accessed by parents, providers, and any other interested stakeholder.

Examples of Hawaii’s various reports on performance and Evidence-based Programs and practices, can be found at: http://www.hawaii.gov/health/mental-health/camhd/resources/index.htm. Here one can find two separate sections titled “Integrated Performance Monitoring Reports” and “Evidence-based Services.” Or see Appendices B and C for an example of Hawaii’s popular “Blue Menu.” This document is a brief set of guidelines used by practitioners and stakeholders to determine appropriate psychosocial and psychopharmacological interventions.

The Hawaii system is instructive in a number of ways. It is multi-dimensional which minimizes the likelihood of “gaming the system,” the system is focused on using timely data for identifying problems and using training and consultation to support staff in areas needing improvement. It has very clear standards presented in an easy to understand way and focuses on trends as well as a particular point in time. The PM/QI system holds all levels of the mental health system accountable and the system is very public and transparent. Hawaii, like Michigan, has data available on an individual level and aggregated up to the state level so all types of comparisons are possible. Hawaii also uses the data for decision support to identify areas such as service gaps, populations in need, and populations difficult to treat. They also test the success of the solutions at a variety of levels. A careful infrastructure has been built to support the efforts (e.g., tickler files with due dates) and the focus of the system is on improvements in child and family outcomes.

The Dawn Project and Wraparound Milwaukee: The discussion of these two projects is relatively brief since they share many of the characteristics of the two statewide projects. The two projects are similar in that they both serve single Midwestern counties; are joint efforts of multiple child-serving systems; are managed care systems with blended funding and capitated rates, and enroll youth being served in multiple systems. Wraparound Milwaukee is part of the
county while the Dawn Project is an independent not-for-profit agency formed by a consortium of community entities. They both have sophisticated electronic MIS systems that have real-time cost, service use, diagnostic, functional and outcome data that can be accessed by staff in easily understandable reports to inform decision-making. Both programs collect information on multiple indicators that measure both process and outcomes. Data are regularly reported back to stakeholders in a format that compares the current data with indicators at the time of enrollment. They are thus able to track progress on an individual and aggregate level. For example, in Milwaukee there are 16 outcome indicators, 11 process indicators, and 13 structural indicators (Kamradt, 2000).

In Indianapolis, the Dawn project is a federally-funded system of care site and uses an external evaluator, not just to collect the national evaluation data, but also to conduct special studies (Anderson, Wright, Kooreman, Mohr & Russell, 2003). Wraparound Milwaukee has a QA/QI Department consisting of three full-time quality assurance specialists and a part-time support staff. Much as in the two state systems, the data is used to identify problem populations, service gaps, differential outcomes for different categories of children, and to track the improvement of individuals and provider performance. The information is widely disseminated in public forums so the system is transparent and the two programs can be held accountable for their performance as well. When challenging populations are identified (e.g., sexual offenders, dual diagnosis MI/low functioning, borderline MR) work groups involving all stakeholders are formed to analyze the data, research effective treatments, and bring in experts to provide training and technical assistance to establish programs and strategies to better serve this population. These efforts are then monitored using the existing data system, with the results fed back to the work group.

The Nebraska Family Central System of Care for Children and Families:
This program stands in sharp contrast to the other two programs. It was based on the 22 rural county Region III Behavioral Health Services in Nebraska, which received a CMHS System of Care Grant. Their approach to PM/QI was to emphasize individual level data as a way of tracking performance. The program collects 18 assessments, three of which are monthly, one weekly and the rest are collected at six-month intervals. The Weekly Adjustment Indicator (WAI) Checklist (Burchard, 1990), the Eyberg Child Behavior Inventory, and the Sutter-Eyberg Behavior Inventory (Eyberg, 1992) along with the CAFAS, CBCL, etc., are used at intake and the initial child and family wraparound meeting to come up with a highly individualized care plan. Not only are the scores on these assessments tracked, but the specific goals (improve grades, reduce verbal abuse) are tracked using the WAI to measure progress toward these individual goals (Reay, Garbin & Scalora, 2002; Baxter, DeKraai & Tvrdik, 2003).

The program also collects process and cost data. By combining process, cost and outcome data the program was able to calculate a case rate for bringing children back from out-of-home placements in the child welfare and juvenile justice system and maintaining them at a lower cost than their current placements. This led to a successful contract that then prompted the expansion of a “systems of
“Care” approach throughout the state. This expansion was seen as a way to improve services and manage increasingly scarce resources. (DeKraai, 2003).

**Summary**

A major finding of this study was that Florida is like most states, collecting data mainly for eligibility, accountability, monitoring and billing purposes rather than for performance measurement or quality improvement. This was a consistent finding across a variety of data sources. Among the national experts there was also consistency in identifying the two state programs that were doing an excellent job at implementing a PM/QI system, although there were a number of other state initiatives mentioned that are in various phases of development. The three programs discussed here were most consistently mentioned across experts but there are clearly other local programs that also have been successful in implementing PM/QI systems. However, such programs are still in the minority.

It is also clear that there is no single best strategy and that context is very important. It is not coincidental that the three most comprehensive systems (Hawaii, Dawn, and Wraparound Milwaukee) had direct operational and fiscal responsibility for serving an eligible population. The three strategies which emerged in these examples all resulted in significant behavior and cultural change at both the organizational and clinician level. While having a comprehensive MIS system that focuses on PM/QI is clearly desirable, it is not necessary to create a functional PM/QI process.

Certainly, one recommendation is that the state, District/Area and local entities should maximize the use of the current data system by collaborating on processes to access useful information that can be used by programs to compare their performance to other programs and to the state as a whole.

The single most important conclusion is that effective PM/QI procedures, while they require an investment of money and human resources, can have a tremendously positive payoff in strengthening systems and services, and improving outcomes for children with mental health challenges and their families. It is highly recommended that Florida devote the resources and attention to the development and implementation of such a system, recognizing that it must be multi-faceted, and involve both the state and local level. Characteristics of PM/QI systems that serve as effective decision support systems include

- Multiple measures that are relevant to the population of concern;
- Timely feedback presented in a format which is easy to understand and use;
- Collaborative development and monitoring by key stakeholders including families and children served by the system;
- The ability to benchmark clinician and agency performance to others and the state as a whole;
- That feedback includes detailed information on the progress of individual children and families in multiple domains, processes and structures as well as data aggregated by clinician, program, agency, District and the state as a whole;
• Regular meetings are held with all stakeholders to share and discuss the data to identify problems and develop solutions;
• Public access to the data through publication and websites to foster accountability for performance;
• The information should be used to develop individual, program, and system capacity, not for punishment;
• Infrastructure is supported to develop and maintain the system; and
• The data system is flexible so it can produce the information in the type of format suitable for the questions being asked (e.g., outcomes for different populations, by setting).

In all of the cases described, the PM/QI systems were developed as cooperative and deliberative efforts. The systems evolved over time as the information revealed more detail about the operations of the program and systems and information needs drove system development. We would urge that Florida take such an approach so that all persons who contribute to and use the system also feel an ownership for the products and processes.

We also recommend the addition of two other types of activities that provide very different information to supplement the more quantitative data systems. One is the use of service testing or system of care practice review, which was described above. The other is the analysis of treatment failures (Doucette, Mahan, Dordal & Bryson, 2004) or persons who have serious crises because of falling through the cracks. One strategy is using the data on existing children enrolled in the program and examining the characteristics of the child and family, referral sources or treatment interventions to try to discern what factors predict treatment failure. In the latter strategy, a “post mortem” is conducted to identify the points at which the system failed and recommend improvements to prevent future occurrences. The most obvious examples around the country in recent times have been the school shootings where, in retrospect, it was clear that many signs were missed by many different people in different agencies. Combining qualitative and quantitative data can create powerful PM/QI systems.

As the case of Michigan shows, such efforts do not have to be expensive, but they need to be collaborative, thoughtful, sustained over time, and targeted. As the populations being served continue to exhibit more difficult problems and the resources to serve them are decreasing, it is imperative that PM/QI systems be used to find the most effective use of resources to improve individual and system outcomes. As AHCA begins to contract out the operation of the system through capitated models, PM/QI will become even more important as it is one of the few means they will have to guide and improve the system. It has to be recognized that this is an essential cost for good decision-making.

As a practical and affordable strategy, we recommend that PM/QI efforts start only with information that can be readily used and afforded. Later it can be expanded as necessary. It is important not to try and tie this in with the existing state accountability MIS system which serves a different purpose and is not set up to provide real time feedback for decision making. These systems do not have to be expensive. For example, the United States Psychosocial Rehabilitation Toolkit
has a $90 stand-alone software program (available at www.uspra.org) that can be installed on any computer and tracks basic data (e.g., functioning, income, living arrangements, income, arrests, etc.). It also can track changes over time for individuals, caseloads or a program as a whole. It produces a variety of easy-to-use reports with charts. While not the most sophisticated program, it provides real time data, requires no specialized entry personnel, and can provide the necessary information for clinical decision-making.
Evidence-Based Practices and Programs in Florida

Background

National reviews by the U.S. Surgeon General, President’s New Freedom Commission on Mental Health, and the Institute of Medicine (U.S. Department of Health and Human Services, 1999; New Freedom Commission on Mental Health, 2003; Institute of Medicine, 2001) have recommended the increased use of Evidence-based Practices (EBP’s) and programs to help improve the overall quality of care nationally. The New Freedom Commission recommended a radical transformation of current mental health practices in the United States with the use of EBP’s and programs as one important part of the transformation process. The surveys and interviews described below provide a view of EBP’s and programs in Florida, the extent of their use and the facilitators and barriers identified by respondents. Given the importance attached to the implementation of EBP’s and programs nationally, they are defined below.

Evidence-based Practices and Programs Defined

Evidence-based Practices are well-researched skills, techniques, and strategies that can be used by a practitioner. Examples of EBP’s include cognitive behavior therapy (Linehan, 1991), cognitive mapping (Dansereau & Dees, 2002), the good behavior game (Embery, 2002), intensive case management (Evans, Armstrong & Kupping, 1996), systematic desensitization (Wolpe & Lazarus, 1966), token economy motivation systems and social skills teaching strategies (Phillips, Phillips, Fixsen & Wolf, 1974), and a variety of clinical practice guidelines. Such practices describe core intervention components that have been shown to reliably produce desirable effects and can be used individually or in combination to form more complex procedures or programs (Embery, 2004).

Evidence-based Programs consist of collections of practices that are done within known parameters (philosophy, values, service delivery structure, and treatment components) and with accountability to the consumers and funders of those practices. Evidence-based Programs represent well-researched ways to translate the conceptual, goal-oriented needs of program funders and agency directors into the specific methods necessary for effective treatment, management, and quality control. The Dissemination Working Group (1999) defined the common elements of Evidence-based Programs as having

1. Clear philosophy, beliefs, and values that (a) provide guidance for all clinical judgments, program decisions, and evaluations; (b) are fully integrated with actual operations and treatment delivery; and (c) promote consistency, integrity, and sustainable effort across all program components.
2. Specific treatment components (treatment technologies) that promote consistency across clinical people at the level of actual implementation of treatment procedures.
3. Treatment decision making (within the program framework) that is invested in each clinical staff person with accountability systems for staff and programs.

4. Structured service delivery components that include an organizational context to facilitate treatment, a definition of service location and duration, staff development systems, and specification of clinical staff: client ratios and clinical staff: supervision ratios.

5. Continuous improvement components that encourage innovation with scrutiny over a long enough period of time to see if the innovation is beneficial to children, families, the organization, or community.

Such programs, for example, may seek to integrate a number of intervention practices (e.g., social skills training, behavioral parent training, cognitive behavior therapy) within a specific service delivery setting (e.g., office-based, family-based, foster home, group home, classroom) and organizational context (e.g., hospital, school, not-for-profit community agency, business) for a given population (e.g., children with severe emotional disturbances, adults with co-occurring disorders, children at risk of developing severe conduct disorders). Examples of Evidence-based Programs for children include Functional Family Therapy (Alexander & Parsons, 1973), Multisystemic Therapy (Henggeler & Borduin, 1990), Nurse-Family Partnership (Olds, et al., 1999), Parent Management Training (Forgatch, in press), and Positive Behavior Support (Horner, Todd, et al., in press).

**Extent of use of Evidence-based Practices and Programs in Florida**

In the survey of AHCA and children's mental health program District personnel (N = 25), the respondents noted that the most prevalent children's mental health EBP's and programs in use in Florida are

Stimulant medication for ADHD (59% of the respondents);
Anti-depressant medication for mood disorders (59%);
Cognitive behavior therapy (55%);
Life skills training (55%);
Behavioral parent training (52%);
Dialectical behavior therapy (30%);
Bullying prevention in the schools (30%);
Functional family therapy (30%); and
Positive behavior support in the schools (30%).

The percentage of respondents gives some idea of the use of various EBPs and programs across the state but does not provide information about the number of children and families who benefit from these programs. The providers who were surveyed were quite satisfied with the EBPs and programs they had implemented and found they lived up to their published results. For the few providers who had discontinued using a
particular Evidence-based Practice or program, loss of funding, issues related to staff turnover and re-training, or lack of technical support were cited as the reasons for discontinuing.

The use of Evidence-based Practices and programs in Florida is being encouraged by AHCA staff, children’s mental health District staff, and by providers themselves. About one-third of the AHCA personnel who were interviewed said they encouraged the use of EBP’s and programs in various meetings and negotiations. The remaining two-thirds of AHCA personnel defined their role as one to enroll, reimburse, bill, and audit compliance and appropriateness of services. AHCA staff in general stated that it was up to mental health personnel and providers to decide the content of those services given the needs of the population.

The providers identified pressures to adopt EBP’s and programs coming from funding and accreditation agencies and advocacy groups to meet currently unmet needs and to improve the consistency of services. In addition, further pressure to adopt EBP’s and programs was viewed as coming from supervisors and practitioners within the provider agencies themselves.

The children’s mental health program staff rated the providers as being most knowledgeable about EBP’s and programs (2.9 on a 5-point scale) followed by themselves (2.6) and families (1.3). In the interviews with family members, they agreed that families in Florida know little about EBP’s and programs. None of the groups considered themselves to be particularly knowledgeable about EBP’s.

Facilitators of Evidence-based Practices and Programs

To make use of EBP’s and programs, providers and District managers need to be aware of them and knowledgeable about their characteristics. Mental health program staff stated that information about Evidence-based Programs is readily available through the Internet and various meetings and accessible to providers and they see no problem getting access to more information. EBP’s and programs were being considered to help solve local problems. For example, the providers who were surveyed said they had made use of EBP’s and programs or were considering their use because of

- Lack of local service options for children and families;
- Unmet local community and family needs;
- Need for greater consistency in delivery and outcomes; and
- Funders and partners demanded it.

Providers noted that the use of EBP’s and programs was facilitated by the availability of financial and technical support for the new practices or programs and by staff who learned to do it and were successful. Specific facilitators for
using EBPs and programs cited by the providers included availability of time and funding to support implementation planning and technical assistance activities (n = 7), requirements by funders and others (5), agency leadership (5), availability of technical assistance (3), use of outcome data (3), information on need (2), and buy in (1).

Implementation of Evidence-based Practices and Programs

A recent review of the implementation evaluation literature (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005) found that authors from around the globe agreed that the challenges and complexities of implementation far outweigh the efforts that went into developing the practices and programs themselves. The review found that implementation is synonymous with coordinated change at system, organization, program, and practice levels. In a fundamental sense, implementation is most successful when carefully selected practitioners receive coordinated training, coaching, and frequent performance assessments; when organizations provide the infrastructure necessary for timely training, skillful supervision and coaching, and regular process and outcome evaluations; when communities and consumers are fully involved in the selection and evaluation of programs and practices; and when state and federal funding avenues, policies, and regulations create a hospitable environment for implementation and program operations. Based on the findings from this review of the literature, it was concluded that thoughtful and effective implementation strategies at multiple levels are essential to any systematic attempt to use the products of science to improve the lives of children, families, and adults. It also appears that relevant implementation factors and effective implementation processes may be common across domains (e.g., mental health, juvenile justice, education, child welfare). Therefore, concerted efforts in Florida and nationally to improve the science and practice of implementation have the potential for positive broad scale impacts on human services.

In the current study, the select group of providers surveyed seemed to have a good grasp of the factors important to the implementation of EBPs and programs. Mental health program respondents also seemed to have a realistic view of what it takes to implement an evidence-based program. They cited

• Knowledge of EBPs and programs;
• Willingness/buy in/management support; resources/funding/contracting; and
• Training, coaching, and ongoing supervision and support.
Barriers to using Evidence-based Practices and Programs

Mental health program staff noted current barriers to greater use of EBP’s and programs for providers, therapists, and District office staff:

- Lack of funding for services, start up, and ongoing infrastructure (N=13);
- Lack of awareness and understanding of the potential benefits (N=9);
- Resistance to change and lack of motivation to change (N=8); and
- Staff turnover (N=2).

Providers saw lack of funding for start up and for continuing services, lack of funding for infrastructure support (ongoing training, coaching, fidelity evaluations), and personnel issues (turn over, lack of training) as major barriers to increased use of EBP’s and programs in Florida. They especially noted that the barriers to implementation of EBP’s and programs include

- Lack of funding for planning and technical assistance (8);
- Lack of qualified staff and program-specific training for staff (5);
- Poor fit between program requirements and Medicaid reimbursement rules (4);
- Resistance to change (4);
- Lack of staff time and buy in (3);
- Poor fit between EBP and provider agency resources (1); and
- Consumers’ inability to participate in a rural area (1).

Providers said that the barriers to implementation for therapists include lack of availability of program-specific training (9), resistance to change (6), lack of time for training and coaching (5), poor fit with Medicaid rules and productivity requirements (1) and administrative burden (1).

National experts agreed that many of these barriers exist in most states. Lack of fit with current funding and operating structures, lack of qualified and well-trained staff, staff turnover, and resistance to changing traditional office-based treatment were cited as barriers to implementation of EBP’s and programs. The experts also noted problems with sustaining EBP’s and programs once they are implemented, especially the loss of fidelity and funding after a few years. Only a few states are investing the resources (time, energy, funding) necessary to implement EBP’s and programs statewide.

Staff Supervision

As found in the recent review of the implementation evaluation literature, and as noted in the interviews done for this study, the availability of clinical supervision is important to the implementation of EBP’s and programs. Providers indicated that group or individual clinical supervision occurred weekly and included chart reviews and discussion of individual cases. Direct observation of therapy was used by about half (57%) of the providers while others used videotapes (37%) or audiotapes (19%) to review therapy as it is actually provided.
These are very positive indications that the levels of supervision for these select provider agencies could accommodate the coaching routines that typify most EBP’s and programs.

When asked to describe how their clinical staff members are supervised, 15 of the 28 providers stated that supervision was provided by licensed mental health professionals. Others noted that they worked in prevention or non-clinical programs that did not require licensed professionals. All providers mentioned frequent supervision ranging from individualized daily supervision for new practitioners to monthly or group supervision for more seasoned professionals. A few also took it to the next step and discussed the supervision of the supervisors. Two of the respondents mentioned extra supervision specific to an Evidence-based Program or practice being implemented in their agency. Only one provider specifically included evaluation data in their supervision and one other discussed practitioner skill development as a focus on supervision. All others focused on clinical case management. Average caseloads for therapists covered a wide range from 2 (intensive in-home services) to 125 (outpatient). Generally, the more intensive services or services geared to consumers with more difficult problems had smaller caseloads (2 to 15) while others in more typical clinical settings had higher caseloads (25 to 125).

A National View

Florida is like most of the other states at this point, considering EBP’s and programs and taking notice of their potential advantages to the array of services, access to those services, and quality of services received by consumers. National experts pointed to some good examples of current activity with regard to implementation of EBP’s and programs as part of state planning efforts.

- California: passed Proposition 63 that mandates a new tax on incomes over $1 million to fund more mental health services.
- Hawaii: widespread adoption of EBP’s and programs as part of their response to a class action lawsuit coupled with an exemplary statewide quality assurance system designed to support decision making at the practitioner, manager, organization, and systems levels.
- Michigan: the use of a statewide evaluation system (based on the Child and Adolescent Functional Assessment Scale) to find sub-groups of children for whom treatment is not effective, then matching them to EBP’s and programs.
- New Mexico: nearing the end of a two-year planning effort to align funding policies with the needs of EBP’s and programs.
- New York: “Winds of Change” statewide effort to encourage and support the implementation of EBP’s and programs.
- Ohio: established Centers of Excellence to help communities and provider agencies implement EBP’s and programs and to evaluate their results.
- Oklahoma: statewide implementation committee consisting of the heads of the major human service departments chaired by the Governor. Their task is to
initiate EBP’s and programs in the state and to help remove barriers and solve system alignment problems that arise.

• Oregon: legislation mandating that increasing percentages of funding must go to EBP’s and programs over the next few years and those programs must be evaluated with regard to fidelity and outcomes.

• Washington: emphasis within juvenile justice to provide more EBP’s and programs and to evaluate their effects.

Nationally, resources (time, energy, funding) need to be made available for three critical needs: 1) start up (exploration, planning), 2) evidence-based services themselves (each one has specific requirements), and 3) on-going infrastructure supports (selection, training, coaching, fidelity assessments). Some states have pooled Medicaid funds with other resources (Juvenile Justice, Child Welfare) to provide funds for these three critical needs. The experts recommended taking a measured and considered approach to developing a statewide approach to implementing EBP’s and programs so they can be more than a “flash in the pan” with respect to quality services for consumers.

Summary

Providers stated that the use of EBP’s and programs could be increased with

• More information provided at a District level;
• Funding explicitly for EBP’s and programs;
• Funding for start up costs and costs of the required ongoing infrastructure (e.g., training, coaching, fidelity evaluations); and
• A sincere governmental and provider interest in individualized treatment for children and families.

The meeting of stakeholders indicated that there is great interest in making greater use of EBP’s and programs in Florida and there is openness to making changes that may be required. The group recognized the importance of planning and buy in at various levels and was willing to continue meeting to take a leadership role in developing a statewide plan for the implementation of EBP’s and programs.

In summary, there seems to be great recognition of the potential value of EBP’s and of the complexity of implementing them. Also there seems to be a high level of enthusiasm and eagerness to move ahead with the implementation of EBP’s. The challenge now is to create an infrastructure and the necessary administrative supports to allow for the effective implementation of EBP’s.

Conclusion and Recommendations

The research described in this report was made possible by the outstanding cooperation of many dedicated and talented individuals throughout the state of Florida. The research team was impressed not only by their responsiveness and commitment, but by their eagerness to learn how to better meet the needs of
Florida’s children with mental health challenges and their families. The team was also impressed by the similarity of the issues and challenges in Florida to those in other states in the country. In some respects, Florida may be ahead of other states and have much to contribute to other states; in other respects, Florida may be behind other states and have much to learn. Overall, however, based on the reports from knowledgeable people within and outside of Florida, and other research done by the research team, the similarity of issues is striking.

Given the extensive amount of information that was obtained in this study, this section could include a long list of recommendations. Such a long list is typical but would not be helpful here. First of all, in the discussions on the service array, performance measurement, and EBP’s, a number of recommendations have already been presented. Second, long lists are often overwhelming, not very useful, and frequently don’t lead to substantial action. Third, the research team believes that while there are specific steps that can and should be taken to improve the service array, to develop a more helpful performance measurement system, and to support the implementation of EBP’s, it is most important that AHCA, and DCF, in partnership with many other stakeholders, take steps to address in an integrated and comprehensive way the needs of children with mental health challenges and their families.

The data collected in this study, through surveys, interviews, and focus groups, consistently indicate the need for strong community and state-level planning to build on the good work that has already been done in Florida to support the implementation of effective systems of care. The President’s New Freedom Commission on Mental Health, which was appointed by President Bush in 2002 and issued its report in 2003, also called for moving beyond minimal, incremental system improvements to emphasize the need for “system transformation” (President’s New Freedom Commission on Mental Health, 2003). It particularly called for creating a consumer and family-driven system to promote recovery and resilience. It emphasized, as this report does, the importance of a wide-range of effective services, and of a data-based culture in which information of practical importance is routinely collected and used not in a punitive way but as part of a data-based decision-support system.

The Child and Family Subcommittee of the President’s Commission (Huang, Stroul, Friedman, et al., in press) called for a comprehensive, systematic approach to the crisis in children’s mental health. The crisis was defined as a combination of high prevalence, inadequate access to care, and often ineffective care. It called for such actions as developing and funding comprehensive and effective home and community-based services and supports, consistent with the findings in this study, reducing fragmentation, individualizing care, and strengthening accountability and quality improvement based on a clear statement of the population of concern, system goals, and strategies for achieving the intended outcomes (often called a “Theory of Change,” Hernandez & Hodges, 2003).

To accomplish these goals, there needs to be a fundamental shift in how we approach the problems children with mental health challenges and their families face. The current systems do not look at the whole family or child and thus
explicitly recognize that there needs to be a coordinated strategy across systems. Instead, each system (e.g., education, child welfare, mental health) looks at its piece of the problem in isolation. The exemplary states and programs we have discussed in this report have developed financing strategies to pool or braid funding across these systems, so that the multiple needs of the family can be addressed in a coordinated way. This is an important next step for research and should be one of the tasks undertaken in any effort to work with selected communities toward system development.

The current study documented that AHCA is primarily a funding agency, DCF staff are overburdened with contracting and monitoring processes, many other entities such as the schools, child welfare, and juvenile justice are closely involved in the lives of children with mental health challenges, and as a result responsibility and leadership is diffuse within communities. There are many participants in the process, including families, but as the system is currently organized it is unclear whether there is an entity with responsibility and authority for overseeing the development and implementation of an overall plan to meet the needs of this fragile group of youngsters, and their families. As complex and challenging as this task is under the best of circumstances, it is even more so when leadership is diffuse. The recent creation of the Substance Abuse and Mental Health Corporation should eliminate this problem of diffuse leadership.

The data collected for this study both from within and outside of Florida clearly indicate, as is noted at the end of the section on service array, that it is possible to serve children in less restrictive environments than they are currently being served in, with outcomes that are better, and at less cost. However, to do so requires building community capacity for cross-system planning and collaboration, providing supports for community leaders, an infrastructure to support evidence-based interventions, and the creation of a data-based culture in which data on system performance are regularly collected and used to strengthen the system.

In building a data-based culture, it is critical that multiple strategies of performance measurement be used. In addition to decision support systems that utilize rapid feedback of critical data, some form of service testing or system of care practice review to supplement data systems should also be used. Service testing and system of care practice review involves selecting a random sample of cases and then interviewing everyone involved with the case according to a carefully developed protocol (Improvement Concepts Inc., 1995; Hernandez, Worthington & Davis, 2003; Hernandez, Worthington & Davis, 2005.) This could be done as an alternative to some of the current monitoring activities that are often seen as redundant.

Several of these steps can be taken concurrently. One strategy toward achieving the goal of creating effective systems of care in communities throughout the state is to select a small number of communities as a starting point, provide their leaders with the supports they need and the organizational and fiscal flexibility that is required to build an effective system, and demonstrate the feasibility of doing it with an intent of expanding this effort to other communities. This can build on lessons learned from communities that have received federal grants to establish
systems of care, while recognizing that it is not realistic to rely on federal funds to be able to develop, implement, and sustain effective systems statewide. The Legislature might want to consider supporting these as pilot or demonstration sites, since it is important to have an in-state example evolve so that others can see it and comprehend what it means.

At the same time as this is done, steps can be taken to strengthen community capacity through such mechanisms as supporting a resource center that can provide information, consultation, and responses to specific questions on implementation of effective and evidence-based practice, and increasing the capacity of community leaders to develop clear theories of change. The development of resource centers to help build community capacity is an approach that is being taken in several states across the country, and looks promising. Such resource centers can also help to convene state-level stakeholders in an effort to reduce fragmentation and develop coordinated funding strategies, and system organization plans.

Such a combined effort might

- Build capacity at the local and state level to plan, implement, and continually improve systems through information-sharing, training, and coaching;
- Bring stakeholders, including families, together to develop integrated plans, particularly around challenging financing and service delivery issues;
- Establish resource centers to assist at both the local and state level;
- Demonstrate the feasibility of creating effective goal-driven community-based systems of care; and
- Test out performance measurement procedures geared to strengthen the systems.

Given the complexity of the system involved in serving children with mental health challenges and their families, the numerous stakeholders involved, the complex financing mechanisms, the different levels of government, and the increased understanding of what it takes for effective implementation, we resist the temptation to offer a long list of specific recommendations. There is likely to be limited benefit from small, isolated system improvement steps. Instead, the findings from this study call for a multi-year, comprehensive, systematic effort to bring together key stakeholders to build on the strengths of the current system, and develop, implement, and monitor plans to enhance the well-being of children by increasing accessibility to effective and evidence-based services, and by creating data-based cultures and useful performance measurement systems.
Continuous Quality Improvement Via Level of Functioning (LOF) Data: Site-Specific Example Report For a Michigan Agency

© by Kay Hodges, Ph.D.
Prepared October 15, 2002

LOF Project: Purpose

➢ To promote clinically meaningful outcome assessment
➢ To promote use of this information to provide better services via continuous agency self-study
➢ To promote practices that have been associated with good outcome.

LOF Project: Goals

➢ Professional:
  • is knowledgeable about effective treatments
  • has service array available
  • understands context client lives in
  • informs family of treatment options
➢ Family chooses goals, intervention and target outcome
➢ Professional and family:
  • assess “pre” intervention
  • continually monitor progress

LOF Project: Data Collected

Collected at intake only

➢ Demographic Data
➢ Child Risk Factors
  • Previous placement out-of-home
  • Previous juvenile justice involvement
  • Previous psychiatric hospitalization
  • Previous involvement with protective services
➢ Clinical Diagnoses

Collected at intake, every 3 months, and on exit.

➢ Indicators of Functioning
  • Degree of impairment on CAFAS
  • Other behavioral functioning indicators
➢ Multi-Agency Involvement and Collaboration
➢ Treatment Needs
  • Residential
  • Non-residential
  • Medications

Collected at exit.

➢ Circumstances of termination of services

LOF Project: Arrangement

➢ Submit data monthly using CAFAS software
➢ A client report & treatment plan are produced by software
➢ Sites can do own export of data
  • Produce Access, Excel, SPSS syntax & data files
  • Can be used for State export
➢ Sites get monthly reports - outcome by client
➢ Quarterly meetings: “Data & Best Practices Parties”
  • Aggregated data for sites and the State
  • Reliability and computer training workshops
### LOF Project: Aggregate Outcome

Collapsing across all clients:
- Written & electronic (Excel) formats
- State data presented periodically at LOF Quarterly Meetings
- Site-specific summary charts sent monthly for
  - Number of admissions & CAFAS evaluations
  - Type & extent of youths’ impairment (i.e., SED status)

### LOF Project: Individual Outcome

Individual Client Outcome:
- Written & electronic (Excel) formats for reports
- Reports sent monthly
- Open cases
  - Records compliance
  - Identification of cases with poor progress
  - Identification of high risk cases
  - Recently admitted cases (for treatment planning)
- Closed cases: Outcome

### Overview of the CAFAS

- **Why?**
  To assess impairment: the negative effect of problem behaviors and symptoms on functioning.
- **Who?**
  Rated by clinician (10 minutes) who reads thru items until a description of the youth is found (for each subscale)
- **What?**
  8 youth subscales

### CAFAS Subscales for the Youth

- **School/Work**
  Functions satisfactorily in a group education
- **Home**
  Observes reasonable rules and performs age-appropriate tasks
- **Community**
  Respects the rights of others and their property and acts lawfully
- **Behavior Toward Others**
  Appropriateness of youth’s daily behavior
- **Moods/Emotions**
  Modulation of the youth’s emotional life
- **Self-Harmful Behavior**
  Extent to which the youth can cope without self-harmful behavior or verbalizations
- **Substance Use**
  Youth’s substance use and the extent to which it is inappropriate & disruptive
- **Thinking**
  Ability of youth to use rational thought

### Organization of Each Subscale

For each scale, the behavioral items are grouped into 4 columns, along a continuum of severity of impairment. The four levels of severity are:
- **Severe Impairment**: Severe disruption or incapacitation (30)
- **Moderate Impairment**: Major or persistent disruption (20)
- **Mild Impairment**: Significant problems or distress (10)
- **Minimal or No Impairment**: No disruption of functioning (0)

### CAFAS Total Score

**Range for each of the 8 CAFAS subscales**
- 0 to 30

**CAFAS total score = Sum of 8 youth subscales**
- Range = 0 to 240
- Higher score = Higher impairment
Strengths and Goals

For each subscale, there is an accompanying list of positive behaviors from which strengths & goals can be selected. Examples from School subscale:

**Strengths/Goals**
- Is permitted to attend school
- Attends more days than not
- Attends regularly
- Is able to get assistance from an adult at school when problems arise

Example Treatment Plan: School

<table>
<thead>
<tr>
<th>Item(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>019</td>
<td>Grade average is lower than “C” and is not due to lack of ability or any physical disabilities</td>
</tr>
<tr>
<td>022</td>
<td>Non-compliant behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth’s activities so as to avoid predictable difficulties, more than other youth.</td>
</tr>
<tr>
<td>G17</td>
<td>School grades are average or above</td>
</tr>
<tr>
<td>S03</td>
<td>Attends regularly</td>
</tr>
<tr>
<td>S04</td>
<td>Likes going to school</td>
</tr>
</tbody>
</table>

Tracking Progress During Treatment

Uses of the CAFAS

- Determining intensity of services needed
- Developing treatment plan
- Linking CAFAS Profile at intake to evidence-based treatment protocol
- Monitoring outcome during treatment & actively managing the case
- Organizing case conference discussion
- Involving caregivers in the process
- Assessing program effectiveness

Research on the CAFAS

- Three large data sets
- CAFAS at intake predicts subsequent:
  - Restrictiveness of treatment setting
  - Cost of services
  - Number of services
  - School truancy
  - Contact with the law
- CAFAS at discharge from residential juvenile justice facility predicts recidivism in 12 months post discharge
- CAFAS is sensitive to change over time

Aggregated Data for An Example Site

(Fiscal Year Report)
NOTE! Interpreting These Charts

- Charts are numbered for easy reference.
- In most charts, the Y axis (vertical) is % of youths.
- Numbers above the bars are always number of cases (frequencies).
- “Unknown” data (i.e., missing, unreported, other, not applicable) are not included in chart. If percents on a chart do not add up to 100%, the remaining percents were unknown.

NOTE! Example Chart

179 youths were male, which accounted for 55% of all of the youths in the sample.

Who Do We Serve?
Demographic Characteristics & Risk Factors Present at Intake

(N=319 in this example site)

#1 - Sex

Number of Youths

% of Youths

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>179</td>
<td>140</td>
</tr>
</tbody>
</table>

#2 - Age

(Mean Age = 12.2)

Number of Youths

% of Youths

<table>
<thead>
<tr>
<th></th>
<th>Preadolescents</th>
<th>Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>165</td>
<td>154</td>
</tr>
</tbody>
</table>

#3 - Ethnic Group

Number of Youths

% of Youths

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>280</td>
</tr>
<tr>
<td>African American</td>
<td>10</td>
</tr>
<tr>
<td>Hispanic</td>
<td>0</td>
</tr>
<tr>
<td>Native</td>
<td>3</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
</tr>
<tr>
<td>Multiracial</td>
<td>5</td>
</tr>
</tbody>
</table>
What are the Types and Extent of Youths’ Impairments at Intake?

Youths’ Status at Intake

(N=319 in this example site)

NOTE! Central Tendency

Mean: average score
Median: the middle score
Mode: most frequently occurring score
Children's Mental Health: Service Array, Evidence-Based Practices, and Quality Improvement • 67

### #14 - Youths' Total Score on CAFAS at Intake: Mean, Median, and Mode

<table>
<thead>
<tr>
<th>Score on CAFAS</th>
<th>Mean</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>86.27</td>
<td>90</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE! Informal Guidelines Used in LOF Meetings**

<table>
<thead>
<tr>
<th>CAFAS Total Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30</td>
<td>Likely referred to qualified health professional</td>
</tr>
<tr>
<td>40-70</td>
<td>Likely receives outpatient services</td>
</tr>
<tr>
<td>80-120</td>
<td>Likely receives intensive services</td>
</tr>
<tr>
<td>&gt;120</td>
<td>“Not surprised” if residential or inpatient services are provided at some point</td>
</tr>
</tbody>
</table>

### #15 - Percentage of Youths in Severity Intervals for CAFAS Total Score at Intake

<table>
<thead>
<tr>
<th>CAFAS Total Score</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30</td>
<td>32</td>
</tr>
<tr>
<td>40-70</td>
<td>71</td>
</tr>
<tr>
<td>80-120</td>
<td>177</td>
</tr>
<tr>
<td>Greater Than 120</td>
<td>39</td>
</tr>
</tbody>
</table>

### #16 - Percentage of Youths Who Were Rated as Severely or Moderately Impaired on None to 8 of the 8 CAFAS Subscales at Intake

<table>
<thead>
<tr>
<th>Number of Subscales with Severe or Moderate Impairment Rating</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>34</td>
</tr>
<tr>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>2</td>
<td>38</td>
</tr>
<tr>
<td>3</td>
<td>62</td>
</tr>
<tr>
<td>4</td>
<td>80</td>
</tr>
<tr>
<td>5</td>
<td>58</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

### NOTE! 8 CAFAS Subscales Assessing the Youth

- School/Work
- Home
- Community
- Behavior Toward Others
- Moods/Emotions
- Self-Harmful Behavior
- Substance Use
- Thinking

### NOTE! Example Items from School Scale

**SEVERE IMPAIRMENT:** Expelled or equivalent from school due to behavior (e.g., multiple suspensions, removed from community school, placed in an alternative school).

**MODERATE IMPAIRMENT:** Non-compliant behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity.

**MILD IMPAIRMENT:** Non-compliant behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth’s activities so as to avoid predictable difficulties, more than other youth.

**MINIMAL OR NO IMPAIRMENT:** Minor problems satisfactorily resolved.
#17 - Percentage of Youths Who Were Rated as Severely Impaired on None, 1, 2, 3, or 4 of the 8 CAFAS Subscales at Intake

<table>
<thead>
<tr>
<th>Number of Subscales</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>153</td>
</tr>
<tr>
<td>1</td>
<td>80</td>
</tr>
<tr>
<td>2</td>
<td>61</td>
</tr>
<tr>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

#18 - Percentage of Youths with Severe or Moderate Impairment on CAFAS Subscales at Intake

<table>
<thead>
<tr>
<th>CAFAS Subscales</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>School / Work</td>
<td>208</td>
</tr>
<tr>
<td>Home</td>
<td>209</td>
</tr>
<tr>
<td>Community</td>
<td>207</td>
</tr>
<tr>
<td>Behavior</td>
<td>107</td>
</tr>
<tr>
<td>Moods / Emotions</td>
<td>82</td>
</tr>
<tr>
<td>Self-Harmful</td>
<td>26</td>
</tr>
<tr>
<td>Substance Use</td>
<td>23</td>
</tr>
<tr>
<td>Thinking</td>
<td></td>
</tr>
</tbody>
</table>

#19 - Percentage of Youths with Severe Impairment on CAFAS Subscales at Intake

<table>
<thead>
<tr>
<th>CAFAS Subscales</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>School / Work</td>
<td>84</td>
</tr>
<tr>
<td>Home</td>
<td>92</td>
</tr>
<tr>
<td>Community</td>
<td>16</td>
</tr>
<tr>
<td>Behavior</td>
<td>26</td>
</tr>
<tr>
<td>Moods / Emotions</td>
<td>43</td>
</tr>
<tr>
<td>Self-Harmful</td>
<td>14</td>
</tr>
<tr>
<td>Substance Use</td>
<td>10</td>
</tr>
<tr>
<td>Thinking</td>
<td>2</td>
</tr>
</tbody>
</table>

NOTE! CAFAS Tiers® Hierarchical Client Types

- Thinking (Thinking subscale)
- Maladaptive Substance Use (Substance Use subscale)
- Self-Harmful Potential (Self-Harmful & Moods/Emotions)
- Delinquency (Community subscale)
- Behavior Problems with Moderate Mood Disturbance (School, Home, or BTO & Moods/Emotions subscales)
- Behavior Problems without Mood (School, Home, or BTO)
- Moderate Mood/Mild Behavior

#20 - Percentage of Youths in Each of the CAFAS Tiers ® Client Types at Intake (Mutually Exclusive and Hierarchically Arranged)

<table>
<thead>
<tr>
<th>CAFAS Tiers® Client Types</th>
<th>% of Youths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking Problems</td>
<td>23</td>
</tr>
<tr>
<td>Maladaptive Substance Use</td>
<td>25</td>
</tr>
<tr>
<td>Self-Harmful Potential</td>
<td>16</td>
</tr>
<tr>
<td>Delinquency</td>
<td>48</td>
</tr>
<tr>
<td>Behavior Problems with Moderate Mood</td>
<td>66</td>
</tr>
<tr>
<td>Behavior Problems with Moderate Mood</td>
<td>64</td>
</tr>
<tr>
<td>Moderate Mood/Wall Behavioral</td>
<td>44</td>
</tr>
</tbody>
</table>

What are the Outcomes for Youths?

Outcome from Intake to Last CAFAS (on record when database created)

(N=194 in this example site)
Three Views of Outcome

- Change in Average Scores
- Proportion of Youths Improved (combining all youths)
- Proportion of Youths improved (breakdown by CAFAS Tiers® Client Type)

NOTE! Three Outcome Indicators

- Clinically meaningful reduction in total CAFAS score (>=20 pts)
- No Severe Impairments at exit (Restricted to youths with 1 or more severe impairments at intake)
- Not SED at exit (<40)
#25 - Proportion of Youths Improved: No Severe Impairments at Last CAFAS (Restricted to Youths with 1 or More Severe Impairments at Intake)

% of Youths

Improved: 77%
Not Improved: 45%

#26 - Proportion of Youths Improved: Not SED at Last CAFAS (Defined Here as Total CAFAS Score of 40 or Less)

% of Youths

Improved: 62%
Not Improved: 122%

NOTE! Change To Less Impairing Client Type on CAFAS Tiers®

Thinking
Substance Use
Self-Harmful Potential
Delinquency
Behavior Problems with Moderate Mood Disturbance
Behavior Problems without Mood
Moderate Mood/Mild Behavioral

#27 - Proportion of Youths Improved: Changed toward Less Impairing Client Type on CAFAS Tiers®

% of Youths

Improved: 114%
Not Improved: 80%

NOTE! Reading Charts for Analysis by CAFAS Tiers

- Percents are the % of youths in the specific client type that had the characteristic.
- For example, 45% of youths placed in the “Delinquent” client type at intake changed toward being assigned to a less impairing client type (e.g., Behavior Problems) at last CAFAS.
- The “Moderate Mood/Mild Behavioral” client type does not appear on the charts due to low n for this sample subset.
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Are the Client Records Up-to-Date so that Outcome can be Continuously Evaluated?

Monitoring of Records for Outcome Documentation While Family is Still Receiving Services

(N=319 in this example site)
NOTE! Definition of “Open” & “Closed” Cases

- “Open” & “Closed” refer to status in the CAFAS software only
- A case can have unlimited treatment episodes (defined by an admission date and closing date).
- A “closed” case can be “reopened” if prematurely closed

NOTE! Terms Used in Compliance Report

In Compliance: A CAFAS evaluation was done at intake and quarterly thereafter.

Out of Compliance: last CAFAS evaluation was <=100 days prior to date of report

- TO CLOSE – Case needs to be closed
- NO CAFAS – Case has no CAFAS evaluation for any time point
- SINGLE CAFAS – Case has an overdue CAFAS and there is only one CAFAS evaluation
- MULTIPLE CAFAS – Case has an overdue CAFAS and there is more than one CAFAS evaluation

Is the Agency Serving Targeted Youths?

Monitoring of Cases to Determine Whether Cases Meet Agency Guidelines

(N=319 in this example site)
#37 - Percentage of Youths Qualifying for Enhanced Services at Intake (Total Score at Intake>=80, and 2 or More Moderate/Severe Subscales)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>216</td>
<td>103</td>
</tr>
</tbody>
</table>

What are the Dropout Rates and Outcomes for Closed Cases?
(N=220 in this example site)

#38 - Clinicians' Report: Reasons for No Treatment Delivered

<table>
<thead>
<tr>
<th>Treatment Not Needed</th>
<th>No Show</th>
<th>Withdraw</th>
<th>Other Services</th>
<th>Evaluation Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>9</td>
<td>14</td>
<td>11</td>
</tr>
</tbody>
</table>

#39 - Clinicians' Report of Whether Treatment Was Delivered and, If Yes, Whether Completed

<table>
<thead>
<tr>
<th>No Treatment Attempted</th>
<th>Treatment Interrupted</th>
<th>Treatment Accomplished</th>
</tr>
</thead>
<tbody>
<tr>
<td>79</td>
<td>53</td>
<td>60</td>
</tr>
</tbody>
</table>

#40 - Closed Cases: Improved, Not Improved, and Intake CAFAS Only
(To estimate attrition [i.e., intake CAFAS only], excluded cases with Evaluation Only, No Treatment Needed, or Referred to Other Services)

<table>
<thead>
<tr>
<th>Improved</th>
<th>Not Improved</th>
<th>Intake CAFAS Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>108</td>
<td>34</td>
<td>17</td>
</tr>
</tbody>
</table>

What Types of Services are being Delivered?

Overview of Resource Allocation
(Restricted to cases with >1 CAFAS evaluation)
(N=207 in this example site)
A Secret to Success: Ensuring Integrity of the Data

- Item endorsement determines the score
  - Clinicians do not assign a score
  - Keep record of item endorsements in the youth’s clinical record
- Rater signature on CAFAS form
- Establish & maintain reliability

(continued)
- Reduce information variance
  - Comprehensiveness of information
  - Multiple informants
- Integrate CAFAS into routine clinical procedures & in interactions with caregivers
This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (http://www.hawaii.gov/health/mental-health/camhd/resources/index.html).

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1-</th>
<th>Level 2-</th>
<th>Level 3-</th>
<th>Level 4-</th>
<th>Level 5-</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BEST SUPPORT</td>
<td>GOOD SUPPORT</td>
<td>MODERATE SUPPORT</td>
<td>MINIMAL SUPPORT</td>
<td>KNOWN RISKS</td>
</tr>
<tr>
<td>Anxious or Avoidant Behaviors</td>
<td>Cognitive Behavior Therapy (CBT); Exposure; Modeling</td>
<td>CBT with Parents; Group Cognitive Behavior Therapy; CBT for Child and Parent; Educational Support</td>
<td>None</td>
<td>Eye Movement Desensitization and Reprocessing (EMDR), Play Therapy, Individual (Supportive) Therapy; Group (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Attention and Hyperactivity</td>
<td>Behavior Therapy §</td>
<td>None</td>
<td>None</td>
<td>Biofeedback; Play Therapy, Individual or Group (Supportive) Therapy, Social Skills Training; &quot;Parents are Teacher,&quot; Parent Effectiveness Training, Self-Control Training</td>
<td>None</td>
</tr>
<tr>
<td>Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autistic Spectrum Disorders</td>
<td>None</td>
<td>None</td>
<td>Applied Behavior Analysis; Functional Communication Training; Caregiver Psychoeducation Program</td>
<td>Auditory Integration Training; Play Therapy, Individual or Group (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>None</td>
<td>Interpersonal and social rhythm therapy*</td>
<td>Family psychoeducational interventions*</td>
<td>All other psychosocial therapies</td>
<td>None</td>
</tr>
<tr>
<td>Depressive or Withdrawn</td>
<td>CBT</td>
<td>CBT with Parents; Interpersonal Therapy (Manualized IPT-A); Relaxation</td>
<td>None</td>
<td>Behavioral Problem Solving, Family Therapy, Self-Control Training, Self-Modeling, and Individual (Supportive) Therapy</td>
<td>None</td>
</tr>
<tr>
<td>Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disruptive and Oppositional</td>
<td>Parent and Teacher Training; Parent Child Interaction Therapy</td>
<td>Anger Coping Therapy; Assertiveness Training; Problem Solving Skills Training, Rational Emotive Therapy, AC-SIT, PATHS, and FAST Track Programs</td>
<td>Social Relations Training; Project Achieve</td>
<td>Client-Centered Therapy, Communication Skills, Goal Setting, Human Relations Therapy, Relationship Therapy, Relaxation, Stress Inoculation, Supportive Attention.</td>
<td>Group Therapy</td>
</tr>
<tr>
<td>Behaviors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>CBT* (bulimia only)</td>
<td>Family Therapy (anorexia only)</td>
<td>None</td>
<td>Individual (Supportive) Therapy</td>
<td>Some Group Therapy</td>
</tr>
<tr>
<td>Juvenile Sex Offenders</td>
<td>None</td>
<td>None</td>
<td>Multisystemic Therapy***</td>
<td>Individual or Group (Supportive) Therapy</td>
<td>Group Therapy***</td>
</tr>
<tr>
<td>Delinquency and Willful</td>
<td>Multisystemic Therapy; Functional Family Therapy</td>
<td>Multidimensional Treatment Foster Care, Wrap-Around Foster Care</td>
<td>Individual Therapy, Juvenile Justice System</td>
<td>Group Therapy</td>
<td></td>
</tr>
<tr>
<td>Misconduct Behavior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>None</td>
<td>None</td>
<td>Behavioral Family Management*; Family-Based Intervention*; Personal Therapy*; Social Interventions*</td>
<td>Supportive Family Management*; Applied Family Management*</td>
<td>None</td>
</tr>
<tr>
<td>Substance Use</td>
<td>CBT**</td>
<td>Behavior Therapy; Purdue Brief Family Therapy</td>
<td>None</td>
<td>Individual or Group (Supportive) Therapy, Interactional Therapy, Family Drug Education, Conjoint Family Therapy, Strategic Structural Systems Engagement</td>
<td>Group Therapy</td>
</tr>
</tbody>
</table>

* Based on findings with adults only; ** Appropriate if youth is in out of home setting, otherwise consider level 2; *** If delinquency and willful misconduct are present. § Consider medication or combined treatment as strongest options for hyperactivity only, or combined treatment as strongest for hyperactivity and family interaction.
Appendix C
Evidence-Based Child and Adolescent Psychopharmacology

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in determining appropriate psychopharmacological treatment. Information summarized here was not reviewed at a level of detail to allow detailed inferences about medications within their medication classes. For example, although there might be support for one medication within a class (e.g., SSRIs), there might be minimal or no support for others within that same class. For these more specific decisions, it is advisable to seek additional information and input regarding appropriate medication use. For more details about these medications and their applications see the most recent EBS Committee Biennial Report (http://hawaii.gov/health/mental-health/camhd/resources/index.html).

<table>
<thead>
<tr>
<th>PROBLEM AREA</th>
<th>MEDICATION</th>
<th>SHORT-TERM EFFICACY</th>
<th>LONG-TERM EFFICACY</th>
<th>SHORT-TERM SAFETY</th>
<th>LONG-TERM SAFETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>SSRIs, Benzodiazepines</td>
<td>A</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Obsessive-Compulsive Disorder</td>
<td>SSRIs</td>
<td>A</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>ADHD</td>
<td>Stimulants, TCAs, Central Adrenergic Agonists</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>A</td>
</tr>
<tr>
<td>Aggression in Autism</td>
<td>Antipsychotics</td>
<td>B</td>
<td>C</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Aggressive Conduct</td>
<td>Lithium, Valproate and Carbamazepine</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>B</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Lithium, Valproate and Carbamazepine</td>
<td>C</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Depression</td>
<td>SSRIs, TCAs</td>
<td>A</td>
<td>C</td>
<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Schizophrenia (psychotic disorders)</td>
<td>Antipsychotics</td>
<td>B</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Tourettes</td>
<td>Antipsychotics, Central Adrenergic Agonists</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

Key: SSRI = Selective Serotonin Reuptake Inhibitor  TCA = Tricyclic Antidepressant
A = Adequate data to inform prescribing practices. For efficacy and short-term safety: 2 ≥ randomized controlled trials (RCT) in youth. For long-term safety: Epidemiological evidence and/or minimal adverse incident report to the Food and Drug Administration
B = For efficacy and short-term safety: 1 RCT in youth or mixed results from 2 ≥ RCTs.
C = No controlled evidence.
References


Health: Expanding the Research Base (pp. 281-286). Tampa: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.


Hodges, K., & Wotring, J. (2004). Role of monitoring outcomes in initiating implementation of evidence-based treatments at the state level. Psychiatric Services, 55, 396-400.


