

IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Formative Evaluation Report on Demonstration Site Development

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Executive Summary

This document presents evaluation information collected from three Idaho Community Council Demonstration sites between July 2001 and September 2002. The purpose of the evaluation activities reported here were to: 1) understand the interactions and goals of the demonstration sites in relation to the overall goals of the ICCMH; 2) collect lessons learned information that would be useful for replication purposes at other sites around the state; 3) collect data that could inform policy decisions supporting community council functioning on a state wide level. No attempt is made here to evaluate the effectiveness of the community council initiative. Instead, this report hopes to faithfully represent the demonstration site perspective resulting from two or more years of providing comprehensive, system of care services to clients. This ethnographic approach seeks to provide intensive information to policy makers, rather than generalized and aggregated service information. It is hoped that the "voice" in this report represents the local councils, and that the information presented will help policy makers comprehend the impact of policies on the local councils.

Several conclusions can be drawn from the data collected. First, the results of a goal setting process with the three demonstration community councils indicate close alignment with the Court Approved Plan adopted by the ICCMH as a result of the Jeff D. legal actions. The goals also illustrate activities the three demonstration sites are currently accomplishing in the field. The type of goals set may indicate that the field on a state wide basis is receptive to learning new ways of providing mental health services to children and families through a collaborative, family-driven, child-centered, systems of care model.

Second, the perceived barriers to goal achievement listed by the council members may represent an equal blend of improvements in council interactions and needed policy changes. The perceived barriers thus lend themselves to interpretation as both a training agenda and a policy making agenda.

Third, a critical case review methodology has highlighted practical and philosophical issues that accompany a paradigm shift from a clinical model of children's mental health provision to a collaborative system of care model. The issues surrounding this shift can be seen to include the use of clinical data in service planning, using family/client experiences as a driving force in determining goals and outcomes, and designing state-wide support systems that will empower service providers to use collaboration and advocacy as a means of supporting families and children.

This formative evaluation leads to several recommendations:

1. It is recommended that a means of providing data collection services for the sites be implemented. The voluntary nature of the collaborations and the complexity of collaborative interventions demand a high level of focused data tracking and collection if councils are to use data as a basis for decision making. Discussion with the sites seems to indicate that each site can be supported by having data collection and management services available one day per week. It is possible that this could be accomplished at a regional level by having a full time person to work with each of the local councils in that region.

2. It is also recommended that the type of data used to assess client service needs or progress be reconsidered in light of the shift to a collaborative, family-driven model. The result of an effective assessment tool should be to a) provide data useful for parents and council members to

use in their planning processes, and to b) provide data that illustrates council accountability. To fulfill these purposes, it is likely that assessment tools will need to move away from predictive purposes and focus on outcomes related to family driven changes in client adaptive behaviors.

3. It is recommended that a means be created to allow local councils to feel fully represented at the state level, thus aligning the whole system from state to local sites with a full partnership model.

4. Finally, it is recommended that a training agenda be created that will support council formation by addressing the internal council barriers identified by the demonstration sites.

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This document presents evaluation information collected from three Idaho Community Council Demonstration sites between July 2001 and September 2002. The purposes of the evaluation activities were to: 1) understand the interactions and goals of the demonstration sites in relation to the overall goals of the ICCMH; 2) collect lessons learned information that would be useful for replication purposes at other sites around the state; 3) collect data that could inform policy decisions supporting community council functioning on a state wide level; and, 4) collect program effectiveness data to evaluate the extent to which the councils have impacted clients. The information in this document addresses the first three evaluation activities but does not present summative evaluation data. At the time of writing, summative data were not available, and a supplementary document will provide that information.

This formative, descriptive report is based on data collected from three demonstration sites that have piloted the implementation of a collaborative, family driven, child-centered system of care model of providing mental health services to the children and families of Idaho. The evaluator visited the three sites over a period of 18 months to collect information via surveys, observe case staffing, provide training around evaluation issues, and conduct focus groups with council members to collect process data. The data presented and the conclusion drawn from this report are based not on individual site analysis but on what has been learned in summary from the three sites about their progress in implementing a collaborative system of care model. The information from the sites is presented in several parts.

The first part of this report looks briefly at the goals of the three demonstration sites, and relates those goals to the Jeff D. Plan. The second part of this document presents the barriers encountered by the demonstration sites as they have worked toward their goals. In Part 3, an evaluation technique called the critical case review method is presented to help describe the major issues facing community councils as they strive to accomplish their goals, with an aim of providing information for policy development to support the community council initiative. The document ends with several recommendations.

The data presented here represents a synthesis of the multiple perspectives contained in the three demonstration sites. No attempt is made here to evaluate the effectiveness of the community council initiative. Instead, this report hopes to faithfully represent the demonstration site perspective resulting from two or more years of providing comprehensive, system of care services to clients. This ethnographic approach seeks to provide intensive information to policy makers, rather than generalized and aggregated service information. It is hoped that the "voice" in this report represents the local councils, and that the information presented will help policy makers comprehend the impact of policies on the local councils. Above all, the collected data aggregates to a very strong sense of hope for the future of this initiative; no matter the pain of council formation and of learning to grow through collaboration, the three demonstration sites provide convincing proof that agencies working together to achieve comprehensive family/client-centered mental health goals is superior to agencies working alone to achieve agency-centered goals related to the mental health needs of individual clients.

Part 1: What the Demonstration Sites Hope to Accomplish

The evaluator worked with each of the demonstration sites during the Fall of 2001 and Winter of 2002 to complete a goal setting process to identify the goals they were trying to accomplish as a community council. Council members were surveyed to establish an initial goal list, and then asked to rank the goals to identify those goals most frequently rated as top priorities. This section presents the goals of the councils and shows their relation to the ICCMH statewide

initiative goals. The great similarity in the goals showed by the three sites allowed the goals to be summarized into four categories common across sites.

Goal Category #1: The System Level. The top goal in this category is **to improve through collaboration the way that mental health services get delivered** to children and their families. This is a systems perspective, with individual participants recognizing through experience that individual agencies acting alone are often not successful with children who represent multiple service needs. Under this goal, various sites included sub-concepts like family-centered practice, one family plan for all agencies, providing a continuum of care, or developing a system of care to provide mental health services to children and families.

Goal Category #2: The Services Level. A second common goal areas for all three demonstration sites is **to improve and increase mental health services for children**. This goal includes sub-categories of improved access, increased knowledge of services, increase resource identification, more efficient case management, and providing existing services more effectively.

Goal Category #3: The Family Level. At the family level, demonstration sites hope **to increase family involvement in the planning and delivery of children's mental health services**. This goal includes helping families learn how to become more engaged in the process, how to stay involved with multiple agencies, increased training for families, establishing families as key decision makers in case planning, and prevention of out of home placements.

Goal Category #4: The Process Level. Each of the demonstration sites set goals that reflect their desire **to change the process of how mental health services are delivered to children and families**. Subsets of this goal include coordination between agencies on common service plans, training on developing service strategies that lead to satisfactory conclusions for multiple agencies, filling in the gaps created by the limitations set by individual agencies, increasing interagency communication about confidentiality issues, increasing flexibility of agencies to work outside of their normal boundaries.

The goals set by individual demonstration councils can be seen to align with objectives set by the ICCMH on a statewide basis. The chart below illustrates the statewide objectives, the Jeff D court approved plan number each objective addresses, and the summarized goals from the demonstration sites that address each objective.

Chart 1. Alignment of Demonstration Site Goals with ICCMH Statewide Objectives

ICCMH Statewide Objectives	Court Approved Plan number addressed	Demonstration Site Goals
Develop statewide core services for CMH. Same consistent core services are available to all children with mental health needs.	25-41 1 17	<ul style="list-style-type: none"> • Improve/increase services for children. • Develop common service plans for all agencies. • One family plan for all agencies. • Develop a system of care to provide mental health services to children and families.
Develop an integrated referral protocol with other agencies and families and a standardized assessment for children with perceived mental health needs.	1 27 2-8	<ul style="list-style-type: none"> • Coordination between agencies on common service plans. • Increased interagency communication about confidentiality issues. • Improved access to MH services. • Increased flexibility of agencies to work outside of their normal boundaries.

Chart 1. Alignment of Demonstration Site Goals with ICCMH Statewide Objectives (Con't.)

ICCMH Statewide Objectives	Court Approved Plan number addressed	Demonstration Site Goals
Build an integrated community CMH system responsive to the mental health needs of children.	1 2-11 19 20 24 25-41	<ul style="list-style-type: none"> • Change the process of how mental health services are delivered to children and families. • Develop a system of care to provide mental health services to children and families. • Develop a family-centered practice model. • Increased training for families. • Family as key decision maker in case.
Establish a continuous quality improvement system.	49. 9-1214-16, 18. 19 20, 22, 24, 42 43, 44, 45, 50	<ul style="list-style-type: none"> • Improve and increase mental health services for children and families. • Develop more efficient case management services for children and families. • Providing existing services more effectively.

Part 1 Summary.

The three demonstration community council sites each went through a goal setting process during Fall 2001 and Winter 2001. The goals each council chose to accomplish can be grouped into 4 major levels of children's mental health services at the local level: the services level, the family level, the systems level, and the process level. In addition, the goals chosen by the three demonstration sites can be seen to support the court approved plan objectives set by the ICCMH. This may indicate that the field is conceptually ready to move to accomplish those objectives with support and training to enhance their current collaborative experiences.

Part 2. Barriers Encountered in Pursuit of the Goals

At the same time that council members were asked to become clear on the goals they hoped to accomplish through the council process, members were asked to identify the barriers they were encountering in reaching those goals. Below, the sample barriers encountered are summarized from the three sites by the common goal areas listed above.

Goal Category #1: The Systems Level

A common goal of the three sites at the system level is to improve through collaboration the way that mental health services get delivered to children and their families. Sites reported the following perceived barriers around achievement of systems level change:

- council members becoming defensive
- lack of experience with allowing the family to shape the service plan and agency involvement
- lack of clear understanding of the regulations, guidelines, and resources of each agency in supporting a client-centered system
- lack of trust between agencies
- inability to get key partners to the table

- lack of time for effective collaboration
- agency mandates that must be met and that oppose a client-centered approach
- current focus on child as client from a clinical viewpoint instead of a family-centered focus
- the in-grained 'system' of each agency
- status quo mindset

Goal Category #2: The Services Level

A second common goal area for all three demonstration sites is to improve and increase mental health services for children. Perceived barriers around this goal in this start-up phase were reported as:

- finding programs that are available in relation to transportation, availability etc.
- lack of ability to coordinate a holistic service plan implemented by multiple agencies
- lack of available services or options in the community
- lack of measurement tools that give good data
- lack of knowledge of services available in each agency
- lack of ability to communicate better between ourselves before helping families
- lack of awareness and funding from legislature
- lack of ability to identify the needs of the family/child that are outside of traditional treatment plans
- lack of available wrap-around services

Goal Category #3: Family Level

At the family level, demonstration sites hope to increase family involvement in the planning and delivery of children's mental health services. Perceived barriers in achieving this goal were reported as:

- lack of hope and energy on the family's part, which results in low motivation to collaborate
- not knowing how to educate parents to be proactive without being aggressive
- lack of ability to sustain an ongoing and deep relationship with the family over time
- getting families involved whose needs are so great that participation is difficult
- getting families over negative feelings about agencies based on past experiences
- lack of resources and money; cannot serve all who have a need
- difficulties by council members in thinking outside of the box

Goal Category #4: The Process Level. Perceived barriers in achieving this goal were reported as:

- lack of ability to communicate service plans
- lack of time to develop as a group
- inability to successfully close cases in which there is parental involvement
- coordination of plans (still very fragmented)
- lack of ability to determine where closure is for a specific service plan
- school members vacation absence (summer months)
- not knowing if all members want change; not knowing what the true commitment is

Part 2 Summary

It can be seen from the sample items above that council members perceive as many barriers around goal achievement inside the councils as outside. The implications of these perceived barriers seem clear: Those items that reflect needed changes inside council functioning can serve as a training agenda. Those items that reflect needed changes outside of the councils can reflect a policy making agenda.

Part 3. Issues faced by the Councils

To provide in-depth information for policy makers, the evaluation aimed at identifying and understanding the issues surrounding desirable outcomes of a system of care. In this case, one desired outcome is improvement of the children's mental health system to an inclusive, collaborative model accessible to all children in the state. As with all complex undertakings, multiple issues surface as people in the field strive to reach this outcome. The following pages describe some of the issues surrounding the implementation of a system of care through the demonstration site community councils.

A critical case review methodology was adopted to collect information around the issues faced by community councils. The critical case review process analyzes how individual councils function around one case they identify as having a successful outcome and one case in which they could not identify a successful outcome. Through a group interview process, the evaluator worked with the council members to use personal memory and case files to describe the sequence of one case in each category, and then to use the differences to understand how various issues influence practice. In all, more than 5 hours of taped focus group interviews with the three sites were transcribed to produce six comprehensive case studies. The single data statements presented below are the aggregated summaries of many pages of transcripts.

The charts below show the questions asked of council members, and the summarized responses of the three demonstration sites around each question. In bold under each question is a service function represented by the question. The summarized responses represents commonalties among the three sites, rather than the individual site responses. No attempt is being made here to compare site responses to a best practice model; instead, knowing that their goals and intentions are in line with ICCMH statewide objectives, an attempt is made to use the differences between the successful and unsuccessful cases to further understanding of the multiple influences upon community council functioning.

Table 2.1. Eligibility Criteria

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
Who referred this case to the council? (Eligibility criteria)	One of the community council members or a close co-worker of a member	No-clear entry into the council.

Type and appropriateness of referrals: The successful vs. the unsuccessful case reviews above point out a critical piece of council functioning. Council members are often conflicted about which clients they should staff. On the one hand, they have been directed to deal with clients who have been diagnosed SED; on the other hand, they often deal with clients under their separate agency umbrellas that may or may not have been diagnosed as SED but who are involved in multiple systems and are heading toward a more restrictive environment or out of family or out of town placement. **Thus, the probable results of inaction and the lack of results of current actions may be the most important reasons for referral to the council.**

The lack of clear boundaries around referrals is compounded by the requirements around the SED diagnosis. First of all, clients are often staffed because they are in a crises mode or something is likely to happen very soon. For some councils, the ability to get a quick SED assessment done doesn't exist; council members themselves are not qualified to make the diagnosis and, depending on the council, DHW, due to work load issues, is unable to complete an assessment in the time lines necessary for the council purposes.

However, there is another issue that influences client referral; a successful referral may have more to do with the investment and advocacy of council members than with a SED clinical diagnosis. For most of the cases staffed, previous services have not been effective. Therefore, the diagnosis becomes relatively unimportant as referral information. What seems to be more important is a council member's willingness to advocate for the case and that other council members are either already involved with the case or are willing to become involved.

Discussions with the demonstration councils pertaining to referrals leads to the following summary: The more defined and rigid the referral requirements for application to community council services, the more the process starts to look like the bureaucratic systems approach that the councils are trying to replace through collaborative efforts. This doesn't mean that eligibility criteria shouldn't exist. It does mean that councils need a great deal of flexibility in terms of starting a process that may lead to a more complete diagnosis and service plan as a result of council activities.

Chart 2.2. Needs Assessment

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
What information gathering occurred? (Needs assessment)	An assessment had been done and multiple interventions tried and documented. Parents brought additional data to the original staffing and were a major source of information. Data was processed at the staffing using a brainstorming strategy; needs assessment data was presented, both clinical and parental, and the focus was on what's been tried, what's worked, and what hasn't worked.	Comprehensive information not presented to council.

Initial assessment data or data gathering process. The successful cases showed involvement of multiple persons with clear intentions around the case. Although some clinical data may have been available, it was not the major source of data used to make case plans. Rather, the information brought by the parent was deemed to be the critical information, as it helped to explain why various treatments or interventions had been unsuccessful in the past or were currently failing to support the child and family. From a council perspective, the most important information is a) what has been tried; b) what has worked; c) what has not worked; and d) what does the parent/child want. An important part of the councils' rationale is that the case wouldn't be before the council if previous or current interventions were being successful.

From one council it was learned that actually having clinical or past data present can get in the way of finding creative solutions to the issues involved with the case. The purpose of the initial staffing is to get the broader story out. Historical data, including past clinical intervention results, if present, has been found to speak *for* the family and drown out the family's voice. Some families are easily intimidated and overwhelmed by the historical and the clinical data, and quickly let the "experts" tell them what they should do. A major goal of the staffing, for this council, is to empower the family to enter into a problem solving relationship with the council, and to take a lead in the problem solving process. On the other hand, the council recognizes that parent perceptions about certain data, like school attendance, can be very different from the perceptions of service providers. This is a continuing learning point for councils.

An issue faced by the councils in the area of assessment and data gathering is that councils feel they have been directed to have complete data before they accept a case. In particular, they perceive that the CAFAS and the YLSI or equivalent should be part of the initial assessment data. Current practice is that these are not done up front unless the referring agency has done

them. In addition, it is not seen as appropriate to give all children the YLSI, for not all clients are involved in the juvenile justice system.

The issues faced by councils around the initial assessment data can be summarized by looking at what the councils hope to accomplish through the initial staffing and what kind of information might help them attain their initial staffing goals. Top among the goals of the initial staffing is to get the deeper story out about this particular child and family, principally from the family perspective. To the extent that past clinical and historical data is useful to attaining this goal, it is used. To the extent that it interferes with this process, it is not used. **Mainly, any data that is used in a predictive sense to direct what the parent should do, is data that is seen as harmful to the process of getting the family to engage as partners with the council in setting out a treatment plan for their child.**

Chart 2.3. Case Acceptance

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
Why did you accept this case? (Case acceptance) (Eligibility criteria)	Child met the criteria of 1) multiple agencies involved; 2) obvious mental health needs; 3) child was headed for out-of-home placement	No clear protocol for not accepting cases; case was moving quickly and mental health issues were involved. Uncertainty about the appropriateness of the case, but agencies involved needed support.

Reasons for accepting a case. The successful vs. the unsuccessful case review shown above illustrates several issues around the councils accepting or not accepting a case. The first issue - eligibility criteria - was discussed above. Here we repeat only that 'obvious mental health needs', as perceived by council members, is more often used as the criteria than is a clinical diagnosis.

Another issue faced by the councils in accepting or rejecting a case is that of supporting council members in their efforts to help children and families receive appropriate and successful treatment. Council deliberations, rather than written guidelines, seem to be effective in determining whether to accept a case or not. For example, one juvenile who was staffed had obvious mental health needs, but also ongoing substance abuse habits. Because the family was not able to share in discussing this aspect of the case, the council decided to put the case on a waiting list until the situation changed and the youth and family were willing to address the substance abuse needs. In the meantime, the council would informally work toward that end.

This example illustrates the need to support each other as council members; the case was brought by a council member whose agency was not being successful in intervening in this case. That council member became part of the agreement not to accept the case, but it could have gone the other way. This illustrates the issue: individual agencies have different perspectives on which clients need council intervention. This is at the same time the heart of collaboration and a potential source of conflict. Again, the more rigid the acceptance criteria, the less the likelihood for widespread collaboration by council members who aren't actively involved in mental health treatment as part of their agency responsibilities.

Summary of case acceptance criteria: Who gets staffed by the councils has important implications for who participates on the councils. Council members recognize that the most successful cases include strong buy in and advocacy by council members. **If clients supported through the council are limited by acceptance criteria to a narrow band of perceived needs, then it is likely that council membership will become narrow also.**

Chart 2.4. Service Planning

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
<p>How did you decide what to do with this case?</p> <p>(Service Planning)</p>	<p>1) the parent was a major part of the decision for action 2) the case information was presented to the council, with needs assessment and clinical data emerging throughout the discussion, focus was on what services tried with what results; 3) council members including the parent brainstormed possible strategies; 4) new treatment strategies were presented, with council members agreeing to carry them out; 5) both council and other agency resources were part of the discussion;</p>	<p>Case was staffed at a council meeting but no clear plan emerged. Adults involved could not communicate well and there were multiple agendas on the table during the staffing.</p>

Case planning. Deciding what to do on an individual case presents issues for councils when there are multiple agendas and when data is used to restrict creativity. In the unsuccessful cases, council members, or other individuals felt a need to push their own agendas rather than allow the parent and youth to determine what strategies to utilize. The issue may be that not all participating professionals have accepted a family centered practice as the cornerstone of community council practice.

In addition, council members or agency programs may use clinical data in a prescriptive way to force certain actions on clients because they are indicated from a clinical standpoint. This issue may be one of training and education regarding utilization of the family as a resource in collaboration; the use of prescriptive data can disempower the family, defeating efforts to increase collaboration and family self-determination.

Chart 2.5. Desired Outcomes

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
<p>What were your goals in this case?</p> <p>(Desired outcomes)</p>	<p>Family preservation and community based treatment</p>	<p>No clear goals emerged other than general prevention goals built on contingencies dependent upon the reactions of the child.</p>

Case goals. In the successful cases, councils had clear goals that aligned with their council goals at the same time that they supported the clients in their individualized treatment goals. In other words, the vision of the council was part of the case planning, just as were the treatment goals set by the parent and council. This allowed the councils to take a proactive approach to the strategies chosen by the parent and council. Council members became willing to acknowledge that past interventions, even by their own agencies, had not been successful because, at the time of referral to the council, the services were leading toward a path of out of home placement.

In the unsuccessful cases, clear goals did not emerge, and discussions centered around 'what ifs'. For example, the council might decide to do A, and then talk about what they would do 'if' A didn't work out. Well, then they would do B. 'What if' B didn't work.... and so on. In the

unsuccessful cases, the councils seem to operate on suppositional planning, rather than by keeping in mind the council goals as they worked with clients to set treatment goals.

A major issue around setting case goals is the participation of various members on a consistent basis. Some agencies, like schools, have yearly cycles that prevent participation during certain times of the year, like summer. Or, council membership may change during a case, and new persons join a council without having been thoroughly orientated to the goals and mission of the council. A result of this inconsistency may be confusion around goals, leading to the setting of goals that may not be attainable by the family.

Chart 2.6. Service Coordination

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
<p>Who did what to reach your goals in this case?</p> <p>(Service delivery/coordination)</p>	<p>An individual council member, representing an individual agency or service, took the lead on starting the action plan, often going outside of normal agency routines to do so. That member personally led the family through the process of obtaining services and then continued to facilitate services. The lead member was supported in the actions by the questioning that had occurred during the staffing; the brainstorming during initial staffing both supported and questioned what had been tried, and changes in strategies occurred during the staffing. Most importantly, the councils found ways to help the parent negotiate the systems to receive the services needed by the child.</p>	<p>No clear service coordination on this case. Not clear if anything was accomplished. Never got a good plan implemented because goals were so unclear.</p>

Service delivery/coordination. The successful case reviews illustrate the full networking potential of the community councils. One or more council members invest in taking a lead on supporting the child and family around the goals that they have set. Those members are supported strategically by the brainstorming that has occurred in the staffing or review and clinically by various agency members helping the family to gain access to services. In addition, council members who take the lead in a case are supported professionally by the collaborative process that has questioned previous service and has given permission, so to speak, for going outside of the box to support treatment success.

There are several critical issues faced by the council at this phase of council functioning. One is the ability of council members to bring forth clients they believe can best benefit from council activities, thus leading to strong buy in on the part of the members. This ability can be restricted by narrow and/or rigid referral requirements. Another critical issue is the ability of council members to work informally with each other around the case. Council members describe forming an almost literal web of thought and actions around clients they are supporting; their daily on-going activities with their agencies become filled with ways to support clients through their daily contacts with other agencies or council members. Confidentiality is always a key concern here, and council members were intent on maintaining the highest professional standards as they informally support each other and the client.

The ability of council members to network and web around client treatment can be restricted if standardized instruments and/or data becomes the only acceptable means of assessing client progress. In addition, parent advocacy or other advocacy groups have thoughtful agendas that don't necessarily include successful treatment as an outcome. In other words, when outside expectations of whatever nature are superimposed on the goals set by the client and supported by the council members, then the networking around client progress may become neutralized.

Chart 2.7. Outside Resources

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
What unusual services did you procure in this case? (Outside resources)	Much collaboration between outside agencies facilitated by a council member	No unusual services procured.

Outside resources. One of the potentials from increased networking, as described above, is the possibility of procuring additional resources to support client progress. The success case reviews indicated that resources outside of council members became an integral part of client success. PsychoSocialRehabilitation agency representatives in particular were in a good position to share observations of client progress or needs with council members, who could then take that information back to parents and other council members for problem solving or discussion. There is little doubt that lack of resources is often a severe limitation on what councils and family choose as treatment strategies. However, the ability of the council members to network with multiple service providers around client progress is a way to build the largest resource base available to individual clients.

The issues faced by council in this area again have to do with standardized treatment process or requirements that might be imposed from outside. In cases where almost nothing else has worked, the ability of council members to be professionally flexible and creative is a critical part of client success.

Chart 2.8. Data Collection

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
How did you get feedback on whether the plan was working? (Data collection)	Council members regularly talked with persons working on the case who were not council members, but who were part of their agency's network. There was a great deal of sharing information informally and case was reviewed formally by the council.	Nothing seemed to work so there was little feedback. Case may have been reviewed but crises changed so quickly that no one could keep up. Never got proactive around case.

Data collection. Data collection presents some pivotal issues for council members. Critical case analysis of the successful cases showed that council members had almost continuous feedback of an informal nature, and much less feedback of a formal nature. In addition, the formal feedback at interim case reviews was often of a narrative nature rather than clinical or standardized assessment data. For the unsuccessful cases, data collection was relatively non-existent, except to the extent that members heard about the lack of progress on the part of the client.

One of the pivotal issues involved in this aspect of council functioning is the extent to which clinical data can inform parents' and council members' decision making process. As mentioned above, clinical data can take on a life of its own and drive decisions. There are many circumstances where standardized assessment data may be an appropriate basis for making case

decisions. In choosing to work with clients for whom progress has been almost non-existent in the past, the councils seem also to be choosing to use different types of data to drive decision making. By basing decisions on the perceived needs and satisfactions of clients, councils are increasing family and youth buy in and ownership in the process and allowing them to become increasingly the authors of their own treatment.

This raises the issue of accountability and how that can be measured. Currently, professional accountability is often measured by client progress on a standardized scale, such as the CAFAS. The use of the scale is dependent upon a trained person making judgements about client progress based on conversations or interview data received from the client. The councils seem to be operating on quite a different premise; the desired outcomes are changes in client behavior such that the client and family can stay united and that the client can be treated at a local level. CAFAS scores may have very little to do with such outcomes. However, the councils also feel the need for showing accountability, so the issue becomes this: What type of accountability data can be collected that will be useful in: a) helping clients and families increase their buy in and self-reliance around treatment progress and decisions; b) provide information for professional decision making, and c) reflect the progress actually being made by the clients in terms of changes in adaptive behaviors?

The third issue around data collection is a resource issue; what part of council time should be spent on dealing with collecting accountability data if that data is not useful for supporting clients in making decisions related to their treatment? The current status of data collection activities as integrated into ongoing council functions is that data is collected because of agency requirements but not because of its usefulness in case planning. For the councils, it is becoming increasingly important that accountability data also be useful for case planning.

Chart 2.9. Advocacy

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
Did anyone in particular advocate for this case? (Advocacy)	All council members who were involved in the case became advocates.	No one from council was assigned the case and no one stepped forward to pick up the advocacy part.

Advocacy. Advocacy is seen by the councils as a key component of council effectiveness. Because of the voluntary nature of council membership, council effectiveness can be measured not only by client outcomes but also by the willingness and ability of council members to integrate council client concerns into their daily agency routines. In the successful case reviews, council members who worked with clients became client advocates both within and outside of the council. In the unsuccessful cases, no advocate stepped forward, for a variety of reasons.

One issue related to advocacy has to do with the voluntary nature of council membership. As agency staff, each person completes case files or paperwork relating to their agency's requirements. As a volunteer council member, each person may be more or less reluctant to spend the time they do have to volunteer filling out data collection forms, particularly when those forms may not be seen as useful for increasing the progress on an individual case. Therefore, it is necessary to be sensitive about what advocacy looks like in the functioning of the community councils. Advocacy may look like making connections with other professionals as a council member goes about his or her daily routines. Advocacy may look like intervening in one's own agency to help clients gain access to services. Advocacy may look like being supported by other council members in challenging status quo treatment options. Advocacy may not look like being held accountable for collecting data to show client progress.

The concept of advocacy as used in conjunction with the community councils can be applied at the systems level as well as at the client level. The councils themselves are in need of advocacy; they are trying to make changes just as clients are, and are in need of support in making those changes. Currently, councils may experience being directed more than advocated for. The funds that have been made available to the councils have at times arrived with tight restrictions on their use, which has turned them from a source of support to a source of conflict or confusion. Unlike the collaborative model being developed by the local community councils, in which client advocates are involved in council decision making, no council peer or peer representative sits on the state committee that provides the councils direction. Advocacy for the clients works because the advocates have a vote, both on the council and in their own agencies, where they can provide access for clients through their agency membership. Advocacy at the state level without a vote may not work for the councils because the personal investment of the advocate, so crucial at the local level, isn't present.

Chart 2.10. Collaborative Process

Critical Case Review Questions	Successful Case Summary Responses	Unsuccessful Case Summary Responses
<p>How did the team operate during this case?</p> <p>(Collaborative process)</p>	<p>There was a lot of communication between council members on this case, both during the formal reviews and informally.</p>	<p>Not smoothly. Outside experts not on council came in with solutions rather than as a brainstorming resource and caused confusion and clashes with the parent.</p>

Collaborative process. The collaborative process has been successfully used on a majority of the cases staffed by the community councils. In the successful case reviews, communication occurred continually both during and outside of council meetings. Collaboration is more than communication, and council members also demonstrated a willingness to provide input into the decision making process without becoming personally attached to the strategies or information they might suggest. In this sense, council members see each other as resources to help the child and family reach the mission of the councils, which is to keep the family together and to treat the child locally. During the unsuccessful cases, communication did not always occur in a manner that facilitated discussion. Instead, individuals tended to bring answers with them to the council or even to the services that occurred outside of the council. Collaboration is difficult when there is only one acceptable solution and not everybody is supportive of that solution.

One issue with collaboration is that it requires broadening one's perspective to include ideas from others with varied experience and frames of reference. Collaboration requires opening up to alternative perspectives and seeking to understand other viewpoints regardless of the parameters. The councils have come to understand that under collaboration, every one is an equal partner. A parent who may have pressing mental health needs becomes an equal partner in determining the goals for providing treatment to his/her child. With anything less than being a full and equal partner, the parent potentially becomes a recipient of services, and council members take on a supervisory, expert, or evaluative role. Should that occur, advocacy may lead to increased dependency on the part of the family rather than become a means to help clients achieve goals that are important to them.

Having learned how to collaborate, the demonstration sites are hoping to become collaborative partners at the state level. Although a mechanism for this does not currently exist, in their perceptions, they fully understand that anything less than full and equal partnership in state initiatives will result in local community councils feeling supervised rather than co-partners involved with system change.

Part 3 Summary

Multiple issues surface as the demonstration sites strive to implement a collaborative system of care model to provide comprehensive mental health services to children and families. Many of the issues center around a paradigm shift from a clinical or expert model of service planning and provision to a collaborative model, a model that utilizes expertise and clinical interventions as a means of obtaining the overarching goals of family preservation and community based treatment. This shift seems to require a new look at several key aspects of current professional practice, such as the use of clinical assessments to determine client goals, the role of families in determining treatment options, and the roles that collaboration and advocacy play in designing intervention plans. The flow charts below illustrate the change in models.

Chart 3 illustrates a generalized clinical service model currently in place. The model starts by identifying a client with mental health issues, and proceeds by assessing clinical needs leading to a diagnosis. From that diagnosis a treatment plan and clinical goals are set, with services provided to meet those goals. Periodically, client progress is assessed and the service plan adjusted. Finally, the case is closed when the client no longer qualifies for services because the clinical goals have been met.

Chart 3. Flow Chart of Generalized Clinical Service Model

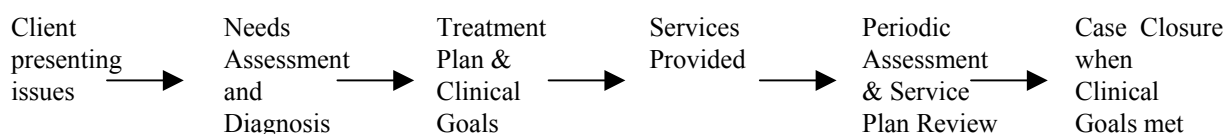


Chart 4 summarizes the sequence of events the three demonstration sites are working toward. The sequence starts by having all council members agreeing with the overarching goals of the council. Next, a client is referred to the council due to perceived children's mental health needs that put those overarching goals in jeopardy. The child and family is next brought in as full partners in the process of problem solving around the service needs and treatment goals, and a service plan is developed based on past experiences, creative solutions, and current goals of the family. Next, individualized interventions are implemented creating and/or coordinating services that are community based, and formal and informal assessments are conducted. Periodically, the family and providers are brought together by the advocating council member to review client progress and needs. The case is closed when the goals of the case plan are met and family preservation and community treatment outcomes are achieved. In addition the family may at any time withdraw from participation, at which time the council would close the case.

Chart 4. Flow Chart of Developing Community Council Model



Conclusion

The information presented above leads to several tentative conclusions. First, the results of a goal setting process with the three demonstration community council sites seem to indicate close alignment with the Court Approved Plan adopted by the ICCMH. The goals also illustrate activities the three demonstration sites are currently accomplishing in the field. This may indicate that the field on a state wide basis is receptive to learning new ways of providing mental

health services to children and families through a collaborative, family-driven, child-centered, systems of care model.

Second, the perceived barriers to goal achievement listed by the council members may represent an equal blend of council interactions and policy change. The perceived barriers thus lend themselves to interpretation as both a training agenda and a policy making agenda.

Finally, a critical case review methodology has highlighted practical and philosophical issues that accompany a paradigm shift from a clinical model of children's mental health provision to a collaborative system of care model. The issues surrounding this shift can be seen to include the use of clinical data in service planning, using family/client experiences as a driving force in determining goals and outcomes, and designing state-wide support systems that empower service providers to use collaboration and advocacy as a means of supporting families and children.

The scope of this formative evaluation has been somewhat determined by the types of information currently available from the demonstration sites. Because a formal data collection process had not been implemented at any site, development of such a process, including forms and procedures, has taken top priority for evaluation purposes. Now that formal data is being collected, several additional evaluation goals can be accomplished, such as using summative data to identify lessons learned at each site, completing a benefit-cost analysis at each site, and identifying the changes in service provision that have led to successful outcomes. In the meantime, it is hoped that the data presented in this document will inform decision makers as they seek to support the development of community council throughout Idaho. It is also hoped that the data will allow persons at all levels to better understand the complexity of implementing a collaborative, family-driven, child-centered system of care model of children's mental health.

Recommendations based on the above data:

1. It is recommended that a means of providing data collection services for the sites be implemented. The voluntary nature of the collaborations and the complexity of collaborative interventions demand a high level of focused data tracking and collection if councils are to use data as a basis for decision making. Discussion with the sites seems to indicate that each site can be supported by having data collection and management services available one day per week. It is possible that this could be accomplished at a regional level by having a full time person to work with each of the local councils in that region.
2. It is also recommended that the type of data used to assess client service needs or progress be reconsidered in light of the shift to a collaborative, family-driven model. The result of an effective assessment tool should be to a) provide data useful for parents and council members to use in their planning processes, and to b) provide data that illustrates council accountability. To fulfill these purposes, it is likely that assessment tools will need to move away from predictive purposes and to focus on outcomes related to family driven changes in client adaptive behaviors. Part of this shift may be an intensive education initiative designed to help non-clinical partners understand how to use the CAFAS and other standardized instrument in a non-predictive way. an important goal here will be to achieve an balance between substantiating progress on clinically approved instruments and providing empowerment opportunities for local providers. This may be one of the more important and long-term impacts of the system of care movement.
3. It is recommended that a means be created to allow local councils to feel fully represented at the state level, thus aligning the whole system in a full partnership model.
4. Finally, it is recommended that a training agenda be created that will support council formation by addressing the internal council barriers identified by the demonstration sites.