



IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Summative Evaluation Report on Demonstration Site Performance

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IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Summative Evaluation Report on Demonstration Site Performance

Executive Summary

This document presents evaluation information collected from three Idaho Community Council Demonstration sites between July 2001 and September 2002. The original intention of the evaluation was to collect and analyze council and client data to measure the progress individual sites were making on reaching the performance indicators of the state-wide court plan. The reality of the processes actually in place in the councils revised the evaluation goals to include:

- Development of common evaluation reporting forms for the purpose of documenting services and service impact;
- Collection of the case file information on clients staffed during the past two years; and,
- Collection of lessons learned information with a goal of informing the development of a state-wide reporting system.

Two important findings result from the data collected. First, analysis of the goals set collaboratively by parents and council members indicates that a majority of the goals to be achieved related to council members' activities, rather than client or family activities. This may be a natural part of the support cycle during the first months of the intervention. However, the percentage of council member performance goals increased over time in those cases that were tracked for six months or more. This finding may mean that council members are not yet in a position to support youth and their families in making progress on the everyday goals necessary for long term changes in behavior.

Another finding is that councils will not likely be able to supply program effectiveness data without a great deal of support and training. The data supplied for this report was insufficient to complete an effectiveness evaluation, not because councils were not cooperative, but because data is currently being used by the councils for purposes other than reporting. These two findings lead to the following recommendations:

Recommendations

Evaluation Tool Kit: The first recommendation concerns the data collection process in place at the demonstration sites. Currently, there seems to be a reluctance to introduce clinical or school data into the parent-led treatment planning process. This may result from the reality that clinical or historical data can intimidate families into seeking a reliance on the 'experts' at the table rather than collaborating with the members to set goals that are meaningful to the family. This creates tension in the system, as one of the major council goals is to increase the effectiveness of services. Omitting or only partially using clinical data means that councils have limited means of evaluating the extent to which youth are making progress on mental health measures, thus denying the councils the ability to measure which actions are leading toward progress.

It is recommended, then, that a community council evaluation toolkit be created. This toolkit would offer local councils standardized, step-by-step procedures and forms for helping clients, families, and council members

understand what various data represent, and how to collect it. The toolkit would also provide workbook structured details on how data can be used to help clients/families set goals and track their progress toward achievement of those goals.

Data-based Decision Making Training: A second recommendation is to provide training to council members, including parents, on the use of the data toolkit. It is imperative that each council recruit parents who are willing to learn how to help guide clients and their families through a data-based decision making process that includes a variety of data to be used in a variety of ways. The formative evaluation report on the community council demonstration sites concluded that each region should have available at least one person to oversee the data collection process for each of the councils. This will help ensure that data is collected concurrently with client participation and progress, and not retrospectively, as has been done for the pilot sites. It is recommended that regional training sessions be conducted that bring together individual site parent members/volunteers, case managers, site chairs, and the regional data managers to learn about and practice using the evaluation toolkit.

Outcome-based Treatment Model Training: A third recommendation concerns the movement of the councils toward an outcome-based treatment model. Each of the demonstration sites asserted the need for different outcomes for the clients served than those traditionally associated with mental health interventions, such as increased scores on standardized scales. Each of the councils also envisioned empowering clients and families as a top priority of their service. Promoting creative, client-centered outcomes with a goal of client empowerment leads to re-defining treatment outcomes in terms of the actual behaviors of clients, often called adaptive behaviors. It is changes in client adaptive behaviors that will lead to achievement of the council goals of keeping clients in the community and in the family. At this time, data indicate that a majority of client goals are actions that council members undertake, not behaviors that clients work toward. This discrepancy between councils goals and what council members actually do to help clients reach their treatment goals appears to be a training/educational issue, not a philosophical one. Setting and tracking client/family-centered, adaptive behavior outcomes represents a departure from traditional practice for many of the agency-based council members. Therefore, it is recommended that region-wide training sessions be implemented, perhaps in conjunction with training around the evaluation toolkit, to support local councils as they move to a client-centered, outcome based treatment model.

System of Care Principles - Supervision Structure: A final recommendation addresses the need for individual community councils to receive support in utilizing a system of care model to provide mental health services to children diagnosed as SED. The system of care model core principles could be used to provide guidance to local councils and to regional councils as they develop their strategies and procedures for partnering with clients. The adopted, state-wide memorandum of agreement provides quality assurance related to many technical and legal aspects of collaborative service. To compliment that structure, the system of care core principles could be used as part of a collaborative supervision process that would provide feedback to local councils on the extent to which their on-going operations fall within the system of care model. The recommendation is that regional representatives come together to study and explore the system of care core principles and to develop a supervision structure that would be useful for providing feedback to the voluntary members of the local councils.

IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Summative Evaluation Report on Demonstration Site Performance

This document presents evaluation information collected from three Idaho Community Council Demonstration sites between July 2001 and September 2002. The original intention of the evaluation was to collect and analyze council and client data to measure the progress individual sites were making on reaching the performance indicators of the state-wide court plan. The reality of the processes actually in place in the councils, however, revised the evaluation goals to include:

- Development of common evaluation reporting forms for the purpose of documenting services and service impact;
- Collection of the case file information available on clients staffed during the past two years; and,
- Collection of lessons learned information with a goal of informing the development of a state-wide reporting system.

To implement this initial evaluation of the demonstration sites, the evaluator worked with each site to determine what data was valued, and then aggregated that information across sites to come up with a set of data collection instruments. The instruments represented a) what the demonstration sites believed they could collect; and b) what demonstration sites believed would be a realistic representation of the type of effect they had on clients.

The information collected during this evaluation is presented in a format that describes two things: 1) the process or place the data occupy in the council functioning, and 2) the actual data collected in relation to the decision making and reporting functions of the council. All forms created in collaboration with the councils are shown in Appendix A through C. These forms are not necessarily the forms that will be adopted by the state-wide program. Rather, they are what the demonstration sites found value in during this pilot evaluation period.

The information collected by each instrument is presented by first describing the purpose of the instrument and then detailing the use of the data or the procedures used to collect the data. Next, the data collected by the pilot sites are described, and finally any findings/discussions related to either the data or the data collection process are described. Data are presented as collected by the following forms:

1. Client Referral/Staffing Form
2. Client Information Form
3. Case Management Form

The report concludes by comparing the data available for this evaluation with the data required to fulfill the state-wide court plan.

It is important to note that the councils see themselves as voluntary groups of persons working to better serve the mental health needs of clients in their communities, and that no demonstration site council had a person dedicated to collecting client data for reporting purposes. Therefore, the councils were concerned that evaluation data be useful to them in actually helping clients make progress. This report will address this dynamic as it strives to identify those areas where council functioning and state-wide reporting requirements are not yet in alignment.

Part I. The Client Referral/Staffing Form

1. Purpose

The purpose of the client referral/staffing form is to collect background information about the client and about the issues faced by the client. The three pilot Councils came to ready agreement on what type of data could be collected during the referral and/or staffing process. They were equally clear that this referral data should not drive the goals set during the actual staffing.

2. Use/Procedure

There was not uniformity among the Councils on how and when referral or staffing data might be collected. For some councils, with some clients, the referral date and the staffing date might be the same day. This could occur when a community council member was working with a client but had not yet collected or documented data to present to the council. Often, the council member would request to bring the client to the council, and the pertinent data was collected on the spot as part of the council proceedings. The information (see Appendix A, Client Referral/Staffing Form) and the collection of it during the council proceedings were seen as helpful in understanding the needs of the client. On the other hand, there were some clients who were already part of the system of DHW, Probation, Juvenile Corrections, or Education and thus had established files with information that could be shared with council members after the client had signed a release.

For many clients, school data and CAFAS and YLSI data were not available at the initial staffing. This was especially true if the client had been working with a council member or member's agency that did not have access to MH services or school performance data. When that occurred, it was up to the case manager, if there was one, to obtain that data after services had started. There was a dilemma here, as this meant that some potentially important data were not present during the initial staffing, when initial intervention goals were set.

On the other hand, some council members asserted that often the more official, standardized data was not of great value at the initial staffing, in that an important goal of that staffing is to get out the story of what has been tried with the client and to enlist the parent/guardian as a partner in intervening in the current situation. Some council members went further than that and asserted that the nature of the clients they are working with - clients who are involved in multiple systems and for whom those multiple systems have not worked - indicates a need for a different approach to supporting clients in resolving their issues. The standardized data used by the major agencies seemed to interfere with adopting a different approach, in that the data seemed to prescribe certain actions, most likely actions that have already been tried and that have failed.

3. Data Collected by the Referral/Staffing Form

Information from the initial staffing form was provided on 63 clients who were referred and staffed by the three demonstration sties, mostly in 2001-02. Much of the data was provided retrospectively; that is, it was collected by a council member or representative working with the evaluator for the purpose of providing client data but long after the intervention had taken place. Therefore, a great deal of data was not available; for example, school data was often not available for clients who had been involved with the council more than a year previous to the data collection.

Client Demographics

Client demographic data is collected by the Client Referral/Staffing form. Chart 1 indicates that the clients served by the demonstration sites were mainly 15-17 year olds. Seventy six percent were male, and 87% of clients were of White ethnicity, as shown in Chart 2.

Chart 1. Client Ages

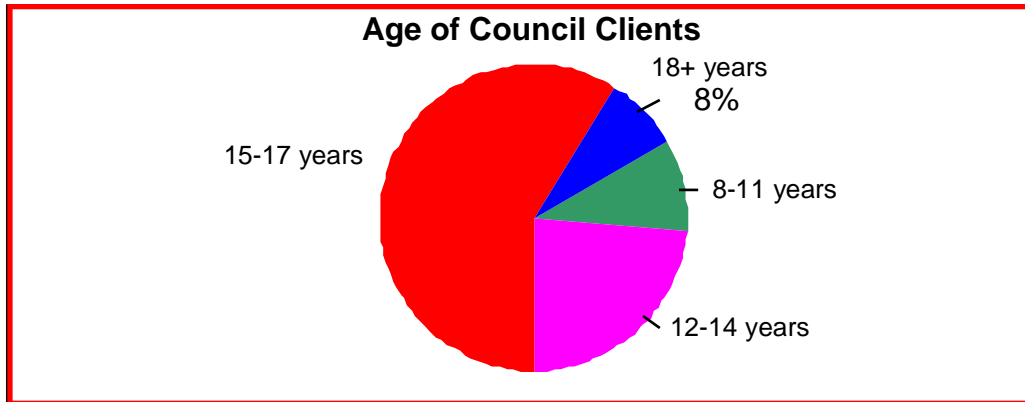
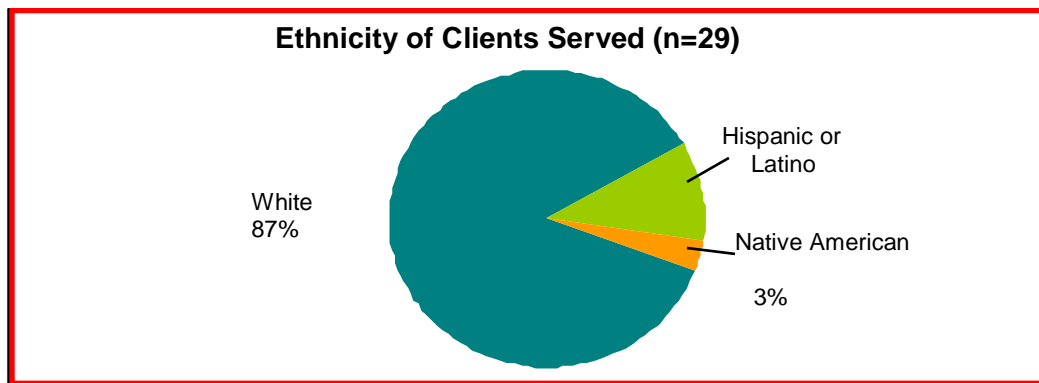
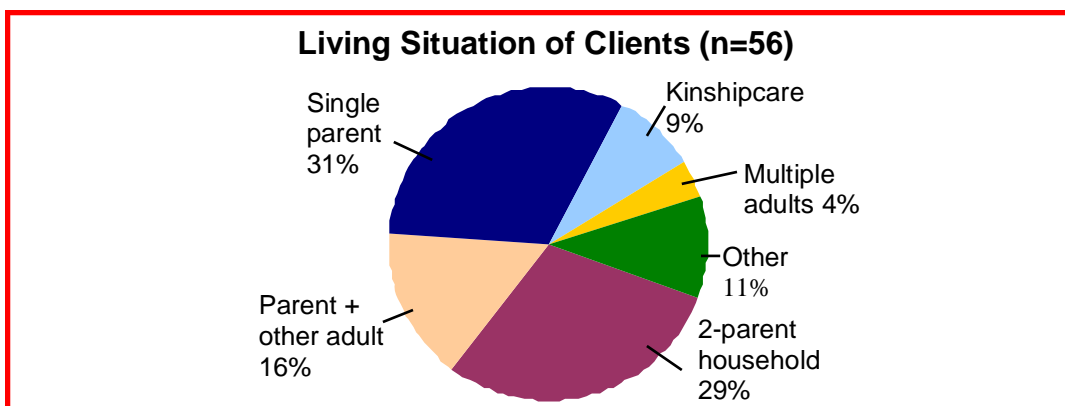


Chart 2. Ethnicity of Clients



Two parent and single parent households were the most typical family settings, as shown below.

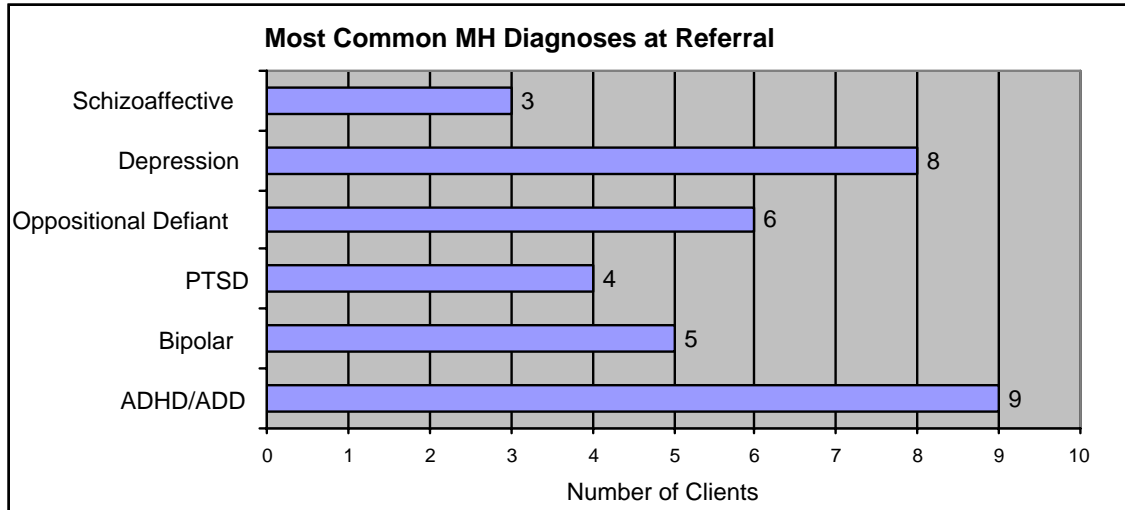
Chart 3. Living Situation of Clients



Client Needs Assessment Data

The Referral/Staffing form also collected current MH diagnoses and presenting problem information. Forty two percent of clients had a MH diagnosis at the beginning of the council intervention. Chart 4 shows the six most common diagnoses, although 54% of diagnosed clients had multiple areas of mental health needs. One implication of these numbers is that up to 58% of clients were not connected to MH services when they were first referred to the council.

Chart 4. Client Mental Health Diagnoses at Referral



On the other hand, 95% of clients had presenting problems recorded by the councils. The breakdown of the presenting problems indicates that clients had multiple issues at the beginning of service: 17% of the clients served had 1 presenting problem; 58% had 2-3 presenting problems; and 25% of all clients had 4 or more presenting problems at the beginning of service by the councils. Charts 5 and 6 below illustrate the type of presenting problems brought to the councils by individual clients. These are divided in a) behavior characteristics (chart 5) and b) supports needed (chart 6).

Chart 5. Client Presenting Problems

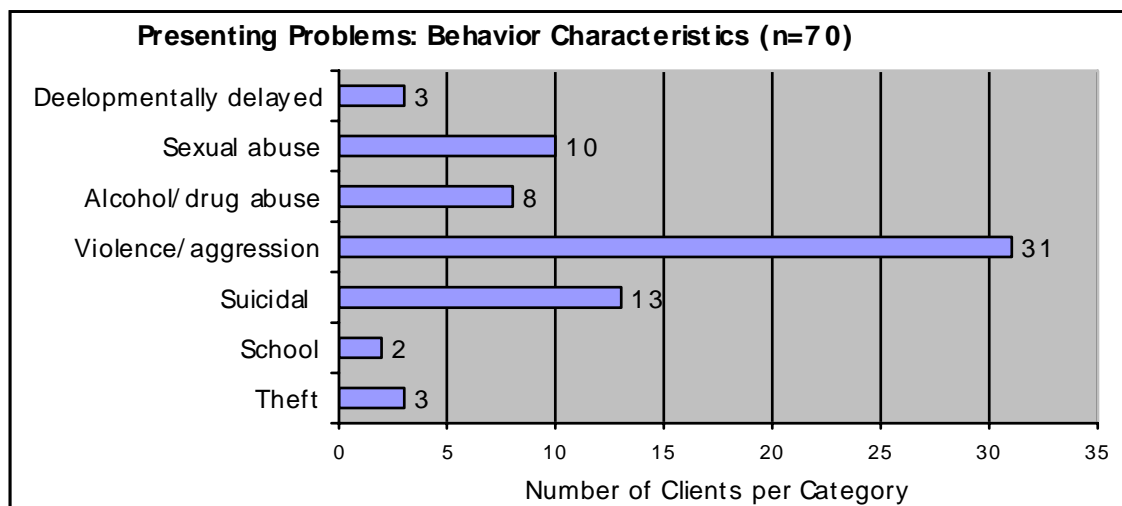
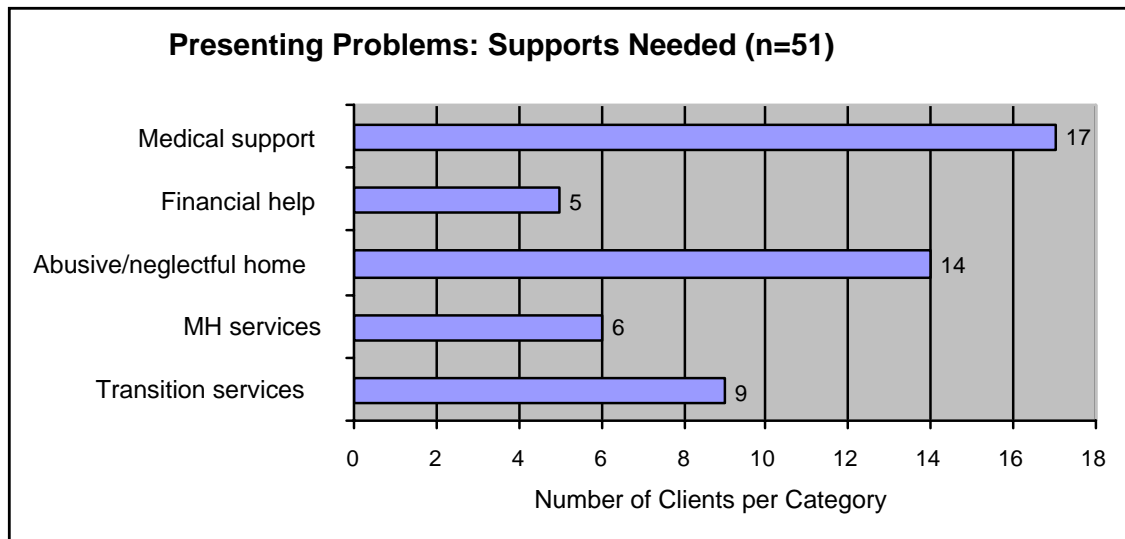


Chart 6. Client Presenting Problems



Examples of the types of supports needed in the different categories are as follows:

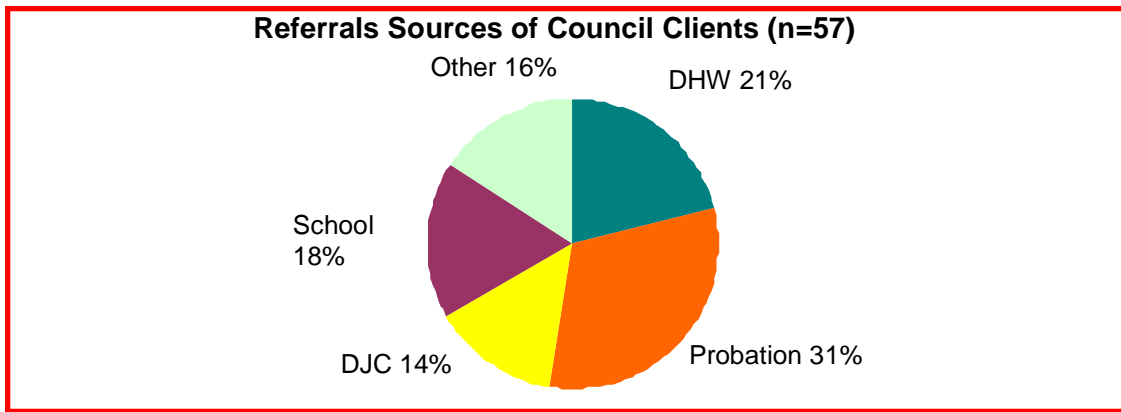
- ◆ Medical support: cardiac condition; mother has depression and not sleeping; headaches; admitted to hospital after suffering apparent seizure.
- ◆ Financial help: child refuses to go home (no phone and no power in home); parent cannot afford medication.
- ◆ Abusive/neglectful home: domestic violence in home; prior ritualistic, long-term sex abuse by biological mother (very low IQ client).
- ◆ MH services: attempted suicide; self-mutilation; masturbation problems; fire setting; lack of anger management leads to physical restraints in school.
- ◆ Transition services: removal from school setting (home schooled); expelled from school; needs a place to live.

Client Background Information

Client background information was collected on clients referred to the councils. This information included names and addresses and phone numbers of significant adults in the child's life, along with other information useful for setting initial goals. One important piece of information was the referral source, as that often indicated what type of records, if any, were available for council discussions. Background information was recorded on 89% of the clients served.

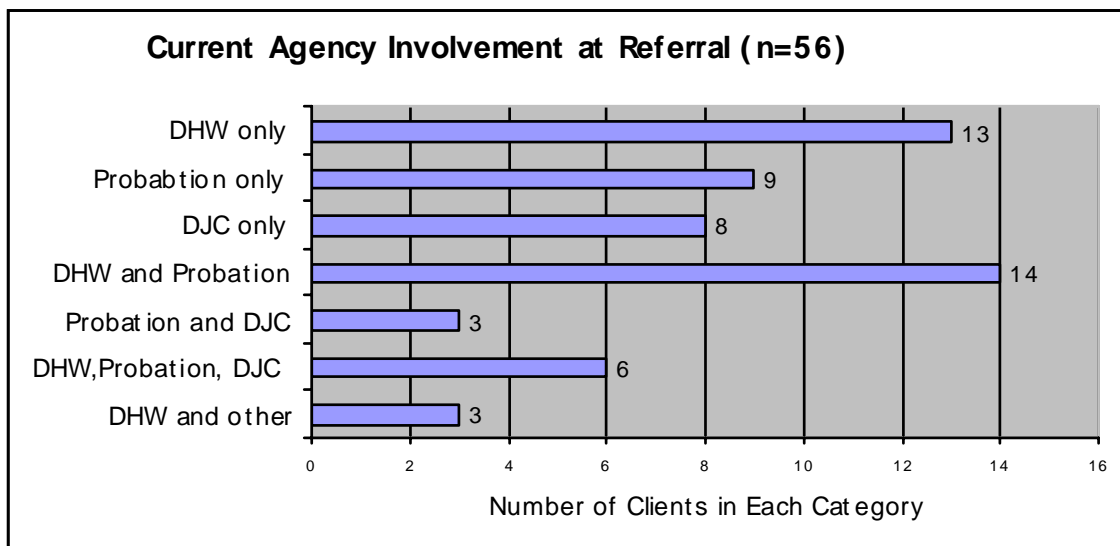
Chart 7 on the next page shows the percentage of clients referred to the councils by different sources.

Chart 7. Referrals Sources of Council Clients



Current agency involvement was another important piece of information for the initial referral or staffing meeting. Chart 8 shows that the majority of clients served were involved with multiple agencies at the time of referral.

Chart 8. Current Agency Involvement at Time of Referral



Councils also collected data on clients' previous placements during the referral or initial staffing meeting. The following table shows the percentage of clients this data was collected on and the average days of placement in two categories.

Table 1. Client Placements Before Referral

Placement	% of Clients data collected on	Average number of Days
Days in Juvenile Detention for 6 months prior to referral	27%	12
Days in out-of-home placement	27%	50

Clinical and School Data

The Client Referral/Staffing Form included clinical and school information that was critical for understanding the impact of the council activity on clients. This data included the CAFAS scores, the YLSI score where it applied, and school data. For this evaluation, most of these data were collected retrospectively, with the result that only about 1/4 of data were collectable. This issue is addressed in the Recommendations below. The following table shows the extent to which data were retrievable by the pilot sites.

Table 2. Client Clinical and School Referral Data

Data category	% of clients data collected on	Average findings	Data notes
School attendance: # of days absent out of total possible for previous term	25%	18.5% of days possible	uniform data not provided
School Discipline data: # of disciplinary actions during previous term	22%	9 actions	
In-school suspension data: # of days previous term	13%	4.6 days	
Out-of-school suspension: # of days previous term	17%	5.1 days	
Number of F's out of total number of grades possible	16%		data not similar across sites
CAFAS scores (pre)	35%	124.8	
YLSI scores (pre)	6%	20.75	

Services to Date

The final portion of the Client Referral/Staffing form collected information on what had been tried as a precursor to discussing what might be tried next. This is critical information for the council; unless they know what hasn't worked, they cannot support the client in trying new things that might work.

Charts 9 and 10 below illustrate that multiple services had been tried with clients. Twenty percent of clients had been provided with 1-2 services; 62% have tried 4 or more services, and 38% of clients had previously tried 6 or more of the services listed in the charts on the next page.

The services are broken down into two categories; a) direct services to clients that usually take the form of an intervention such as counseling, providing guidance and supervision for medication, or ensuring that clients get hospitalization as necessary; and b) placement services that help clients stabilize in an appropriate environment for their presenting conditions.

Chart 9. Previous Services Provided to Clients

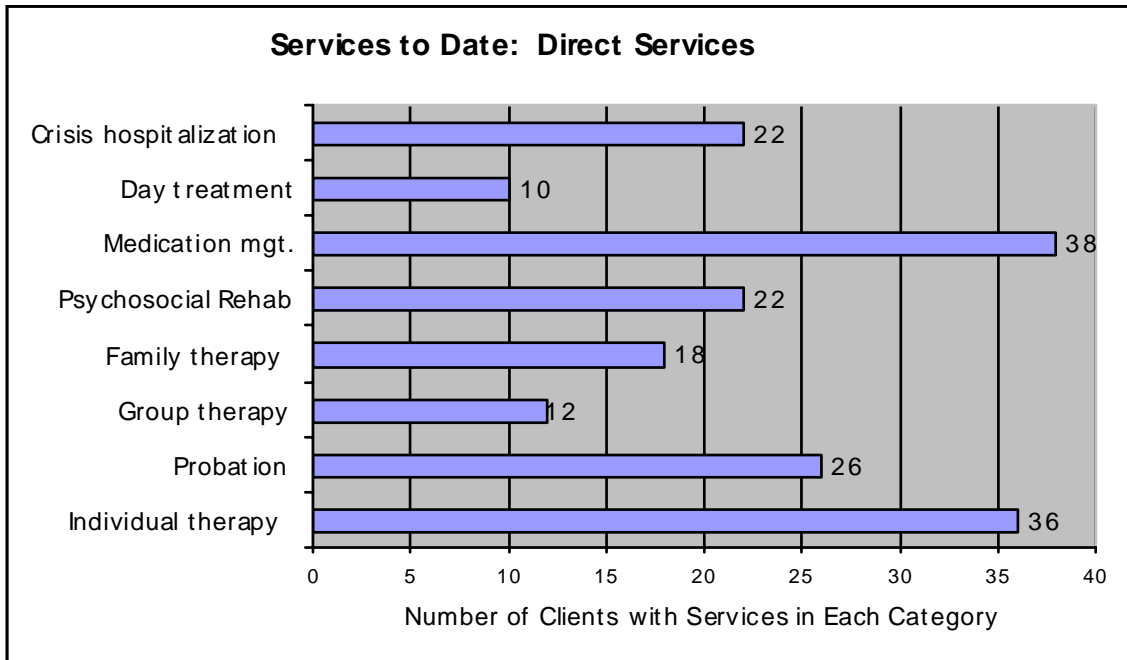
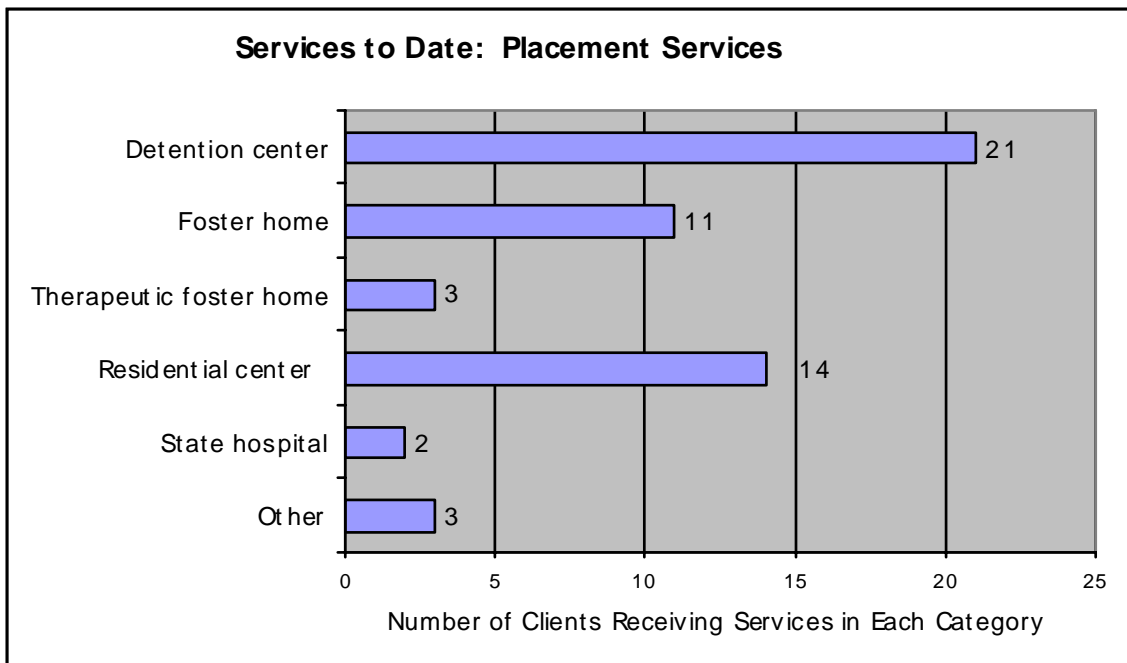


Chart 10. Previous Services Provided to Clients



4. Findings/discussion related to the Client Referral/Staffing Form

A major learning point related to the Client Referral/Staffing Form is that none of the councils saw client information about previous services information as neutral. The case histories of clients were viewed as dynamic in that the information about past treatments had a tendency to influence current perceptions of the council members and to act as a curb on creative thinking on the part of clients. And, creativity in treatment is seen as highly desirable by the demonstration sites; creativity for them means not only trying new treatments or combination of treatments; it also means collaborating with the parent/guardian/caregiver in ways that engage them as equal partners in the intervention. This is part of the reason that clinical data was seen as potentially damaging; prescriptive, evaluative clinical data can hover over the client like a cloud that seems to dictate what must happen, rather than urging clients forward into supposing or visioning what might happen.

The unstructured, flexible ways that clients are referred and staffed by the Councils helps explain the lack of data available for some parts of the Client Referral/Staffing Form. The data that a parent/guardian could supply, such as treatment history, was successfully gathered for a majority of clients. More specialized data, such as school data, CAFAS or YLSI scores, if not made available at the initial staffing by a Council member, was much more difficult to collect retrospectively. If a school member was not present at the staffing, then it was up to a part-time Council coordinator or case manager to track that data down. The same with the CAFAS or YLSI scores. Retrieval of this historical data, even of a clinical nature, was not seen as a priority; most of the clients were in some form of crises and going forward was seen as much more important than going back in time to collect data that often would add little if anything of value to the on-going intervention. For the Councils, it is just this flexibility and lack of structure that allows them to be so responsive to the needs of clients. On the other hand, without sound pre-treatment data it is not possible to evaluate the extent to which the council process is effectively treating the clients served. The type of goals set by the councils may play a role in this; councils are intent on preventing out of home placement and in ensuring that clients get treated locally. Those goals may be reached without necessarily improving behavior as represented by CAFAS or YLSI scores.

Part II. Client Information Form

1. Purpose

At the same time that the Referral/Staffing form was being completed, the Client Information Form was begun. This form contained some of the same information found on the referral/staffing form, but the purpose of this form was to track client information over the life of the client-council relationship.

2. Use/Procedures

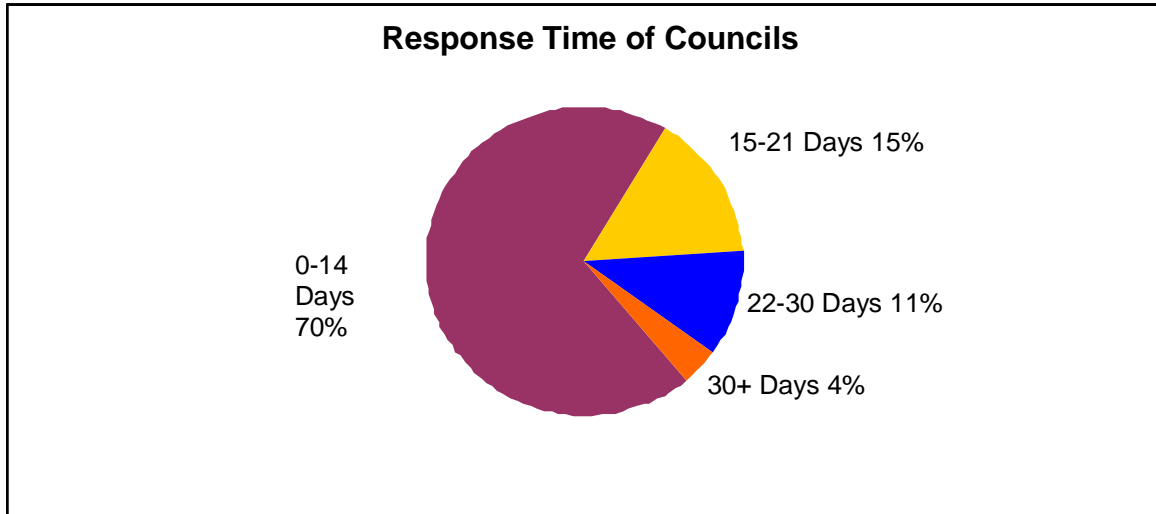
The Client Information Form was completed by someone from the Council who took on the case management role for an individual client. During the demonstration site process, this was usually a part time person employed for that purpose. For this evaluation, most of the data supplied on this form was taken from case notes and other records; the form was not in existence during the time period when a majority of the clients were served.

3. Data Collected

The Client Information form data indicate that clients came into the referral process from different perspectives. Although 79% of the clients were referred for treatment purposes, 8% were referred for what might be called prevention, and 13% were referred for transition activities. In 86% of the transition cases, the transition was from a treatment facility of some kind back to home or to the home community.

The Client Information Form also tracked the time between the initial referral and the initial staffing date. Data indicate that the councils have been responsive; 85% of the clients were staffed within three weeks of being referred to the council. Chart 11 below shows the details.

Chart 11. Response Time From Referral to Staffing



The client information form also served to track client clinical and school data over time. Perhaps because the form was used retrospectively, the majority of these data were not collected for the clients served during the pilot period.

4. Findings/Discussion related to the Client Information Form

The Client Information Form represented a step in the demonstration site procedures that was in place prior to the evaluation. The information contained in this form duplicates information from other forms and should be integrated into those other forms for the purpose of efficiency.

Part III. Case Management Form

1. Purpose

At the time of the initial staffing, which often coincided with the initial referral information, the council decided on a case manager for the individual client. That case manager could be the referring person, who often was currently working with the client, or it could be someone from the council who held the case management position. The purpose of the Case Management Form was to track the disposition of each client, to record the goals set at the initial staffing, and to record the impact over time of services on the goals.

2. Use/Procedures

The acting case manager for each client worked with all of the service providers to collect the data necessary for keeping the council informed of progress on the goals. As in the case of the initial staffing data, if council members represented all of the major service agencies, then client data were often available. However, if the case manager did not have direct access to school data, for example, or to CAFAS or YLSI scores, those data were often collected retrospectively for the evaluation, if at all.

The Case Management Form was particularly important for its record of follow-up data. Each case was to be reviewed at 90 days and again at six months. The form included places to record both narrative and objective case review data, such as what was working well or not, and follow-up CAFAS and school data. Each of the Councils had something in place to collect this type of data, if only in the client file, but in a majority of the cases only narrative data were collected.

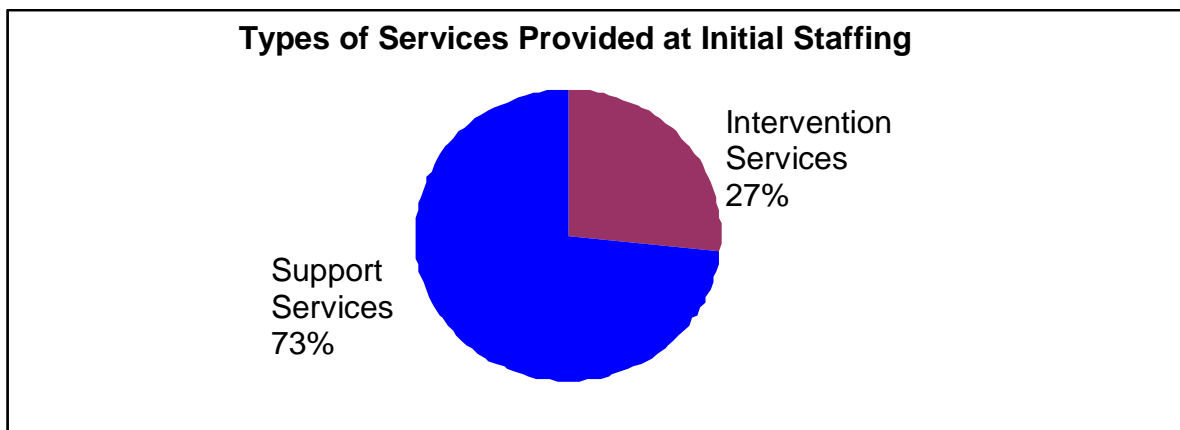
3. Data Collected

Disposition of Referral and Initial Services Provided

The case management form recorded the results of the initial staffing in regards to whether or not the client would work with the council or would continue to receive other and sufficient services. For this data sample, 46% of clients were disposed to the community council; 9% were disposed to an individual agency; 9% were disposed to extend their current services; and 35% were disposed to work with the council plus an agency.

Chart 12 shows the individual services that resulted from the initial dispositions of this data sample. The services have been divided into intervention and support categories.

Chart 12. Types of General Services Provided by Initial Staffing



Charts 13 and 14 on the next page show in more detail the types of services provided in each of the two categories of Intervention Services and Support Services. It should be noted that 74% of clients received services in more than one area.

Chart 13. Intervention Services Provided by Initial Staffing

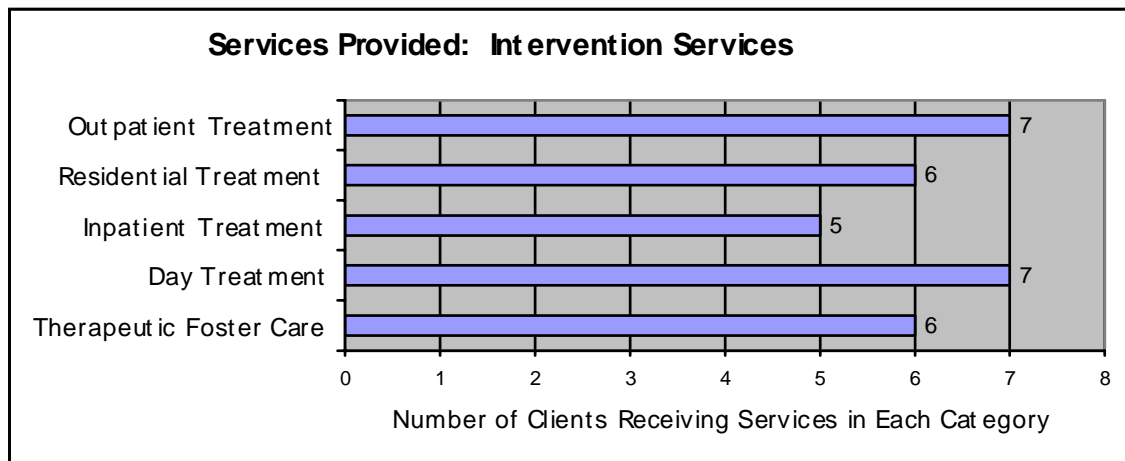
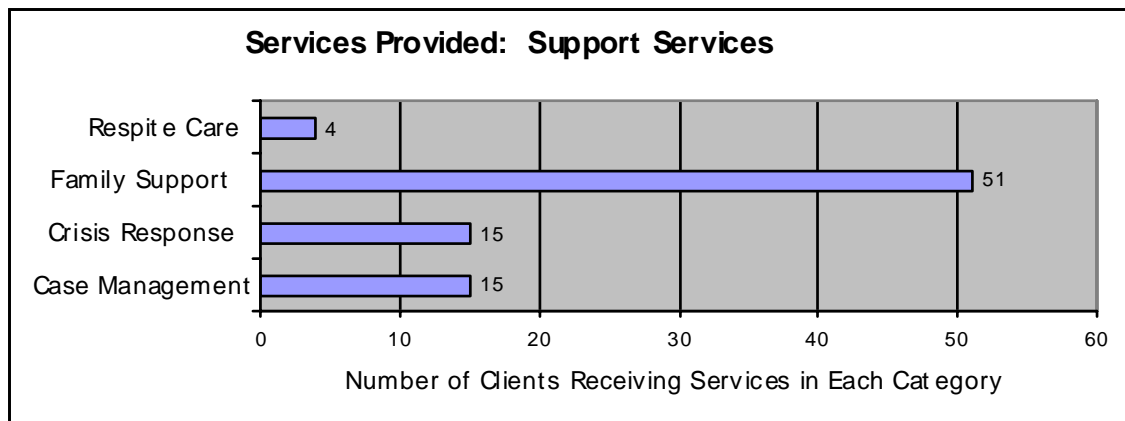


Chart 14. Support Services Provided by Initial Staffing



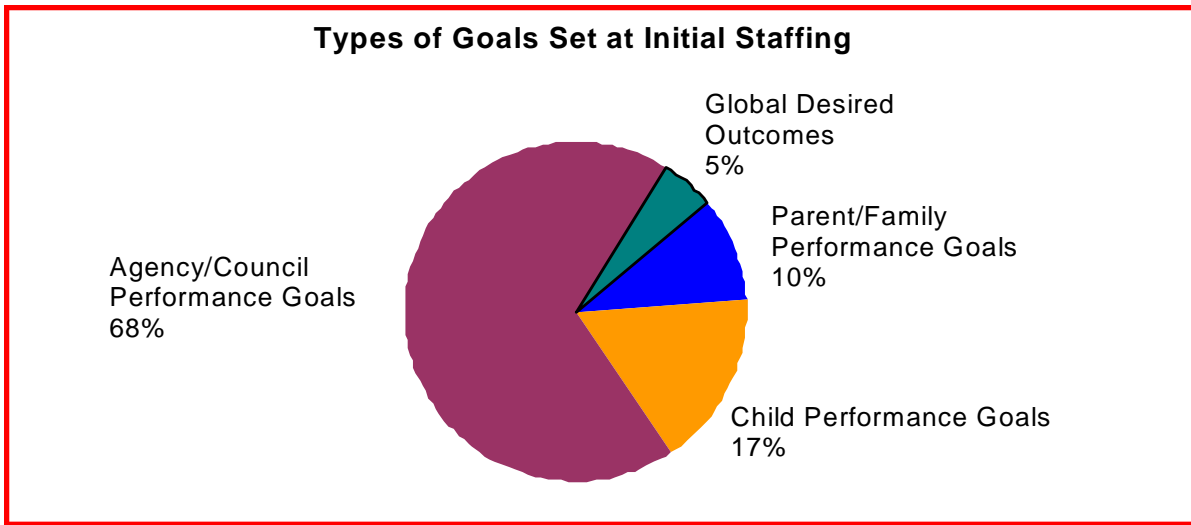
Client/Council Goals

Perhaps the most critical information from a case management point of view were the goals set by the client and council during the initial staffing. For all pilot sites, it was critical that clients were empowered during the goal setting process by being equal partners in setting treatment goals. Because of the importance of this aspect of the process, the goals from the clients served by the pilot sites have been categorized into four performance arenas, as described below:

- ◆ Performance area 1: Parent/Family performance goals, such as: "Mom to resume counseling"; "Apply for Medicaid"; "Better parenting skills."
- ◆ Performance area 2: Client performance goals, such as: "Keep job at Burger King"; "Participate in summer recreation"; "Identify positive recreation activities"; "Attend inpatient therapy."
- ◆ Performance area 3: Agency/Council performance goals, such as: "Find treatment foster home"; "Provide PSR when returned home"; "Set up [private] school"; "locate summer recreation program"; "test for academic [level]."
- ◆ Performance area 4: Global/Unspecified desired outcomes, such as: "Better structure at home"; "Increase family communication skills"; "Keep child safe."

Analysis of the goals provided for this evaluation indicated that a majority of the goals set by/with clients were related to area 3: Agency/Council goals. Chart 15 shows the distribution:

Chart 15. Types of Goals Set at Initial Staffing

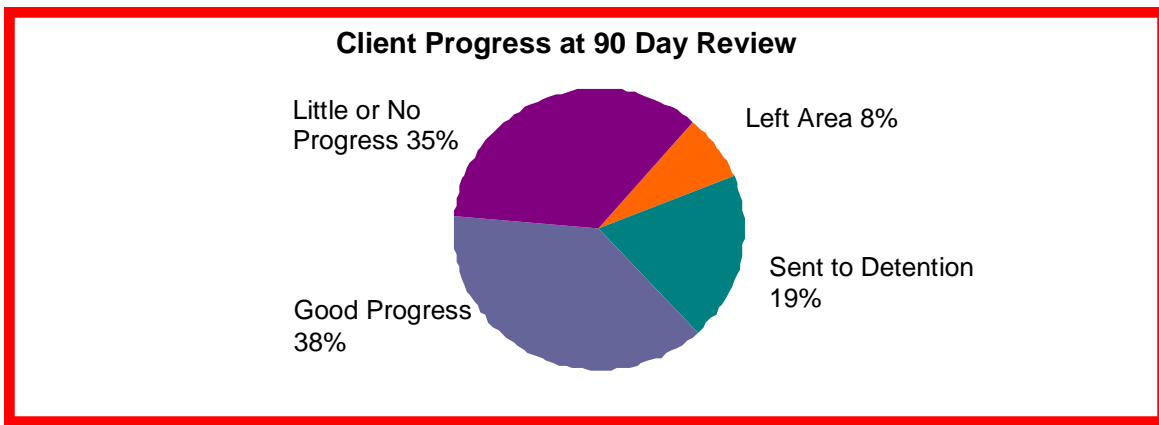


90 Day Review

A second important function of the Case Management Form was to record the information received as part of the 90 day review. Information targeted for this review included progress on goals, school data including attendance, behavior referrals, suspensions and grades, and CAFAS scores.

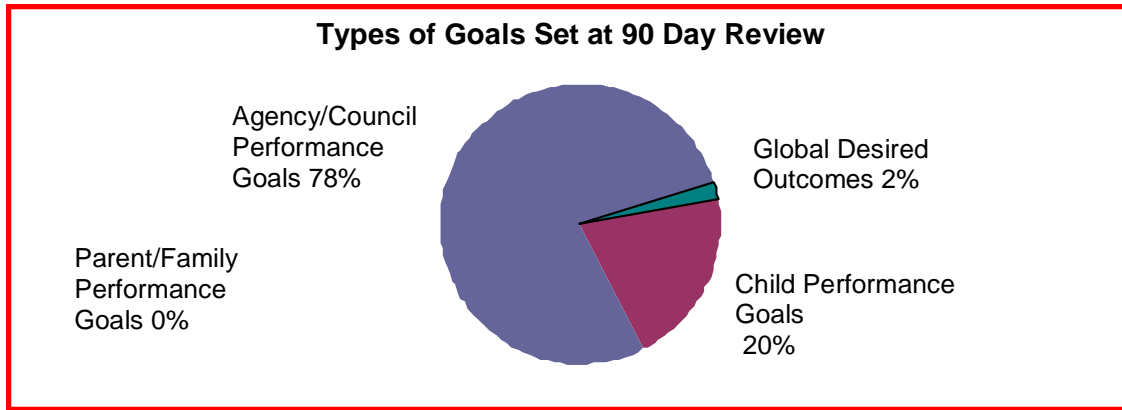
For this sample, the 90 day review information provided pertained to progress on the goals set during the initial staffing and revised goals set for those cases that went through the 90 day review process. These data indicate that 38% of the clients had made "good" progress on their goals, and that 35% had made little or no progress on their goals. In addition, 19% had been placed in detention during this 90 day time period, and 8% had left the area. Chart 16 illustrates these data:

Chart 16. Client Progress on 90 Day Review (n=26)



The 90 Day Review also led to revising client goals. Using the descriptive categories applied above, it can be seen that the revised goals included a higher percentage of Agency/Council performance goals than did the initial goals.

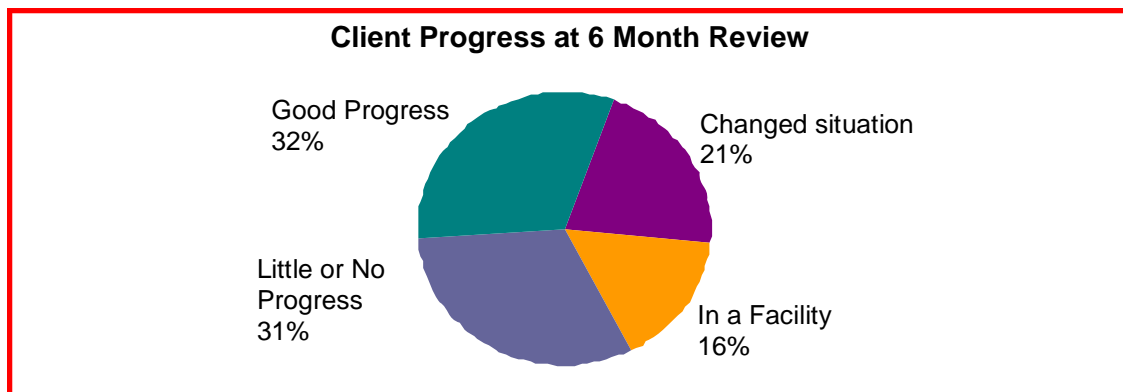
Chart 17. Types of Goals Set at 90 Day Review



6 Month Review

The case management form contained a section that was used to track progress of clients at the 6 month stage of intervention. The target information for the 6 Month Review included progress on goals, goal revision, school data including attendance, office referrals, suspensions, and number of F's, and CAFAS scores. For purposes of this report, demonstration sites provided data on goal progress and goal revision for clients; no school data or CAFAS scores were reported. At the 6 Month Review stage, councils reported on the progress of 20 clients. Chart 18 below summarizes the goal progress of those clients.

Chart 18. Progress on Goals at 6 Month Review



The type of goals set by the councils and clients at the 6 Month Review were much the same as those set initially. A majority of the goals were agency/council performance goals, as seen on the next page:

Chart 19. Types of Goals Set at 6 Month Review



Exit Data

At the time of this writing, no exit data have been reported by the demonstration sites. Data to be reported include:

- Disposition at time of exit
- School data, including attendance, disciplinary referrals, suspensions, and number of failing grades
- CAFAS post scores
- YLSI post scores as appropriate

4. Findings/Discussion related to the Case Manager Form

The data presented from the Case Manager Form indicate that the goal setting process involving clients seemed to result in identifying services that Council members/agency personnel could perform to support the client and family. This may have been an important step in helping the intervention change course. However, the high percentage of council/agency performance goals seems contrary to what Council members envisioned as one of the outcomes of the council process, which was client/family ownership of treatment. Using this sample, the preponderance of type 3, or agency related performance goals, means that the most effective evaluation of the program would be to evaluate the extent to which the council members/agency members have performed the activities they agreed to perform during the goal setting process. This seems to be the opposite of what the councils are striving for.

The progress ratings illustrate the reasons for the councils, and also the clientele being served by the councils. The clients served by this program represent issues that frustrate any single service approach; at the six-month review, 37% of the youth were either in a facility or had changed their situation by moving to another location. Of the 63% of clients who remained in the program for six months, almost 50% showed progress on their goals. Data were not available on the 50% of youth who did not show progress. It will be necessary to follow all clients longitudinally to track whether or not those clients who do not show progress at the 90 day or 6 month periods begin to show progress after longer periods of time.

The data presented, or not presented, also indicate the need for finding alternative ways to manage the data collection and client progress tracking procedures of the community council process. The case manager arrangements in place

during the demonstration period did not provide the means to collect the type of data that will lead to making determinations of client progress and program effectiveness. And yet, increasing client success and intervention effectiveness was high on the list of goals for all demonstration sites.

Evaluation Summary

The evaluation of the Community Council demonstration sites shows that the councils on their own are able to collect data that pertain directly to serving the needs of the clients/families. These data include historical data about what has been tried, goal setting data for what should be tried next, and tracking the services that each client/family receives. The evaluation also shows that the Councils on their own have not collected data that is necessary for program evaluation purposes. Several possible reasons have been presented for this: 1) the lack of relevance of standardized data for client intervention purposes; 2) the ways in which clinical or even school data can intimidate parents/guardians away from fully participating in and even leading the goal setting process; and 3) a lack of time devoted to collecting the type of data that could show program effectiveness. The following chart shows the data collection capability of the Councils during the time of this evaluation:

Type of Data	Required for State Reporting Purposes (Yes/No)	Perceived Importance to Council Functioning	Ability of Local Councils to Collect	When Collected
demographic data	yes	high	high	referral/staffing
presenting problems	yes	high	high	referral/staffing
agency involvement	yes	high	high	referral/staffing
school data (grades, attendance, discipline)	yes	low	low	referral/staffing ; 90 day/6 mo. follow-up
detention data	yes	low	medium	referral/staffing
out-of-home placement data	yes	high	high	referral/staffing
CAFAS scores	yes	low	medium	referral/staffing
YLSI score	yes	low	low	referral/staffing
services utilized to date	yes	high	high	referral/staffing
new goals	no	high	high	referral/staffing
support roles	no	high	high	referral/staffing
referral/staffing dates	yes	high	high	client info form
CAFAS dates	yes	low	low	client info form
referral sources	yes	high	high	client info form
agency involvement	yes	high	high	client info form
intervention status	no	high	high	client info form

Type of Data	Required for State Reporting Purposes (Yes/No)	Perceived Importance to Council Functioning	Ability of Local Councils to Collect	When Collected
disposition data	yes	high	high	case management form
services provided	yes	high	high	case management form
90 day goal progress	no	high	high	case management form
90 day school data	no	low	low	case management form
90 day CAFAS	yes	low	low	case management form
90 goal review	no	high	high	case management form
6 month goal progress	no	high	high	case management form
6 month CAFAS score	yes	low	low	case management form
6 month LYSI score	yes	low	low	case management form
6 month goal review	no	high	high	case management form
exit data: disposition	yes	low	low	case management form
exit data: school data	yes	low	low	case management form
exit data: CAFAS post	yes	low	low	case management form
exit data: LYSI score	yes	low	low	case management form
length of time in core services	yes	low	low	not recorded
# of children assessed	yes	low	low	not recorded
Family Satisfaction Survey	yes	low	low	not recorded

Recommendations

Evaluation Tool Kit: The first recommendation concerns the data collection process in place at the demonstration sites. Currently, there seems to be a reluctance to introduce clinical or school data into the parent-led treatment planning process. This may result from the reality that clinical or historical data can intimidate families into seeking a reliance on the 'experts' at the table rather than collaborating with the members to set goals that are meaningful to the family. This creates tension in the system, as one of the major council goals is to increase the effectiveness of services. Omitting or only partially using clinical data means that councils have limited means of evaluating the extent to which youth are making progress on mental health measures, thus denying the councils the ability to measure which actions are leading toward progress.

It is recommended, then, that a community council evaluation toolkit be created. This toolkit would offer local councils standardized, step-by-step procedures and forms for helping clients, families, and council members understand what various data represent, and how to collect it. The toolkit would also provide workbook structured details on how data can be used to help clients/families set goals and track their progress toward achievement of those goals.

Data-based Decision Making Training: A second recommendation is to provide training to council members, including parents, on the use of the data toolkit. It is imperative that each council recruit parents who are willing to learn how to help guide clients and their families through a data-based decision making process that includes a variety of data to be used in a variety of ways. The formative evaluation report on the community council demonstration sites concluded that each region should have available at least one person to oversee the data collection process for each of the councils. This will help ensure that data is collected concurrently with client participation and progress, and not retrospectively, as has been done for the pilot sites. It is recommended that regional training sessions be conducted that bring together individual site parent members/volunteers, case managers, site chairs, and the regional data managers to learn about and practice using the evaluation toolkit.

Outcome-based Treatment Model Training: A third recommendation concerns the movement of the councils toward an outcome-based treatment model. Each of the demonstration sites asserted the need for different outcomes for the clients served than those traditionally associated with mental health interventions, such as increased scores on standardized scales. Each of the councils also envisioned empowering clients and families as a top priority of their service. Promoting creative, client-centered outcomes with a goal of client empowerment leads to re-defining treatment outcomes in terms of the actual behaviors of clients, often called adaptive behaviors. It is changes in client adaptive behaviors that will lead to achievement of the council goals of keeping clients in the community and in the family. At this time, data indicate that a majority of client goals are actions that council members undertake, not behaviors that clients work toward. This discrepancy between councils goals and what council members actually do to help clients reach their treatment goals appears to be a training/educational issue, not a philosophical one. Setting and tracking client/family-centered, adaptive behavior outcomes represents a departure from traditional practice for many of the agency-based council members. Therefore, it is recommended that region-wide training sessions be implemented, perhaps in conjunction with training around the evaluation toolkit, to support local councils as they move to a client-centered, outcome based treatment model.

System of Care Principles - Supervision Structure: A final recommendation addresses the need for individual community councils to receive support in utilizing a system of care model to provide mental health services to children diagnosed as SED. The system of care model core principles could be used provide guidance to local councils and to regional councils as they develop their strategies and procedures for partnering with clients. The adopted, state-wide memorandum of agreement provides quality assurance related to many technical and legal aspects of collaborative service. To compliment that structure, the system of care core principles could be used as part of a collaborative supervision process that would provide feedback to local councils on the extent to which their on-going operations fall within the system of care model. The recommendation is that regional representatives come together to study and explore the system of care core principles and to develop a supervision structure that would be useful for providing feedback to the voluntary members of the local councils.



Appendix A



**Children's Mental Health Community Council
Client Referral/Staffing Form**

Name of person completing form: _____ Agency _____

Relationship to client: _____

Client last name: _____ First name: _____ Age _____

Gender: M _____ F _____ Phone: _____

Address: _____

Living situation: 2 parent household _____ Single parent _____ parent and other adult _____
Kinship care _____ Multiple adults _____ Other _____

Caretaker name; _____ Phone: _____

Address (if different): _____

Presenting problems/issues: _____

Diagnosis (if known) _____

Agency involvement at time of referral: DHW _____ Probation _____ JC _____
other: _____

Days absent from school during last complete term before referral (total abs./ total possible) _____

School discipline referrals during last complete term (total #). _____

Days of suspension from school during last complete term: in- school _____ out of school _____

Number of failing core subject grades during last complete term out of total possible: _____

Days in Juvenile detention for 6 months prior to referral: _____

Days of other out-of-home placement for 6 months prior to referral _____

CAFAS scores: Total _____ School _____ Home _____ Community _____

Behavior toward others _____ Moods-emotions _____ Self-harmful behaviors _____

Substance Use _____ Thinking _____

comments: _____

YLSI score: _____

**Children's Mental Health Community Council
Client Referral/Staffing Form
Continued**

What has been tried?

Services utilized to date? (check all that apply)

Community organization _____ (list) _____

Individual therapy _____

Alternative education program _____

Group therapy _____

Probation _____

Detention center _____

Foster home _____

Family therapy _____

Therapeutic foster home _____

Psychosocial rehabilitation _____

Residential center _____

Medication management _____

Crisis hospitalization _____

Day treatment _____

State hospital _____

Other: _____

What would you like to try next?

Who will do what?

By when?

Lead person/agency _____



Appendix B





Appendix C



APPENDIX C

Children's Mental Health Community Council

Case Management Data Form

Client name or ID # _____ Date _____

Person completing form _____ Agency _____

Date of Initial Staffing _____ Assessment _____

Date of Signed Release _____ Expiration date _____

Disposition: referred to council _____ referred to individual agency _____
extension of existing services _____ Other _____

Type of service provided as a result of initial staffing: case management _____
therapeutic foster care _____ crisis response _____
day treatment _____ family support _____
inpatient treatment _____ outpatient treatment _____
residential treatment _____ respite care _____
Other _____

Client/Council Goals:	Support Person/Agency(ies)
#1 _____	_____
#2 _____	_____
#3 _____	_____
#4 _____	_____

1st Case Review (90 day review)

Date of 1st case review _____ Lead person _____

Goal Progress Data:

#1 _____

#2 _____

#3 _____

#4 _____

comments:

APPENDIX C

90 Day Review Continued

School data

	# days absent out of total possible (4/43)	# office referrals	# days in-school suspension	# days out-of-school suspension	# of failing grades out of total possible or GPA
For 1 st full quarter or term <u>after</u> released signed*					

*note: if release is signed in middle of quarter/term, then first full quarter begins at the end of at the end of that quarter or trimester.

CAFAS scores: Total _____ School _____ Home _____ Community _____
Behavior toward others _____ Moods-emotions _____ Self-harmful behaviors _____
Substance Use _____ Thinking _____

90 Day Goals Review

New/modified Client/Council Goals

Goal _____ Support Person/Agency(ies) _____

- #1 _____
- #2 _____
- #3 _____
- #4 _____

6 Month Review

Date of review _____ Lead person _____

Goal Progress Data:

- #1 _____
- #2 _____
- #3 _____
- #4 _____

comments:

APPENDIX C

6 Month Review Continued

School Data

	# days absent out of total possible (4/43)	# office referrals	# days in-school suspension	# days out-of-school suspension	# of failing grades out of total possible or GPA
For 2 nd or 3rd full quarter or term <u>after</u> released signed*					

*note: if release is signed in middle of quarter/term, then first full quarter begins at the end of at the end of that quarter or trimester.

CAFAS scores: Total _____ School _____ Home _____ Community _____
Behavior toward others _____ Moods-emotions _____ Self-harmful behaviors _____
Substance Use _____ Thinking _____
6-month LYSI score _____ (if appropriate)

6 Months Goals Review:

New/modified goals

Goal	Support Person/Agency(ies)
#1 _____	_____
#2 _____	_____
#3 _____	_____
#4 _____	_____

comments:

APPENDIX C

Client Exit Data

Date of exit review _____

Disposition at time of exit: Continued services _____ Agencies: _____

Transitioned out of community _____ New Placement _____

Moved out of community _____ Ended treatment _____

Reduced level of need _____ Referred to other support program _____

other: _____

School Data

	# days absent out of total possible (4/43)	# office referrals	# days in-school suspension	# days out-of-school suspension	# of failing grades out of total possible or GPA
For 1 st full quarter or term <u>after</u> exit from program*					

*note: if exit occurs in middle of quarter/term, then first full quarter begins at the end of that quarter or trimester.

CAFAS Post scores: Total _____ School _____ Home _____ Community _____

Behavior toward others _____ Moods-emotions _____ Self-harmful behaviors _____

Substance Use _____ Thinking _____

Post LYSI score _____ (if appropriate)

other:

Comments:

I C W R T C

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