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Editors' Corner

Health Care Reform and Children

As we write the editorial for this issue of *EBDY*, both Houses of Congress as well as the President are in the midst of intensive deliberations on how we can reform our health care system. The outcome of this debate is uncertain. What is clear is that the status quo is unacceptable as it relates to both the health and behavioral health needs of families and their children.

The increasing costs of maintaining our current system of health care delivery negatively affect not only families' ability to purchase health insurance but also states' capacity to support Medicaid programs. Moreover, business as usual will continue to impair the capacity of our country to move out of the current recession.

How does the health reform debate specifically relate to children's mental health? It will come as no surprise to the readers of *EBDY*—as well as to primary care providers—that the most prevalent overall health problems of children are those associated with emotional and behavioral health (Kessler, 2009). There are ample data indicating that adverse and untreated childhood problems lead to a host of bad social and emotional outcomes in adulthood. Even more striking is the finding that ineffectively

See EDITORS' CORNER, next page

Partnerships for Success in Washington State: Supporting Evidence-Based Programming for Children's Mental Health 55

by Suzanne E.U. Kerns, Andrew M. Rivers, and Gary W. Enns

Improving Outcomes for Foster Care Youth With Complex Emotional and Behavioral Needs: A Comparison of Outcomes for Wraparound vs. Residential Care in Los Angeles County. . . 63

by Michael Rauso, Tran M. Ly, Ming H. Lee, and Christopher J. Jarosz

Establishing a Foundation for Collaboration Among Child-Serving Systems 69

by Laura L. Rogers and Philip R. Endress

From the Literature: What's Hot ... What's Not. 73

by Lorraine Dubuisson

Calendar of Events. 76

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EDITORS' CORNER, from page 53

treated childhood problems contribute significantly to the development of physical disorders in adults, such as diabetes, cancer, and cardiac disorders. Economic-effect studies have demonstrated enormous cost savings to the public when evidence-based practices are implemented with fidelity early in the course of an emotional or behavioral problem. Persons with

Health Parity Act passed in 2008. We think of this legislation—if passed—as a “foot in the door” for the necessary next steps for developing effective systems of care and improving behavioral health outcomes for children.

Access to benefits, however, is not enough to improve outcomes! Although emphasis in the proposed legislation is placed on integrating mental health with primary care (i.e., through Medical Homes), specific strategies to engage families in evidence-based, culturally

several key components are necessary. These are:

- Expanding evidence-based practices;
- Providing prevention and early intervention services;
- Embedding family perspectives into clinical decision-making and system infrastructure;
- Strengthening provider accountability for improved outcomes; and
- Aligning fiscal and best-treatment practices so providers and systems have incentives to use evidence-based strategies.

Future editions of *EBDY* will focus on how well the health care reform effort has addressed these components. We have reason to be optimistic, but we must be vigilant about supporting real change.

It will come as no surprise that the most prevalent overall health problems of children are those associated with emotional and behavioral health.

mental illness in our country have a life expectancy that is 25 years shorter than those without!

Policymakers and legislators have come a long way (though not far enough) in understanding the important role behavioral health plays in health reform. All current bills addressing health reform specifically identify mental health as a core component of any benefit to be provided. The proposed bills expand on the Mental

competent preventative care, as well as early involvement in interventions in these primary care settings, will need to evolve.

We may now have the best chance we have ever had to put what we have learned about effective prevention and intervention into practice, but the devil is in the details. Jane Knitzer and Janice Cooper (2006) have recently written that in order to achieve comprehensive and lasting reform,

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REPORT ON

Emotional & Behavioral Disorders in Youth™

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Partnerships for Success in Washington State: Supporting Evidence-Based Programming for Children's Mental Health

by Suzanne E.U. Kerns, Andrew M. Rivers, and Gary W. Enns*

Seeking Effective Program Models

The emergence of an increasingly substantial research literature supporting the effectiveness of specific interventions for children's behavioral and emotional problems (Hoagwood et al., 2001), coupled with knowledge that some popular programs, once studied, have been found to have null or even deleterious effects (e.g., the DARE program; Lynam et al., 1999, and cognitive behavioral groups for high-risk adolescents; Poulin et al., 2001), has led to burgeoning efforts across the United States to institute policies and mandates to support the use of proven-effective programs (Raghavan et al., 2008; Tanenbaum, 2005). Furthermore, research clearly describing the cost benefits of several evidence-based programs has succeeded in pushing evidence-based practices to the forefront of policies and agendas across national, state, and community levels (e.g., Aos et al., 2006). Although many leading researchers and policymakers support this current trend, the emergence of challenges at the community and agency level in adopting, implementing, and sustaining programs reveals the limitations in merely

mandating use of evidence-based practices (EBPs) without providing commensurate support and integration into the culture of the community.

Community-based mobilization and strategic planning models are increasingly being applied to children's mental health in an effort to address these challenges (Fixsen et al., 2005). With roots in community organization and community psychology, models such as Partnerships for Success (Julian, 2006), Getting to Outcomes (Wandersman et al., 2000), Communities that Care (Hawkins et al., 2008) and PROSPER (Spoth et al., 2007) have been developed to help communities plan effectively for implementing and sustaining EBPs that are aligned with demonstrated need, known gaps in services, and community values and culture.

Although particular models have some differences in structure, levels of intensity, or specific components, they share several common elements. For example, most models facilitate a community process through which the needs of the community are articulated (needs assessment), the current resources available are documented (resource assessment), and the most prevalent community gaps are critically examined (gaps analysis). Several community models support a facilitated discussion about appropriate EBPs that are well matched to community need and are feasible to implement and sustain given available infrastructure. Additional training and technical assistance may provide enhanced structures for long-term sustainability of implemented EBPs.

The aim of this paper is to describe the experience and to present initial outcomes of an adaptation of the Partnerships for Success model (PFS; described below) in Washington State with a two-county area and a Native American Tribal Nation, and to present a hybridized approach toward purposeful community mobilization through community-university-legislative partnerships.

This approach employs strategic planning and training of providers in specific, community-chosen EBPs in a way that promotes agency- and community-level enthusiasm for EBPs, debunks common myths associ-

ated with EBPs, and provides opportunities for system-level problem solving to address program limitations, contextual barriers, and other common challenges associated with initiating new programming.

The Context in Washington State

Over the past five years, Washington State has been consistently moving toward supporting agency-level and, in a couple of cases, state-level adoption and implementation of EBPs. In 2006, the state developed a matrix of EBPs across a range of different developmental ages, behavioral and emotional problems, and levels of research support. The State Mental Health Division (MHD) publicly expressed increasing interest in supporting only those programs ranked as having the highest levels of support. However, at that time, there was not an articulated strategy for how the state would systematically move toward this goal.

Knowing the challenges inherent in implementing new programs, we proposed a pilot project to the legislature whereby the University of Washington would provide technical assistance and guidance to support a defined model, through which a community would strategically select, implement, and work toward sustaining at least one new EBP. A request for proposals was issued for interested counties, common geographic areas, or tribes. Prospective applicants had to demonstrate sufficient readiness for participation in this project, including development of a stakeholder group that included consumers or family members of consumers and a community mental health agency willing to adopt an empirically supported program. The successful recipient of the funding, and the focus of this paper, was the Regional Support Network (RSN) of Thurston and Mason Counties. This community's competitive and compelling proposal demonstrated substantial initiative and clearly articulated community need for new programming for youth with complex needs, especially those youth involved in multiple child-serving systems.

See *PARTNERSHIPS FOR SUCCESS*, next page

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PARTNERSHIPS FOR SUCCESS, from page 55

The Partnerships for Success Model

The overall PfS model has been described fully elsewhere (Julian, 2006; Julian et al., 2008), but in brief, PfS is a community-based participatory approach toward strategically identifying EBPs for prevention, early intervention, and treatment of mental and behavioral health problems in children and youth. The PfS model articulates five overarching goals:

1. Community mobilization;
2. Reducing duplicative efforts among state and local agencies;
3. Promoting fiscal responsibility;
4. Evaluation, and
5. Achieving effective sustainability.

overall, have demonstrated both positive outcomes for youth across a wide range of problem behaviors as well as favorable fiscal impacts (finding an \$11.52 return for every \$1 spent).

The Interactive Systems Framework (Wandersman et al., 2008), which attempts to provide a schema for bridging theory, research, and practice, has informed much of the PfS theory. In this framework, there are three primary systems moving from research to practice:

1. The prevention synthesis and translation system;
2. The prevention delivery system; and
3. The prevention support system.

These three systems interact transactionally, while also being influenced by funding, climate, macro policy, and extant research and theory. Many activities inherent in PfS

(Wells et al., 2004). Although this model contains many of the same elements as the PfS model (e.g., matching community needs, resources, and values with evidence-based practices), it additionally identifies the importance of bridging effective relationships between researchers and the community at large. The evidence-based community/partnership model recognizes that manualized EBPs contain the necessary ingredients for effective practice but sometimes fall short in addressing all factors that may be necessary to facilitate community-salient and culturally relevant programming that is sustainable within a given community context.

Thurston and Mason Counties. As mentioned above, this project piloted an adaptation of the Ohio PfS model in the two-county Thurston and Mason (T-M) area, which shares a common RSN (a county-level entity charged with the administration of publicly funded mental health services), and subsequently within the Skokomish Tribal Nation, which is geographically located within Mason County. Thurston County comprises a combination of small city areas, including the state capitol, and rural areas (80% of the two-county population), and Mason County is largely small town and rural (20% of the two-county population). The Skokomish Nation has just over 700 members living on the reservation.

Many activities inherent in PfS offer strategies to assist with navigating the “science to service gap” while garnering the requisite enthusiasm and community buy-in to increase the likelihood of ongoing, sustained success.

These goals are achieved through a series of manualized activities that can be flexibly adapted to meet overall community needs. Each participating community engages in strategic planning, which includes:

- Conducting a needs and resource assessment;
- Performing a gaps analysis;
- Identifying targeted impacts and populations; and
- Aligning these impacts and populations with EBPs.

Subsequent activities include planning for program implementation, evaluation, and sustainability.

The PfS Program in Ohio. Since 1998, there has been legislative support in Ohio to promote the implementation of PfS. As of this writing, the model has been implemented in 39 of the 88 counties in Ohio, with an additional 11 either in their first or second year of implementation (see <http://cle.osu.edu/projects/partnerships-for-success> for further information). All of the counties track program results and,

offer strategies to assist with navigating the “science to service gap” while garnering the requisite enthusiasm and community buy-in to increase the likelihood of ongoing, sustained success (Wandersman, 2009).

Adapting PfS for Washington. For the present project, we used the framework and strategies outlined by the PfS model, adapting them slightly to increase the emphasis on identification and implementation of EBPs specific to children’s behavioral and emotional problems. We included locally relevant and Washington State-specific information and altered the core team and workgroup structures (Ohio houses its PfS activities within state-mandated Children and Family First Councils, and no such structure exists in Washington). We provided technical assistance and guidance directed specifically toward implementation of EBPs, whereas traditional PfS technical assistance focuses more directly on developing trainers within a local community. In addition to the Interactive Systems Framework and PfS, we drew on the evidence-based community/partnership model proposed by Wells and colleagues

The Planning Phase of the PfS Project

The first stage of the project was a planning phase that spanned approximately five months. The length of time appropriated by the legislature for the planning phase was dramatically shorter than the one-year timeline suggested by the traditional PfS model. This timeline was mandated by the pilot legislation, and planning activities were thus initiated under significant time pressure. The initial phase of planning involved convening a “core team” of key decision makers across representative community agencies charged with caring for youth with complex needs. In this case, the core team consisted of:

- The director of children’s services at the public mental health agency (Behavioral Health Resources);
- The area administrator for the local branch of the department of child and family services;

See PARTNERSHIPS FOR SUCCESS, next page

PARTNERSHIPS FOR SUCCESS, from page 56

- The children’s care manager for the local RSN;
- The clinical director for a nonprofit youth service agency; and
- A deputy administrator for the juvenile court.

The T-M Core Team. The newly formed core team (T-M core team), in partnership with collaborators at the University of Washington, facilitated the development of a community team that consisted of a broad group of committed stakeholders (including parents and foster parents) for youth with emotional or behavioral health problems. This larger coalition, which was considered a “learning collaborative,” tasked with providing guidance and support to the core team, ultimately became the decision-making body for the project. Although the core team guided the day-to-day activities, the community team provided instrumental and informational support and made consensus-based decisions to guide project direction.

Activities during the planning phase included:

- Defining principles that would guide the work (Table 1);
- Defining broad targets for change in the community (targeted impacts; Table 2);
- Identifying factors (risk, protection, assets) that were most closely associated with selected targeted impacts;
- Creating a realistic profile of current programs, services, and activities in the community related to the targeted impacts identified in the needs assessment;
- Narrowing down a population of focus; and
- Working toward development of a strategic plan that indicates how best to address the targets for change within the community.

As part of the strategic plan, the community created a logic model and defined anticipated outcomes.

A core value of all those involved in this project was that decisions regarding targeted impacts, populations of focus, and EBP selection be data driven. To that end, the core team, in collaboration with partners at the University of Washington, made every reasonable effort to collect

meaningful data from and about the community to support the planning process and, ultimately, to ensure that the EBP selections matched community need. Sources of data included:

- Small-group exercises and facilitated group discussions with stakeholders;
- Youth focus groups;
- Focus groups with other community coalitions;
- Summaries of administrative data; and
- Surveys of a variety of community members, including parents, direct service providers, other stakeholders working with youth with behavioral or emotional problems, and administrators of various state and local agencies.

The T-M Needs Assessment. The T-M needs assessment identified needs for youth and families, as well as more systems-level needs that would require consideration during the process of program implementation.

Some of the most compelling data came from administrative sources, largely from the one to two years prior to the project. These data revealed disproportionality between community representation and service acquisition for several ethnic groups. Asian/Pacific Islander youth were underrepresented and African-American and Native American youth were overrepresented in the local mental health system. Youth most often presented with disruptive behavior and mood-related problems.

Youth who were in the mental health system were disproportionately likely to have multi-system involvement and, subsequently, to utilize high-intensity, high-cost mental health services. In the T-M community, approximately half the expenditures for mental health services were spent on the 9% of youth who received mental health care from two or more Department of Health and Human Services agencies—i.e., Children’s Administration, Juvenile Rehabilitation Administration, or Mental Health Division.

From a systems perspective, the web-based surveys and focus groups revealed that most people viewed agencies in Thurston and Mason Counties as working well together and having effective leaders. However, fewer respondents reported a shared vision or perception that there is the right mix of prevention and treatment services for youth. Only 30% of respondents believed

See PARTNERSHIPS FOR SUCCESS, next page

Principle	Definition
Full family partnership	Planning and implementation will be conducted in full partnership with children, youth, and family members from Thurston and Mason Counties.
Accessibility	There will be clear avenues for access to selected practices by children, youth, and families who would benefit from the practices.
Community collaboration	Planning and implementation will be conducted with support and participation of local stakeholders and constituents, particularly those affected by the practice.
Fit to community needs	Planning and implementation will be relevant to the needs of local children and families, compatible with the local environment, and congruent with the local culture.
Shared leadership	Planning and implementation will be conducted in a way that fosters integration and shared leadership of public agencies and providers in the community.
Full partnership with and support to provider staff	Planning and implementation will be conducted in full partnership with local provider staff who would be affected by the practice.
Cultural and linguistic competence	Planning and implementation will support the cultures of involved youth, families, and communities. Practices chosen will demonstrate respect for and build on the values, preferences, beliefs, and cultures of involved children, families, and communities.
Data-driven decision making	Planning and implementation will be informed by timely data on progress toward goals, implementation fidelity, and child, family, and community outcomes.
Sustainability	Practices chosen for implementation will be sustainable over time and demonstrate a reasonable cost-effectiveness ratio.

PARTNERSHIPS FOR SUCCESS, from page 57

Table 2: Community-Identified Target Impacts

Target Impact	Desired Direction of Change
Family	
Family functioning	↑
Parent education	↑
Communication between parents and school	↑
Family engagement	↑
Domestic violence	↓
Parental conflict	↓
Use of foster care	↓
School	
School success	↑
Incidence of discipline at school	↓
Youth	
Aggressive/defiant behavior	↓
Substance use/abuse	↓
Placement disruptions	↓
Use of juvenile justice facilities	↓
Suicide/suicidal gestures	↓
Abuse/neglect trauma	↓
Community	
Resource access	↑
Community support	↑
Stigma	↓
Access to services	↑

that the currently available programs demonstrate meaningful outcomes.

Evaluating Existing Programs. After the community completed identifying and prioritizing targeted impacts and the population of focus, the University of Washington team evaluated the programs included on the Washington State EBP Matrix to determine which of the programs had the best evidence for successfully addressing the impacts identified by the community team. An initial list of more than 20 programs—each of which addressed some, but not all, of the targeted impacts—was presented to the core team. A variety of factors facilitated narrowing down this list, including removing programs that:

- Targeted only one or two impacts;
- Were previously unsuccessfully implemented in the community;
- Were not viable, given union and other issues; or
- Were not feasible because of the limited start-up period of this project.

The narrowed-down list of applicable, empirically supported programs, along with

detailed information about key components of each program, was presented to the community team. The community team asked questions and discussed the pros and cons of the various EBP options.

MST Chosen by T-M Core Team. After lively and productive discussion, the community team selected Multisystemic Therapy (MST; Henggeler et al., 1998), an EBP closely aligned with the team's target impacts and population of focus. MST is an intensive home- and community-based treatment approach addressing the mental health needs of adolescents (typically 12 to 17 years old) who are engaging in serious antisocial behaviors. Typical program outcomes include reductions in criminal activity and institutionalization, fewer arrests, greater family cohesion, decreased adolescent aggression, and decreased substance abuse (Henggeler et al., 1996).

Additional PFS Project With Skokomish Tribe. At this point, a community team representative from the Skokomish Nation stepped forward and expressed support for the overall process but proposed that, given

an opportunity for a separate process, the tribe very well might come to a different conclusion with regard to what types of services would be most aligned with the needs of Skokomish youth and their families. With funds available, the community team decided this was a compelling proposal that was well aligned with the community's identified priorities and released some funds to the tribe to support a separate but parallel process. The tribe formed a core team comprising a cross-section of tribal stakeholders, allied service providers, and members from the T-M core team.

The Skokomish core team proceeded to engage in a very successful strategic planning process and had tremendous success engaging the community to participate in assessing needs, cataloging current resources, and determining what type of evidence-based services would best meet the community's needs. After numerous community and leadership meetings, the tribe selected Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an EBP very closely aligned with the specific needs in the Skokomish community. TF-CBT is an intervention designed to address symptoms of trauma in children between the ages of four and 18. Children and their parents/caregivers learn skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and ways to promote safety and encourage family communication (Cohen et al., 2006).

Two Years In: Prevention and Early Intervention

Approximately two years into the project, not all budgeted funds were being used for the existing EBPs. The community team reconvened and directed additional dollars toward a program that would target other initially identified impacts (see Table 2) and would preferably act more on the continuum of prevention or early intervention. Additionally, implementation of a new program provided a perfect opportunity to include other community-based organizations that were unable to be directly involved in the implementation of MST. Two new programs were implemented as a result of this process: The Triple P Positive Parenting Program (Sanders, 2008) and the Parent Empowerment Program (PEP; Jensen & Hoagwood, 2008).

See PARTNERSHIPS FOR SUCCESS, next page

PARTNERSHIPS FOR SUCCESS, from page 58

The Triple P Positive Parenting Program. Triple P is designed to provide support to parents who are experiencing behavioral challenges with their children. Typically, services are appropriate for parents of youth between the ages of two and 12 and for a range of symptom severity, generally from mild to moderately severe. About 30 practitioners throughout the two-county area, including two providers from the Skokomish Nation, received training for the Triple P Positive Parenting Program (Sanders, 2008). Approximately half participated in the lower-intensity “Primary Care” level of the intervention, and the other half participated in the higher intensity “Standard” and “Enhanced” training.

The Parent Empowerment Program. Furthermore, the core team recognized that there continued to be a paucity of effective parent-directed support services available in the community. The team decided to host a training of PEP (Jensen & Hoagwood, 2008) and trained 13 parent advocates. The purpose of this program is to help parents of children with significant emotional or behavioral problems navigate the often murky waters of public mental health and to promote parental competence and self-esteem.

Ultimately, this pilot initiative directly monitored the adoption, implementation, and sustainability of four EBPs (MST, TF-CBT, Triple P, and PEP). This community found that once a solid planning foundation was laid, the early groundwork was easily leveraged to implement new programs as the funding picture evolved.

The Implementation Phase of the Project

The implementation phase for both the T-M community and the Skokomish Tribe began with the definition of program outcomes. An implementation workgroup was formed by each core team to ensure that programs were developed within the values and guiding principles articulated by their respective communities and implemented with fidelity. The workgroup established evaluation components, deployed program marketing strategies, and produced a preliminary report on outcome achievement.

Outcome Data: Research vs. Community Use. During the implementation phase, technical assistance for the PfS model shifted from the more manualized activities of the planning phases to being more flexible and responding to anticipated

and unanticipated barriers. Perhaps one of the biggest challenges during this phase of the project, and one that ideally would have been addressed during the planning phase, was consideration of how program-specific outcome data (largely intervention and pre-post clinical outcomes) would be collected and understood by the community-based providers. To optimize the valuable information that outcome data provide, a consistent, user-friendly method for data collection and extraction must be devised. Common questions from both funders and the community stakeholders concerning how many youth and families are being served, their general demographics, and what typical outcomes look like can be answered only through careful collection of information from program providers.

Once a solid planning foundation was laid, the early groundwork was easily leveraged to implement new programs as the funding picture evolved.

We found differences between the types of data that are valuable for research and those that are most useful from an agency or community standpoint. For example, all stakeholders (researchers, funders, and community alike) wanted to document the length of MST treatment per client. From a research standpoint, we conceptualized the beginning of treatment to be commensurate with when a client is enrolled in MST services. From an agency perspective, however, multiple activities (some billable) may occur prior to MST enrollment, including a generic agency intake process and initial crisis services. The agency conceptualized the start date as the first client contact (regardless of whether or not MST services were initiated at that time). Therefore, using encounter dates from the agency could potentially provide misleading research data and vice versa. The implementation workgroup was an essential problem-solving body able to address process and program-specific challenges as they arose.

University-Based Assistance. Another inherent advantage in using the PfS model coupled with university-based technical assistance is the opportunity to coach the community and EBP providers about navigating the often complex world of program purveyors, fidelity and adherence protocols, and documenting the rationale for any program adaptations. While this was a salient issue for both teams, such

activities were particularly relevant for the Skokomish team. The tribe initially selected an EBP for which there are adaptations for Native American youth (Honoring Children, Mending the Circle; BigFoot & Schmidt, 2007). However, the adaptation has yet to undergo rigorous study, and, at least initially, there was some question about the applicability of the adaptation to the Skokomish community. Therefore, the decision was made to move forward with standard training first. After tribal-based clinicians had an opportunity to learn the TF-CBT model, they attended the Honoring Children, Mending the Circle training. The current plan, as of this writing, is for the clinicians to move forward with a “hybridized” TF-CBT model that incorporates some of the principles from the Honoring

Children, Mending the Circle intervention while continuing to collect outcome data. Using this strategy, the core team will be able to determine the impact of any adaptations and facilitate strategic planning for future efforts.

Tracking Fidelity and Satisfaction. Briefly, the client-level outcomes for MST and Triple P were tracked to ensure that the program benefits cited in extant literature were, indeed, being replicated within the community settings. Across both programs, pre-post treatment outcomes were collected for participating families. For MST, behaviors were recorded for the six months prior to treatment and then again at the end of treatment. Findings from our MST evaluation of 53 youth who successfully completed treatment (about 65% of enrolled youth) revealed significant reductions in arrests, physical assaults/violence, property damage, theft, running away, and drug problems. No significant differences were found for suicidal behaviors (attempts or gestures) or alcohol problems, although both were very low base-rate behaviors, and outcomes trended in the desired direction.

For Triple P, we examined treatment outcomes and treatment satisfaction for 18 families for which pre-post data were available (approximately 40% of the 46 families

See PARTNERSHIPS FOR SUCCESS, next page

PARTNERSHIPS FOR SUCCESS, from page 59

originally enrolled) and found significant improvements in parental self-efficacy, reductions in child symptoms of hyperactivity and overall behavior problems, and improvements in co-parenting relationships. No differences were found for caregiver's depression, anxiety, or stress symptoms. Of the families who completed treatment, generally high levels of program satisfaction were reported. The findings for MST and Triple P were generally commensurate with published reports of treatment outcomes and in alignment with expected outcomes for community-based programs.

The team was also successful in leveraging the Washington State Legislature to provide some limited ongoing support. Between these two sources, plus Medicaid reimbursement, it appears that MST will be fully funded for at least the next biennium and, likely, into the future. It is important to note here that these additional funds were able to be leveraged primarily because of the diligence of the provider in collecting outcome data for youth receiving services. We were able to demonstrate significant positive changes for enrolled youth and this was compelling to the funders. When finances are tight, having compelling evidence of effectiveness becomes even more important.

Because of the diligence of the provider in collecting outcome data for youth receiving services, we were able to demonstrate significant positive changes, and this was compelling to the funders.

The Sustainability Phase of the Project

Throughout each stage of planning and implementation, implications for sustainability were considered. Activities included drafting a strategic plan and working closely with the fiscal specialists to outline a realistic budget. Despite our best planning for sustainability, this pilot project coincided with a national recession and one of the worst budget shortfalls in Washington State's history. Several project partners who, early on, pledged financial contributions were unable to fulfill their commitments because many of their own programs were being reduced or cut.

Despite these considerable challenges, sustainability beyond the formally funded portion of this project has been achieved for all four programs, albeit in different ways. Multisystemic therapy presented the greatest challenge, because only approximately 60% (at best) of the costs of implementing the program could be recaptured through Medicaid billing. This is not significantly different from challenges other communities have had in implementing this program (Surace, 2008). Sustainability of MST relied on bringing stakeholders together to identify creative funding sources. As of this writing, the core team was successful in leveraging a 0.1% county sales tax (an option for local counties through prior state legislation) to partially fund the program.

TF-CBT and Triple P were more straightforward in terms of sustainability. Both of these programs are "workforce enhancement" programs easily delivered within the structure of typical practice. Ongoing costs for these programs were largely redirected, as opposed to new, costs (i.e., the therapists or practitioners would have been doing *something in terms of professional development*; these programs defined more directly what that "something" was).

Volunteers or parent partners deliver the PEP. Like TF-CBT and Triple P, this program is easily delivered within existing service structures.

Evaluation of the Project

The evaluation of this project is ongoing; evaluation activities already conducted have provided valuable information throughout the above-mentioned phases of planning and implementation. The overall evaluation strategy was designed to be comprehensive and to capture changes occurring across different system levels (state, local community, provider agency, therapist/direct service provider) and at the individual client level. A mixed-methods (quantitative and qualitative) evaluation design was used to identify changes across each level and was based on articulated outcomes from the logic model.

The role of the adapted PFS model in facilitating system-level outcomes is pre-

sented below. We focus this process evaluation on the value added of the PFS model, not specifically the outcomes associated with the individual EBPs. The evaluation received institutional review board (IRB) approval from the University of Washington.

Method. Interviews were conducted with participants from the:

- *T-M core team:* Participants in key informant interviews included a representative from the Washington State Mental Health Division, two individuals affiliated with the RSN, and five core team members (one individual was interviewed both as a core team member and as an RSN affiliate). All individuals participated in the PFS planning process and in implementation of the new community programs.
- *Skokomish core team:* Six core team members were interviewed, including representatives from the local service provider agency, Tuwaduq Family Services (both administrative and direct service provider staff), Indian Child Welfare (ICW), and tribal management.

All participants responded to semi-structured interview questions tailored to capture the perspective of the group they were representing (RSN, respective core teams).

Interview Guide. Interview questions were tailored differently for the RSN and the core teams:

- *The RSN semi-structured interview:* Interview questions for representatives from the RSN were composed exclusively of open-ended items asking about the community process of identifying an EBP, logistical problems for the RSN, processes needed to adapt new EBPs, sustainability, alignment with the RSN mission, and general benefits and problems associated with the PFS process.
- *Core team semi-structured interview:* Interview questions for representatives from both core teams were composed of both open-ended and Likert scale items. Questions asked about the ability of the community to serve high-risk youth (availability of effective services, coordination of services, services for minority youth, services provided within the community), cross-agency relations

See PARTNERSHIPS FOR SUCCESS, next page

PARTNERSHIPS FOR SUCCESS, from page 60

and collaboration (mobilization around additional opportunities, ability to blend resources and receive funding), and general challenges and benefits of participation in the project.

**Results of the Evaluation:
T-M Core Team Respondents**

Qualitative findings from the key informant interviews are presented below. Mean ratings from the two core teams provided on standardized questions are presented in Figure 1. It is important to note that the teams were tackling different problems and within very distinct systems. Additionally, the T-M team had one more year to achieve community-level outcomes.

All core team respondents said that they would be very likely to participate in a similar project in the future, and all respondents strongly agreed that each of their individual agencies benefited from involvement in the project. Particularly positive ratings were given to the effectiveness of the Pfs process in improving service coordination for children, increasing cross-agency collaborations, and increasing access to effective services in general and those which kept youth in the community. As one respondent noted, “We have all enhanced our relationships with one another and set the stage for future opportunities.”

Respondents listed many benefits and challenges related to using the Pfs model.

In particular, respondents felt that services being provided were of high quality, that the community was well situated for pursuing future funding for new programs, and that the structure for communication between agencies was enhanced because of the model. Respondents noted that the recent economic crisis, costs (time and resources), and rushed timelines are all challenges that the group faced while working with the model. Respondents indicated that the condensed timeline limited the opportunity to solidify collaborative relationships. Participants noted ongoing challenges with role definition, especially because roles for some members evolved over time.

Respondents also listed many benefits and challenges related to the specific EBPs (MST, Triple P, TF-CBT) implemented as part of this project. All three EBPs were perceived to produce good outcomes for youth (although some programs were listed by more respondents than others). While TF-CBT was perceived to be addressing the needs of minority youth, MST and Triple P were not seen as fully meeting this goal, because most enrolled youth and families were non-minority. In addition, MST and Triple P were seen by some to be meeting the needs of *higher*, but not *highest*, need children and youth.

All three programs were seen by RSN representatives as having high initial costs, although after those costs were incurred, Triple P and TF-CBT could be financially sustained through Medicaid dollars. The

Pfs model was well aligned with the goals and mandates of the RSN, and representatives indicated that they were attempting to use a similar strategy for other RSN-related efforts.

Taken together, results of the evaluation of the Pfs model, as well as preliminary outcomes from selected programs indicate that the Pfs model was indeed a success. The challenges presented to the community reflect the real-world effort that implementation of EBPs entails. Although the model was not able to anticipate every challenge, having a structure and strategy in place and technical assistance when needed greatly facilitated the implementation and sustainability of new practices serving diverse needs of youth in the community. The benefit of having a model to guide decisions around EBPs is evident in responses from stakeholders, including:

[Pfs] has set up a way to approach problems that didn't exist before. Now, we go through a methodical approach using needs assessment, resource assessment and community collaboration. We are currently using the same model for using the 0.1% [sales tax] funding resource

and

There is no comparison about the higher quality of services and our ability to measure the outcomes for these EBPs from what we were providing prior to Pfs. To have TF-CBT, Triple P, MST in our curriculum is pretty awesome.

Finally, one participant summed:

The payoff to the state is that with one [county effort], they can leverage this initial investment into two or three EBPs. . . . [The Pfs model] rests on community partnerships and knowledge of decision-makers and partnerships with the tribe, and sustained interest of all members.

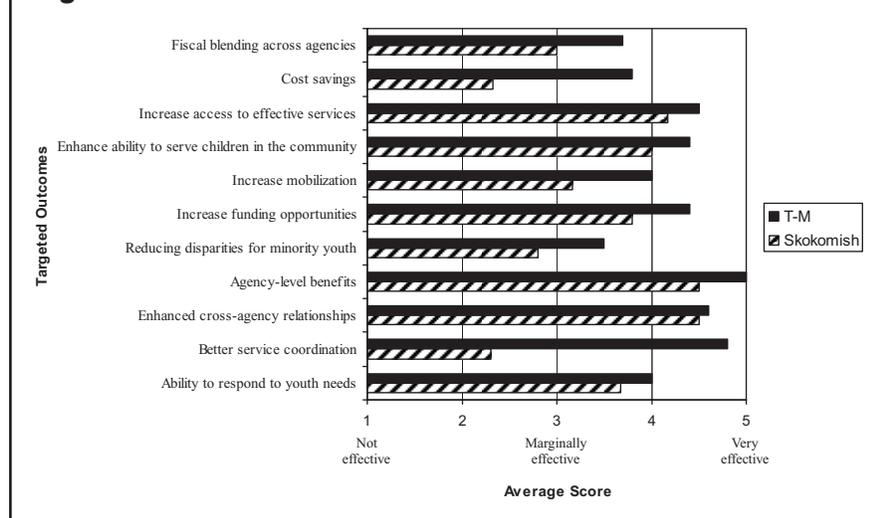
**Results of the Evaluation:
Skokomish Core Team
Respondents**

Overall, the Pfs model was viewed by Skokomish Nation stakeholders as being effective in;

- Producing agency-level benefits;
- Enhancing cross-agency relationships;

See PARTNERSHIPS FOR SUCCESS, next page

Figure 1: Core Team Process Outcomes



PARTNERSHIPS FOR SUCCESS, from page 61

- Increasing access to effective services;
- Enhancing the ability to serve children in the tribal community; and
- Increasing funding opportunities.

Participants indicated that they would very likely want to participate in a similar program in the future. However, at the time of this evaluation, there had been less success addressing some other goals, including improving service coordination, producing a cost savings, and reducing disparities for tribal youth.

Although participants were generally enthusiastic about the *potential* for the new program (in this case, TF-CBT) to make a difference, very few youth had been enrolled in the new services to date and PFS participants had yet to note demonstrable changes across client-level indicators (such as symptom reduction).

Although participants were generally enthusiastic about the *potential* for the new program (in this case, TF-CBT) to make a difference, very few youth had been enrolled in the new services to date and PFS participants had yet to note demonstrable changes across client-level indicators (such as symptom reduction).

Results from key informant interviews with the Skokomish core team revealed areas of relative strength and ideas for future directions. Emergent themes revealed that the majority of participants agree that the biggest benefit of the project was the building of relationships with agencies outside of the tribe, particularly the University of Washington and the RSN.

Historically the relationships with outside agencies . . . have been virtually non-existent; the ability to come together with a common purpose is fantastic and bodes well for future collaboration.

Additionally, results demonstrated that another important benefit was the community's ability to increase mental health services to the youth of the tribal community through programs that are evidence based.

Respondents indicated a desire to expand the scope of the pilot project to additional community needs, targeted impacts, and populations of focus. Respondents stated an intent to utilize the experiences and data derived from the pilot study to examine future funding options.

The most often reported challenges to participation in the pilot project were internal coordination, infrastructure supports, and project support services. All respondents indicated significant challenges in the designated referral process. "Where the referrals were coming from and how they were to be received by the providers" impeded progress of the project by limiting the number of referred participants. Also,

respondents noted that the lack of a project manager early in the process to coordinate and track grant deliverables and timelines was problematic.

Conclusion

Taken together, the experience of implementing this adaptation of the PFS model within a two-county area and with a local Native American tribe revealed significant benefits, especially in promoting cross-agency collaborations and implementing effective new programs for children's emotional and behavioral health. The communities participating in this pilot project were able to increase the range of empirically supported services available and to do so in a manner that was consistent with local culture and values. Although there were certainly obstacles and challenges along the way, having the foundation of a model such as PFS to facilitate the process mitigated many of the ubiquitous barriers noted in the extant literature (e.g., addressing financial barriers for startup, navigating the often complex world of EBPs, coordinating with program purveyors) and enabled a more direct focus on addressing the unique challenges that occur at the local level.

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Improving Outcomes for Foster Care Youth With Complex Emotional and Behavioral Needs: A Comparison of Outcomes for Wraparound vs. Residential Care in Los Angeles County

by Michael Rauso, Tran M. Ly, Ming H. Lee, and Christopher J. Jarosz*

The Challenges of Foster Care

Over the past decade, there has been a considerable increase in the proportion of foster children and adolescents (referred to hereafter as “youth”) with serious behavioral and emotional challenges (Clark et al., 1996; Simms & Halfon, 1994). According to recent accounts, foster youth have exceptionally high rates of mental health and behavioral challenges (Bruns et al., 2006; McMillen et al., 2004; Persi & Sisson, 2008), and foster youth are also at a higher risk for homelessness and criminal placement (Dishion et al., 1999; Ryan et al., in press). One potential explanation for these high rates, beyond the original need for entering foster care, is the impact that being removed from their community has on foster youth. When removed from their caregivers, foster youth are often placed with strangers, usually outside of their community. They frequently change schools, lose contact with friends, and must adapt to a new placement and community.

These changes, coupled with the original trauma of being removed, can exacerbate behavioral and emotional challenges, resulting in hospitalizations and more restrictive settings, such as residential care. Within residential care, placement instability is a common occurrence that is associated with various negative outcomes such as child

behavior problems (Keil & Price, 2005) and juvenile delinquency (Ryan et al., in press). The social and economic costs associated with such placement disruptions are substantial (Keil & Price, 2005). For example, although residential care placements in California made up approximately 11% of the foster care population in 2000, they constituted more than one-half of foster care expenditures (California Department of Social Services, 2001).

“Residential care” and “group home care” are terms that are sometimes used interchangeably within the research literature, with no consensus on a single definition (Curtis et al., 2001; Wells, 1991). Residential care is a term applied to a diverse array of services that are provided to youth living in such congregate care settings as apartments, emergency shelters, half-way homes, secure settings, and group homes (Child Welfare League, 2005; Curtis et al., 2001). Group homes provide continuous staff supervisory making them an expensive placement option within the child welfare system (Ryan et al., in press). In California, all group home providers are categorized into Rate Classification Levels (RCLs) based on the level of care and services provided, with RCL 14 being the most restrictive (California Alliance of Child and Family Services, 2008).

The purpose of this paper is to compare the placement outcomes and associated costs for youth receiving residential care (defined as group home care in this study) versus a community-based intervention known as Wraparound. Wraparound is a team-based planning process that provides individualized, coordinated, family- and community-driven care to meet the complex needs of youth who are involved with one or more child- and family-serving systems (i.e., child welfare, mental health, juvenile justice, and special education; Walker et al., 2008). Please see www.wrapinfo.org

for more information and resources on Wraparound.

Wraparound in Los Angeles County

Wraparound has provided Los Angeles County with an alternative to residential care, consistent with a recommendation made by the Cole Report (1998), a national review panel report based on observations at MacLaren Children’s Center (MCC), Los Angeles County’s children’s shelter:

[The review panel identified a fragmentation and a lack of coordination of support to] effectively meet the needs and challenges of children with severe emotional, mental, and behavioral disturbances and their families [and recommended] an integration of efforts to meet the needs of individual children and their families through new organization initiatives. [Specifically, the panel identified the need to] develop a common plan of care . . . that actively and dynamically documents the strengths and needs of the child and that identifies the development and deployment of resources to meet those needs.

These recommendations essentially mirror core values, principles, and procedures of the Wraparound process.

At the time of the Cole Report (1998), research was emerging that suggested a relationship between number of placement changes and emotional and behavioral disorders in youth (Cooper et al., 1987). However, few published research studies on the placement outcomes of Wraparound existed. The available research nevertheless demonstrated promising outcomes. In a study conducted by Clark and colleagues (1996), 132 children were randomly

See *IMPROVING OUTCOMES*, next page

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IMPROVING OUTCOMES, from page 63

assigned to the Fostering Individualized Assistance Program (FIAP), a Wraparound intervention, or to a group that received traditional foster care services. The results indicated that children in the FIAP Wraparound group had substantially fewer placement changes two and a half years after entrance into the study.

Two additional studies examined the impact of Wraparound on subsequent living restrictiveness. Yoe, Santarcangelo, Atkins, and Burchard (1996) followed a cohort of 40 youth enrolled in community-based Wraparound in the state of Vermont for a minimum of 12 months. The results indicated that the percentage of youth living in community-based settings increased from 58% at intake to 88% at the end of the 12-month study period.

In the second study, Hyde, Burchard, and Woodward (1996) followed several groups of youth returning from, or at risk for, residential placement, some of whom received Wraparound services. Although the groups were not equivalent at baseline, after two years, almost half of the youth who received Wraparound services were living in the community. Conversely, only 8% of the youth who did not receive Wraparound were living in the community.

The 1998 Pilot Study. When Los Angeles County implemented Wraparound as a 10-child pilot study in 1998 as an alternative to residential care, the goals were to explore its impact on reducing the reliance on out-of-home care and to assess outcomes. The initial outcomes suggested that, compared to youth in residential care, youth involved in the pilot were more likely to return and stay at home. When MCC closed in 2003, as ordered by the interim director of child welfare in Los Angeles County, Wraparound was identified as a primary mechanism to help return youth to the community. Despite the closure of MCC and the availability of Wraparound, referrals were initially slow. Although there were several reasons for the slow start, the primary factors included the lack of understanding of Wraparound and a lack of research on its potential impact, which consisted of only a handful of controlled studies (see Suter & Bruns, 2008, for a review).

The 2004 Exploratory Study. To more fully evaluate Wraparound's potential for positive impact, Los Angeles County conducted an exploratory study in 2004 to

compare the outcomes of Wraparound graduates with youth who were discharged from RCL 12 and 14 residential care placements and who went into less restrictive placements in fiscal year 2004–2005 (LA County DCFS, 2007). RCL 12-14 was chosen for the comparison group because Wraparound accepts youth currently in or at imminent risk of placement in residentially based institutional settings due to emotional, behavioral, or mental health difficulties (Bruns et al., 2004; , 1996). The two groups in Los Angeles County were followed for two and a half years using available administrative data.

An analysis of the results suggested that the Wraparound group did substantially better than the RCL 12-14 group in key areas. The Wraparound graduates had fewer subsequent out-of-home placements and therefore considerably less financial cost to the county than the youth who were discharged from their RCL 12 and 14 placements. In addition, a greater percentage of Wraparound graduates exited the foster care system than did those in the RCL 12-14 group. At the end of the two-and-a-half-year period, 94% of the Wraparound graduates had exited the child welfare system in Los Angeles County while only 7% of the RCL group had done so.

The results of the study were presented within Los Angeles County and around the country. Locally, the study helped to promote the effectiveness of Wraparound and the potential impact on Los Angeles County's service delivery model. Since the 2004 study, the use of residential care has been reduced by over 60%. In 2004, approximately 2,400 foster youth were in residential care, while in 2009, the number decreased to just fewer than 1,000 foster youth. Conversely, Wraparound enrollment was under 200 in 2003 and expanded to more than 1,200 youth by 2009. The study gained the support of the county's board of supervisors for substantial expansions of Wraparound in 2006 and 2009. In 2006, the number of Wraparound providers went from eight to 34, and in 2009, the total availability of Wraparound expanded to a potential of 4,200 slots.

These evaluation results in Los Angeles County parallel an expansion of the research base nationally. For example, Bruns and colleagues conducted a pilot evaluation to assess Wraparound's effectiveness and cost impact in Nevada (Bruns et al., 2006). The pilot included 33 youth enrolled in Wraparound and 32 youth receiving tradi-

tional foster care services. The comparison group was matched on age, sex, race, current residential placement, and severity of mental health problems. The results showed that after 18 months, 82% of youth in the Wraparound group, compared to only 38% of youth in the comparison group, had moved to less restrictive environments. Conversely, 6% of the Wraparound youth and 22% of comparison youth had moved to more restrictive settings.

The Current Study

Hypothesis and Methodology. This paper describes results of a new study that aimed to continue to build the evaluation research base on Wraparound in Los Angeles County, using an expanded study cohort, a more rigorous matched comparison design, and a cost analysis. In this study, we compared the placement outcomes and associated costs of youth who graduated from Wraparound in the county to youth living in equivalent residential care (i.e., RCL 12 and 14). We hypothesized that Wraparound would result in better outcomes for foster youth (less restrictive placements) and lower costs to the system than when these youth are placed in residential care at RCL 12 and 14.

Study Design. A static-group comparison was selected for the research design for this study. The Wraparound group consisted of youth who enrolled in and graduated from Wraparound. The comparison group consisted of youth who had been discharged successfully to less restrictive levels of care from residential care placements at the highest rate classification levels (RCL 12-14). This comparison group was selected because youth who enrolled in Wraparound had been placed or were at risk of being placed in these RCLs. An ex post facto analysis was conducted for the 12-month period after graduation from Wraparound or discharge from RCL 12 and 14 to a lower placement level. Several outcome measures, to be described, were assessed during the follow-up period.

Participants. The evaluation initially consisted of 312 youth under the care of the Department of Children and Family Services (DCFS) in Los Angeles County. One group consisted of 102 youth who had graduated from Wraparound. The other group comprised 210 youth who had been in residential care placements at RCL 12 and 14 and were successfully discharged into lower levels of residential care.

See *IMPROVING OUTCOMES*, next page

IMPROVING OUTCOMES, from page 64

The selection criteria for youth in the two groups are listed in Table 1. The last two criteria in Table 1 were added to expand the methodological rigor of our previous study. These are:

1. Youth had been in Wraparound or RCL 12-14 placements for at least six months to assure placement stability and comparability of the groups; and
2. Youth were no older than 17 years, 0 months at Wraparound graduation or RCL 12-14 discharge so we could analyze the full 12 months of placement data without age-outs from the child welfare system.

Populations were used as the basis of comparison to avoid the potential of sampling error from relatively small groups.

Preliminary Analyses. Youth who graduated from Wraparound were more likely to have their cases closed within 12 months than were youth discharged from RCL 12 and 14. Fifty-nine of 102 graduates in the Wraparound group (58%) and 33 of 210 youth in the RCL 12-14 group (16%) had their cases closed within 12 months of graduation or discharge. Although an RCL 12-14 case may be closed immediately if the child is discharged to home, this outcome happens infrequently. To assure comparability of the groups, we used the subset of each population that included only cases that remained open for at least 12 months

for evaluation (43 for Wraparound from the original population of 102 and 177 for RCL 12-14 from the original population of 210). All subsequent analyses are presented on the 43 remaining Wraparound youth and 177 remaining RCL 12-14 youth, respectively.

Baseline Characteristics. As shown in Table 2, a large proportion of youth in each group was between 12 and 17 years old, $\chi^2 = 2.80$, ns. This age group reflects the Wraparound program's focus on adolescents rather than younger children. With an average of 13.42 years ($SD = 2.23$), youth in the Wraparound group were slightly younger than youth in the RCL 12-14 group, which had a mean age of 14.47 years ($SD = 1.77$), $t = 2.40$, $p < 0.05$. Age, however, did not correlate with any of the outcome measures (to be described in the next section). All r 's were lower than 0.12 and were not statistically significant. There was a higher percentage of males in the Wraparound group (70% vs. 55% for RCL 12-14), but this difference was not significant, $\chi^2 = 2.95$, ns.

There was a statistically significant between-group difference in the racial composition of the two groups ($\chi^2 = 10.64$; $p < 0.05$). A higher percentage of African Americans in residential care (44% vs. 33%) may be at least in part an indication of the racial disparity that exists in the child welfare system (Needell et al., 2009). Using administrative data of all youth involved with DCFS and the Department

of Probation in Los Angeles County, Ryan and colleagues (in press) also found a higher percentage of African Americans in group home placements versus foster care placements.

Procedures and Outcome Measures. Data were extracted from the Child Welfare Services/Case Management System (CWS/CMS), a centralized statewide database application for all child welfare services records in California. CWS/CMS is used by the Los Angeles County DCFS as its principal information system. We maintained the anonymity of the youth by using the unique identifier code assigned to each child in the system.

The outcome measures for the 12-month period after graduation from Wraparound or discharge from RCL 12 and 14 to a lower placement level were:

- Number of placements;
- Duration of placements;
- Types of placements (i.e., guardian/relative, foster family, court specified/small family, FFA-certified home, and residential care); and
- Cumulative financial costs incurred by DCFS associated with each placement episode.

Cumulative financial costs were calculated by applying the reimbursement rates to the total number of days in each type of placement.

Study Results

We used SAS v.9.1 descriptive statistics and Student's t-test functions to analyze the placement outcomes and associated financial costs. Results indicated that 44% of the Wraparound graduates had no subsequent out-of-home placements, compared to 9% of the RCL 12-14 group. Therefore, 91% of the youth in the RCL group had at least one subsequent out-of-home placement.

Placement Outcomes. As depicted in Figures 1 and 2, respectively, youth who graduated from Wraparound had, on average, 0.91 placement ($SD = 1.04$) and spent about 199.33 days in subsequent placements ($SD = 178.69$). In contrast, youth who were discharged from RCL 12 and 14 had an average of 2.15 placements ($SD = 1.57$) and spent about 289.50 days ($SD = 125.90$) in out-of-home placements. These findings show that youth in the Wraparound group had significantly fewer subsequent placements than youth who were discharged

See IMPROVING OUTCOMES, next page

Table 1: Selection Criteria for Youth in the Wraparound and RCL 12-14 Study Populations

Selection Criteria	Wraparound	RCL 12 - 14
The youth's case record is available in CWS/CMS	X	X
Graduated from Wraparound between July 1, 2006, and June 30, 2007	X	
Was discharged from RCL 12 and 14 to a lower placement level or home between July 1, 2006, and June 30, 2007		X
Had not previously been enrolled in the Wraparound program		X
Had not received Wraparound services in the 12 months after discharge		X
Was in a Wraparound or RCL 12-14 placement for at least six months prior to graduation or discharge	X	X
Was no older than 17 years, 0 months at graduation or discharge	X	X

IMPROVING OUTCOMES, from page 65

from RCL 12 and 14 ($t = 6.29, p < 0.001$). When placements did occur, youth in the Wraparound group spent significantly fewer days in subsequent placements during the 12 months after graduation than youth in the RCL 12-14 group, $t = 3.33, p < 0.01$. In other words, youth who graduated from Wraparound were found to have a relatively more stable living environment than youth discharged from RCL 12-14 placements.

Youth who graduated from Wraparound also differed from youth discharged from RCL 12 and 14 in the restrictiveness of placement types. Figure 3 illustrates the out-of-home placement distribution for both groups. During the 12 months of follow-up, 77% of the placements for the Wraparound graduates occurred in less restrictive settings such as with foster families, relatives, or legal guardians. In comparison, 70% of the placements for youth who were discharged from RCL 12 and 14 took place

in more restrictive environments such as residentially based settings or FFA-certified homes. More than half of the placements after graduation from Wraparound take place in less restrictive settings, whereas almost half of placements subsequent to discharge from RCL 12 and 14 occur in the most restrictive setting (residential care).

Cost Outcomes. When a child is in an out-of-home placement, the amount of direct financial costs incurred is a function of the types of placements and how long the child stays in each placement. The average post-graduation cost for the Wraparound group was calculated to be \$10,737 (SD = \$19,059), whereas the average post-discharge cost for the RCL group was \$27,383 (SD = \$21,679). This difference in average placement costs was found to be significant ($t = 4.62, p < 0.001$). As shown in Figure 4, 47% of subsequent placements in the Wraparound group, compared to 10% of the placements in RCL 12-14 group, did not generate any financial costs. In addition, whereas 86% of the placements in the Wraparound group had \$20,000 or less in associated costs, only 45% of placements in the RCL 12-14 group had costs totaling less than \$20,000 in the first year after initial discharge from residential care.

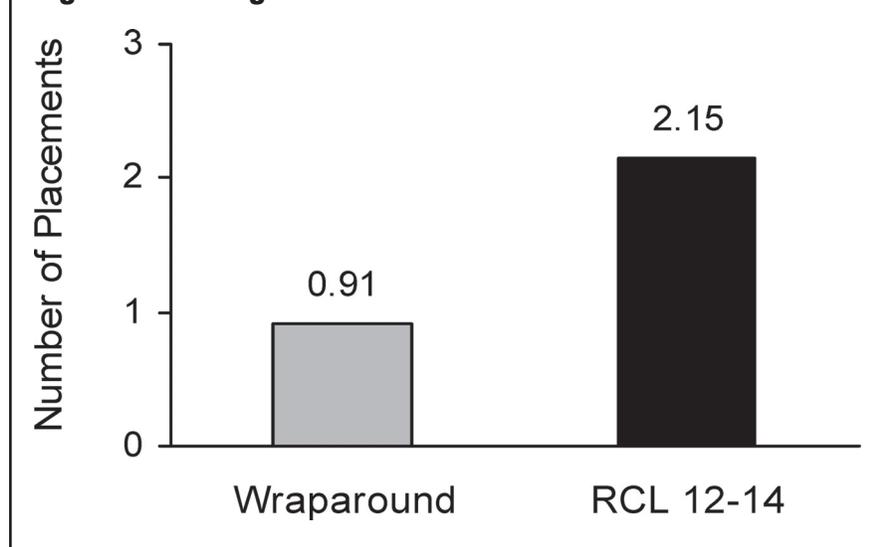
Table 2: Demographic Characteristics of Youth Who Graduated From Wraparound vs. Youth Who Were Discharged From RCL 12 and 14

Demographic Characteristics	Wraparound (N = 43)	RCL 12-14 (N = 177)	χ^2 (p-value)
Age ranges			2.80, ns
5-11 years	21%	11%	
12-17 years	79%	89%	
Gender			2.95, ns
Female	30%	45%	
Male	70%	55%	
Ethnicity^a			10.64, $p < 0.05$
African American	33%	44%	
Hispanic	33%	34%	
White	23%	20%	
Other ^b	12%	2%	

^a Total may not sum to 100% due to cumulative rounding.

^b Includes Asian/Pacific Islander and Native American/Alaskan Native.

Figure 1: Average Number of Out-of-Home Placements



An Effective Mechanism

Both child welfare policy and practice have focused on reducing the reliance on out-of-home care by preventing out-of-home care altogether or by decreasing the length of stay in residential care and stabilizing the placement if placement is inevitable (James et al., 2004). The current findings from Los Angeles County point to the effectiveness of Wraparound in improving placement outcomes for foster care youth. Our findings show that during the 12-month period, youth who graduated from Wraparound experienced fewer out-of-home placements than youth discharged from residential care, thereby increasing the stability of their future living situations. Given that frequent placement changes are associated with negative outcomes such as externalizing behaviors (Keil & Price, 2005) and propensity for delinquency (Ryan et al., in press), Wraparound has a positive impact on youth's outcomes relating to permanency, safety, and well-being.

Placements, when they do occur for Wraparound youth, require fewer numbers of days. On average, Wraparound youth who

See IMPROVING OUTCOMES, next page

IMPROVING OUTCOMES, from page 66

were placed after graduation spent about six months in subsequent out-of-home placements compared to their residential-care counterparts, who spent about 10 months. The decrease in the youth's length of stay in residential care suggests that Wraparound seems to have provided an effective mechanism for reducing the county's reliance on out-of-home care.

The results also indicate that youth who graduated from Wraparound have less restrictive living environments than youth discharged from RCL 12 and 14 placements. This finding supports previous evaluation studies (Bruns et al., 2006; Yoe et al., 1996). Although most of the youth in the Wraparound group were placed with a guardian or relative, almost half of the youth in the RCL 12-14 group continued in the most restrictive levels of residential care. It may be that youth who graduated from Wraparound are more likely to maintain continuity in school and home settings, and thus to maintain their relationships with families, friends, and teachers.

Because youth who graduated from Wraparound had fewer out-of-home placements and were placed in less restrictive environments overall, their placement costs were substantially less. Almost half of the placements in the Wraparound group incurred no cost at all. In addition, a higher percentage of subsequent placements for

the RCL 12-14 youth, relative to the Wraparound youth, involved residentially based settings. As a result, placements in the RCL 12-14 group, compared to placements in the Wraparound group, incurred two and a half times the cost. This finding is consistent with the observation that group homes are an expensive option within the child welfare system (Ryan et al., in press).

Our data also show that Wraparound youth are much more likely to have their cases closed within 12 months of graduation relative to youth discharged from RCL 12 and 14. From the point of view of the Los Angeles County child welfare system, case closure may indicate that the youth's safety and permanency goals have been met. From the point of view of Wraparound, case closure may signify that the family is equipped with skills and community-based resources to address future needs or crises that arise.

Limitations and Future Research Directions

The current study contributes to the evidence base of Wraparound's effectiveness and cost impact in Los Angeles County. Nevertheless, there are some limitations to the evaluation.

First, the study design is a retrospective study and youth were not randomly assigned to groups. This means that groups might not have been equivalent at baseline and that factors other than receipt of Wraparound versus residential care may have led

to the observed differences in placement outcomes and associated costs. Currently, we are determining the equivalency of the two groups, looking at the following background covariates prior to Wraparound or RCL 12-14:

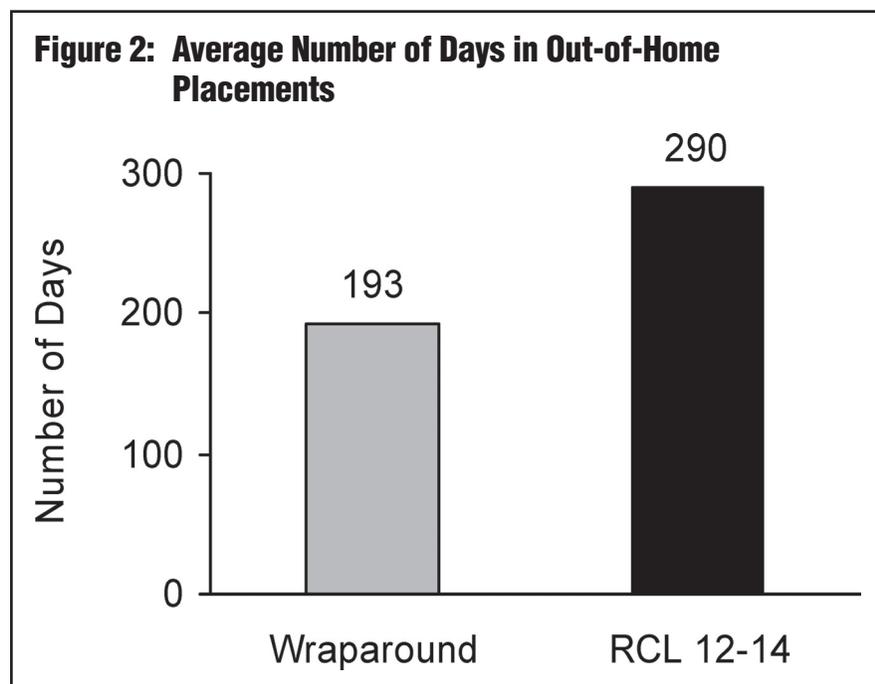
- Age at first placement;
- Number and types of placements prior to Wraparound or RCL 12-14;
- Reason for placement changes;
- Cumulative length of stays for all out-of-home placements; and
- Last placement before entry to Wraparound or RCL 12-14.

Second, we examined the placement outcomes of these youth for a period of only one year. To examine the longer-term outcomes of Wraparound versus RCL 12 and 14, we will develop in the coming year a two-year cohort of youth from the original study populations who have not aged out of the foster care system. We will also add a new first-year cohort to expand the current analysis. Tracking outcomes over multiple years will also enable us to examine the replacement rate of youth into foster care and into residential care.

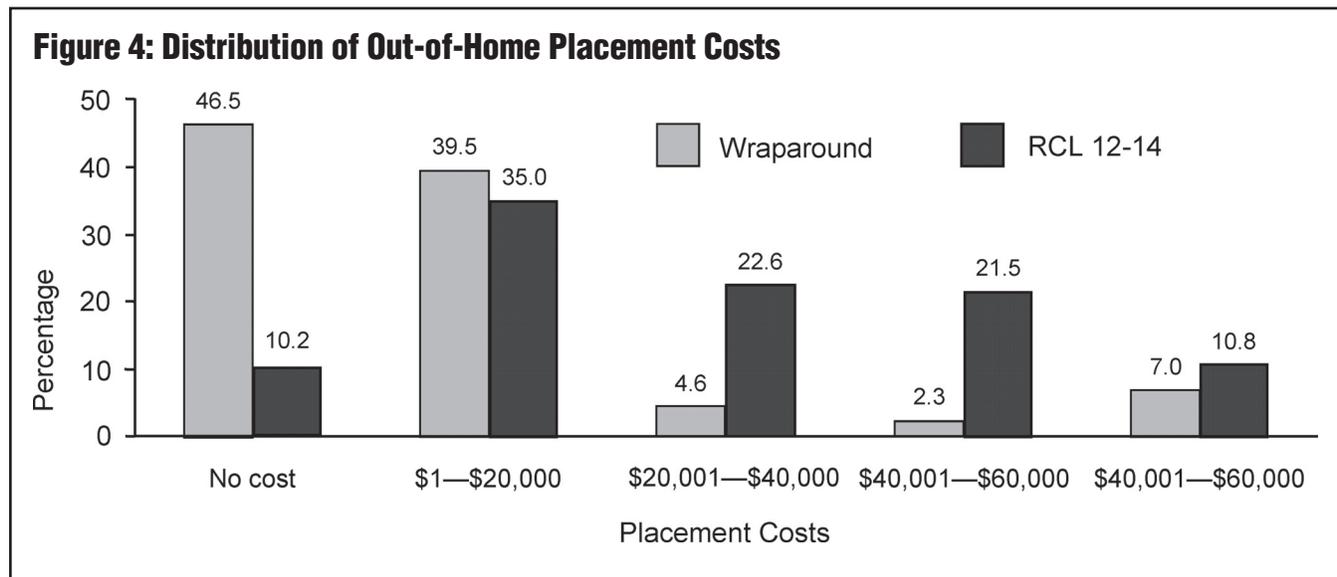
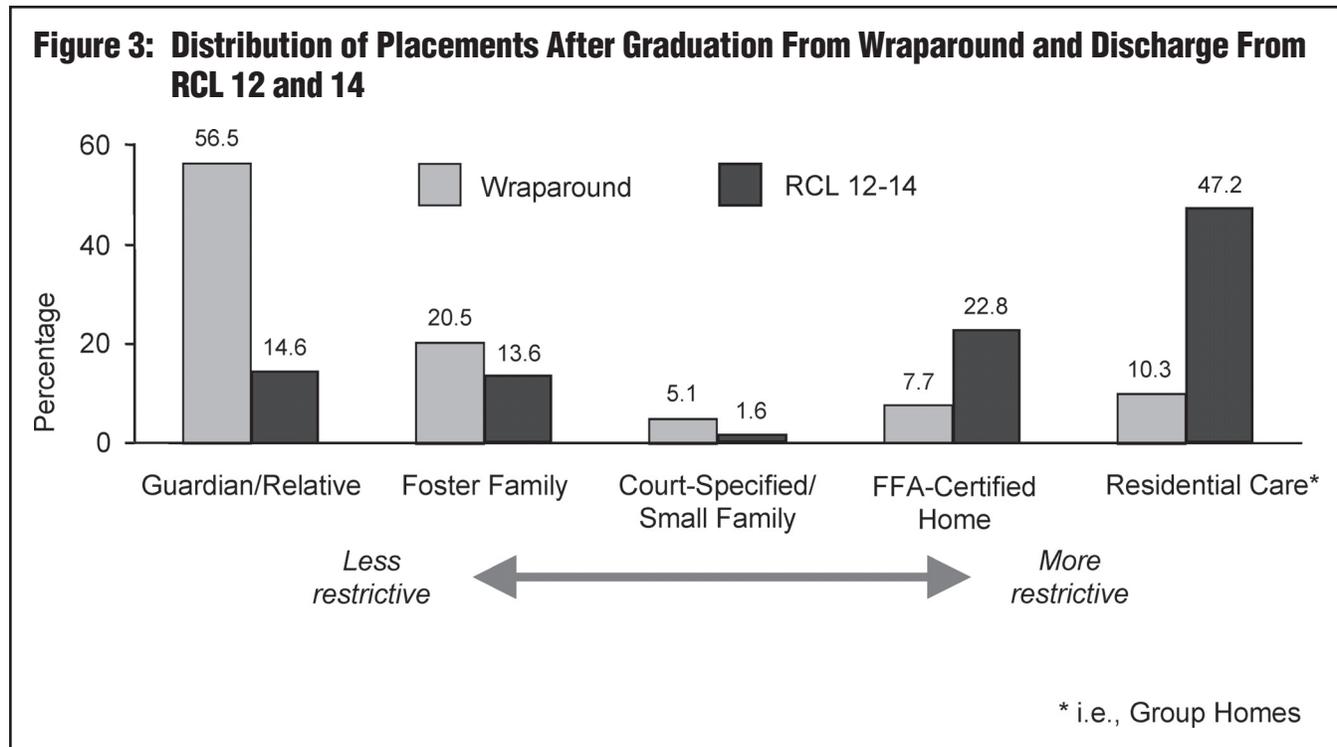
Last, in using available administrative data, we do not have information on the behavioral characteristics or functioning of the comparison youth. Although we have an assessment of the degree of impairment in functioning for those youth enrolled in Wraparound through the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1999), we do not have CAFAS data for the youth in residential care. Ongoing evaluation of the outcomes of youth in the system will benefit from incorporation of an expanded set of outcome measures that include measures of functioning or behavioral adjustment.

Policy and Practice Implications

Despite the limitations described above, the present research, coupled with the 2004 exploratory study, has had immediate and long-term policy and practice implications in Los Angeles County. One implication is that Wraparound provides an effective service delivery option for youth with behavioral and emotional problems. As demonstrated in both the 2004 evaluation and the current study, a higher percentage of youth who graduated from Wraparound exited the child welfare system than did



See IMPROVING OUTCOMES, next page



IMPROVING OUTCOMES, from page 67

youth in residential care. Conversely, a lower percentage of Wraparound graduates had subsequent out-of-home placements compared to RCL 12-14 discharges. Wraparound, endorsed as a high-priority strategy in Los Angeles County, was recently expanded to accept youth who are not currently in or at imminent risk of placement into higher levels of residential care. By

providing Wraparound earlier, we expect fewer youth will need high-level residential care and thus have fewer placement disruptions resulting from removal from their families and communities. We also expect that youth are less likely to reenter the child welfare system following graduation from Wraparound.

The adoption of the Wraparound practice and approach will also influence how children’s social workers are trained in

Los Angeles County. A training model for service delivery is being developed that shares many of the Wraparound values and principles. The departmental goal is to assure that children’s social workers have knowledge of and access to a broader range of strategies for improving outcomes for youth in foster care.

See IMPROVING OUTCOMES, see page 74

Establishing a Foundation for Collaboration Among Child-Serving Systems

by Laura L. Rogers and Philip R. Endress*

Background: Oneida County

Oneida County, located in upstate New York, is a small city suburban area with significant rural areas. The county has a proximal population of 235,000 people and, as of 2001, included 24,000 youths between the ages of 10 and 18. Oneida County prides itself on its caring nature, especially toward new immigrants and individuals suffering from a mental illness or developmental disability. Historically, Oneida County's city of Utica was home to the second U.S. institution built for the mentally ill. This facility was the first to offer specialized treatment for alcohol and drug addiction. All that now remains of this institution is one inpatient facility with fewer than 120 beds.

Once a center for industry, Oneida County is currently facing a declining industrial and tax base, an aging population, and an increasing Medicaid-eligible population. The closure of the Griffiths Air Force Base and the departure of several large manufacturing plants in the late 1990s compounded these problems. In an attempt to reinvent itself and recapture its economic prominence, the government of Oneida County was open to new ideas for addressing these and other pressing issues.

Beginning in the early 1990s, the Oneida County Department of Mental Health, in association with the Department of Social Services and several community-based providers, initiated a series of community efforts to reduce the county's dependence on foster and residential care for children and adolescents. The Robert Wood Johnson Foundation, through its replication grant

program, rewarded Oneida County for its efforts with a \$75,000, one-year grant to formally launch a coordinated care system for children with emotional and behavioral problems and their families. With vision, commitment, and strong political leadership, Kids Oneida, a program serving youth and families with complex needs and limited resources, became a reality. Kids Oneida has now been in operation for nearly eight years and has emerged as a successful multi-system effort that blends child welfare, Medicaid, and mental health funds into a single system of care for children and youth with serious emotional and/or behavioral disorders.

On the preventative end, the services in Oneida County include:

- Multisystemic Therapy (MST, Henegler et al., 2002) for the juvenile population;
- Supportive case management;
- A school partnership for youth program;
- A family nurturing center;
- Case planning; and
- Mental health and substance abuse outpatient counseling.

Other services include:

- Residential treatment facilities and centers;
- Kids Oneida;
- Intensive case management; and
- Day treatment.

To this end, regardless of the system through which a child enters, the child and family will be provided services across all child-serving systems.

Cross-System Barriers

Children and their families often enter public systems during a period of crisis. This crisis may be exacerbated as they face a fragmented and, at times, overlapping and conflicting array of services. Families, legal guardians, probation officers, judges, principals, guidance counselors, child welfare caseworkers, mental health professionals, and other parties find these systems complex and difficult to navigate. For example,

those entering the juvenile justice system can expect to be involved with as many as six different and independent systems designed to provide treatment and support services. This complexity might be manageable if the systems were well coordinated—but often they are not.

Because each system focuses on a particular aspect of a child's actions, it fails to address the family's needs in an integrated and comprehensive manner. To add to this complexity, each system may include multiple programs with separate and discrete providers replete with different regulations governing issues such as record keeping and confidentiality. Because agencies seek to provide a variety of services to address the needs of the child and family, these services may be governed by different systems, and the agency may be required to maintain separate and independent records for each child and/or family member. Too often, this complexity is too much for a family to overcome and a child is removed from the home and community and/or is allowed to move down a path toward recidivism. The following are some typical and salient cross-system barriers:

- *Service system:* Services are provided only in the system the child/family enters, despite the family's having multiple issues (e.g., education, juvenile justice, child welfare, mental health).
- *Finger pointing:* Systems state that their particular system is not responsible and that another system should be taking over the care of the child. For example, "Because this child has a mental health diagnosis, the mental health system should handle him."
- *Uncoordinated care:* Care is not coordinated across the multiple needs of the child and family.
- *Monitoring:* Services are not uniformly monitored for quality assurance.
- *Reactive vs. proactive approach:* Many children end up in higher need, more expensive services; there is little detection of these children at the preventative end.

See *CHILD-SERVING SYSTEMS*, next page

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CHILD-SERVING SYSTEMS, from page 69

- *Servicing guidelines:* Services are not efficiently used, because there is no mechanism in place that works as a guideline in identifying which service would best meet the needs of the child and family.

Reform Initiatives: The Single Point of Access and Accountability (SPOA/A) System

Oneida County's SPOA/A process was established to address the barriers of system fragmentation. In January 2001, the New York State Office of Mental Health (OMH) announced its New Initiatives (OMH, 2001a, 2001b), which include guidelines for developing an SPOA/A for children and adults. The OMH recognized that the target population of high-risk children and youth entered the public systems via multiple routes. One of the tasks it charged each county with was to develop or adopt a risk assessment tool that would ensure this population's access to appropriate services through an integrated, virtual SPOA/A. In Oneida County, the major systems/points of entry that were identified as primary-system-of-care partners included the departments of mental health, juvenile justice, social service, and education. These systems are now the county's SPOA/A partners.

The public mental health system in New York delivers an extensive array of services, with the goal of being a flexible system that addresses families' stated needs and that is focused on strengths, is evidenced based, and is responsive to each individual's need. SPOA/A is intended to oversee the provision of a broader array of services, to organize and manage services, and to ensure that the care provided is individualized, collaborative, and culturally competent. The overall goal is to get children and families the services they need, when they need them, without waiting lists or eligibility barriers.

The first year of the SPOA/A initiative was dedicated to pulling systems processes together and fostering collaboration among the systems for the best interest of the child. A first step was one of a common assessment tool. The county chose the Child and Adolescent Needs and Strengths (CANS; Lyons et al., 2002) assessment tool and then rolled out its use. Any child and family that entered through the SPOA/A had a CANS completed, and the information from the CANS was the basis for a service plan to be

implemented and adhered to by responsible parties across systems.

The second year involved training various system partners and the line staff responsible for administering the tool. This took much time and energy, because some resisted changing to a new format. The resistance had mostly to do with paperwork and confusion about how to use the information learned from the CANS assessment. In addition, staff persons in four system levels needed to be trained. Eventually, whole divisions were trained on the CANS to teach new staff. The SPOA/A committees were also beginning to take shape in the second year, and CANS assessments were being received and entered into a database.

In addition to the CANS, the Oneida County SPOA/A draws on the philosophies and methodologies of a number of system reform frameworks. One is the System of Care framework (Stroul & Friedman, 1993). System of Care principles apply to social services, probation, education, and mental health, and all of these interact with SPOA/A. Another related framework is Communities That Care (CTC), which enlists the help of community leaders and professionals as well as local citizens to support positive youth development (Hawkins & Catalano, 2007). In addition, the county has established its own database, called C-Info, to manage information from the various service providers and agencies. Meanwhile, the SPOA/A functions as the overarching process within the county's system of care. It coordinates the delivery of services offered by the various systems components into an integrated plan of care and support for children and families. Each of the major child care serving systems has its own process for accessing services. The SPOA/A brings together the various systems into an integrated system of care.

The SPOA/A System of Care

The purpose of the Oneida County's SPOA/A for children and families is twofold. First, the SPOA/A can identify early the children and families needing a referral to an appropriate system or treatment. Second, the SPOA/A can identify children with the highest risk of placement in out-of-home settings, which helps in developing appropriate strategies to manage those children in their home communities. Through early identification and definition of a child's and family's needs, targeted evidence or promising practice services can be developed. The SPOA/A partners assist

in developing a creative and individualized plan using services across systems.

The SPOA/A system is designed to be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided. In other words, issues the families are facing are brought to the forefront by case managers, clinicians, and physicians. The family decides which issue(s) to address, and the system is designed to provide access to the needed services.

Services are community based; the locus of services as well as the management and decision-making responsibility is at the local level. Oneida County representatives who sit on or chair service committees have the authority and responsibility to approve the decisions made through this family process.

The SPOA/A continuum strives to be culturally competent, with agencies, programs, and services responsive to the cultural, racial, ethnic, and linguistic differences of the children and families served. In addition, based on outcomes from the CANS data, SPOA/A will ensure the implementation of evidenced-based and best-practices strategies within the provider community. The needs of the family are first identified through a CANS assessment, which identifies not only the needs and strengths of the family, its risk and protective factors, but the service gaps and service needs within the community. This information can be fed back, for example, to the CTC to help develop system-level responses to services and meet the needs of the community the CTC serves.

SPOA/A Guiding Principles

The guiding principles of SPOA/A include the following:

- Children with social welfare, emotional disturbance, and/or juvenile justice needs will have access to a comprehensive array of community-based, culturally competent services that serve the child's physical, emotional, social, and educational needs.
- Children with social welfare, emotional disturbance, and/or juvenile justice needs will receive services within the least restrictive, most normative environment that is socially and clinically appropriate.
- Children with social welfare, emotional disturbance, and/or juvenile justice needs will be provided with case

See CHILD-SERVING SYSTEMS, next page

CHILD-SERVING SYSTEMS, from page 70

management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner.

- SPOA/A will promote early identification and intervention for children with social welfare, emotional disturbance, and/or juvenile justice needs to enhance the likelihood of positive outcomes.
- Families of children with social welfare, emotional disturbance, and/or juvenile justice needs will be participants in planning and delivery of services.
- Children with social welfare, emotional disturbance, and/or juvenile justice needs will receive integrated services with linkages between the various systems for planning, developing, and coordinating services.
- The rights of children with social welfare, emotional disturbance, and/or juvenile justice needs will be protected, and effective advocacy efforts for children and youth with emotional disturbances will be encouraged.
- SPOA/A will follow the rules and guidelines of the Health Insurance Portability and Accountability Act (HIPAA) and will provide access to parent and family advocates.
- Children with social welfare, emotional disturbance, and/or juvenile justice needs will be ensured a smooth transition to the adult SPOA as the child reaches maturity.

These principles empower SPOA/A participants to collaborate. The excitement and promise of collaboration, instead of the traditional, fragmented, single-system treatment, helps the system support itself. Collaboration is essential to achieve the promise held by integrating services in flexible, high-leverage models, because most of our children and their families are involved in multiple agencies and systems. This network approach partners with the participating SPOA/A systems as well as with other public and private providers for children and adolescent services in an efficacious and accountable fashion.

Use of the Children and Adolescents Needs and Strengths (CANS) Measure

The decision to implement a single, comprehensive screening tool was critical in

bringing these multiple systems together. Following an exhaustive review of various psychometric tools and assessments available, Oneida County system partners chose to use the CANS methodology because of its ability to transcend cross-system barriers. Characteristics of the CANS assessment include:

- A focus on service delivery needs versus simply identifying a pathology;
- Identifying both current status and historical context for clinical needs;
- Various versions, to give caretakers a common language while respecting each system's focus, including the CANS-MH, CANS-CW (child welfare), CANS-DD (developmental disabilities), and CANS-JJ (juvenile justice);
- Highly flexible structure;
- Treatment plans that can be developed at the table with the child and family;
- Service providers using the outcomes of the assessment;
- Monitoring of the child's progress over time; and
- Encouragement of cross-system collaboration.

The CANS is administered to evaluate not only the child and family, but the systems and providers who interact with the family unit. The child is screened at the point of current access for risk, clinical need, and family strengths. A family care plan is developed based on the outcome of the CANS assessment. This information becomes a working document to be used by the SPOA/A committee. The committee will implement the program/services needed to establish uncomplicated care and to get services authorized and delivered effectively and efficiently. The CANS, then, works for multiple purposes, enhancing communication, collaboration, accountability, and coordination across systems, as follows:

- *Communication:* Through the use of the CANS and Oneida County's C-Info database, SPOA/A partners and their affiliates are able to access information and communicate with other providers and systems about the child and family with whom they are working. Use of the CANS has created a standard language to describe the challenges the child and family face and a standardization of the types of services being offered.
- *Collaboration:* The use of the CANS identifies service needs and service gaps. This information can be commu-

nicated to providers and funders alike. Where the CANS identifies a need for services that must be provided through multiple or divergent systems, the work of the SPOA/A committees will commence. As noted, the primary function of the SPOA/A is to bring together systems, services, and families for the exclusive purpose of developing a plan that addresses the multiple and complex needs of the family in a coordinated way. At SPOA/A meetings, a facilitator reviews the CANS assessment, particularly the most highly rated needs and strengths. These "2s and 3s" serve as the focus for the child and family's Individualized Service Plan (ISP).

- *Accountability:* The CANS is also used as a quality assurance/utilization review mechanism. It justifies that the service a child is currently receiving is appropriate and/or that the service provision is necessary. Periodic use of the CANS ensures that services are achieving the desired outcomes for the child and family.
- *Coordination:* To reiterate, a primary use of the CANS is to aid in the coordination of services for children and families that present as having needs that can best be addressed through a multi-system strategy. A service provider will be deemed the lead manager in coordinating and implementing an ISP for the child and family. The ISP will specify the following: needs/concerns and strengths, action plan, and responsible party to ensure implementation and follow-through for the child and family. The CANS will be used to track the progress, or lack thereof, of the ISP, and revisions will occur as needed.

Based on the CANS, C-Info, in compliance with the HIPAA standards, will aid in coordinating the various system services through its capacity to share information about mutual clients. This process creates a multisystemic effort to help children and families with social welfare, emotional disturbance, and/or juvenile justice needs.

The C-Info System

Oneida County recognized that its SPOA/A needed a coordinated management information system (MIS) to help the various agencies collaborate their efforts. To meet this need, the Oneida County

See CHILD-SERVING SYSTEMS, next page

CHILD-SERVING SYSTEMS, from page 71

Department of Mental Health in 2001 embarked on the development of its own comprehensive, cross-system MIS—the C-Info system—to store and manage clinical evaluation information that can be used to support treatment efforts from all levels of systems, governments, providers, and the community. This system allows for the development of an ISP anchored by a strong service coordination approach and based on a comprehensive assessment of each individual's need(s). As services are provided, C-Info tracks the individuals and families across the various systems (child welfare, mental health, vocational, probation agencies, etc.). It also collects information from the various sources identified on the New York State Quarterly Form, including a breakdown of cases referred from hospitals, emergency rooms, mobile crisis units, community mental health centers, juvenile justice, and schools, among other sources.

The local implementation of the CANS on the C-Info system allowed Oneida County to gather and analyze data as a first step toward developing a family-oriented “report card” on services and providers. Access to timely, locally generated data is essential in improving the quality of services for children and families.

Building an Integrated System

A Child-Centered, Family-Friendly System. Oneida County uses a sound clinical and family advocate team approach to assess for needs, strengths, and risk and protective factors as well as recommended services. Based on the CANS assessment, a family can advocate for the services that members think will best support them as they work through the current challenge. From a systemic perspective, the CANS can be used to determine whether a case is appropriate for preventative or at-risk services.

The elements of collaborative services include:

- *Implementation of the following key elements into a coordinated care package:*
 - Individualized service plan;
 - Family-centered perspective;
 - Strengths-based planning;
 - Commitment to unconditional care;
 - Community-based perspective;
 - Culturally competent planning.

- *Family support network.* The support team develops and monitors a family support network (FSN) that connects families to other parents and support services to ensure that the ISP is child and family centered. The FSNs are family-run organizations that provide direct parent support and assistance to family members of children with emotional and behavioral disturbances.

- *Clinician network.* The support team establishes, monitors, and supervises a clinician network. This network should consist of master's level mental health professionals and caseworkers who will work with a parent advocate from the FSN. The clinician/caseworker responsible for collecting CANS information adds her or his own data as well as information gained from the parent advocate. Typically, the service provider collects information from life domain functioning, acculturation, child strengths, and child behavioral/emotional modules, as well as trauma, child risk, educational, substance abuse, juvenile justice, and sexual behavior modules, while the parent advocate collects the caregivers' needs and strengths module. The clinician will provide a list of recommendations based on this overall assessment.

- *Child/family team meeting.* The clinician and parent advocate will act as a team in conducting the child/family team meeting. This occurs before the child and family meet with the team of providers. The clinician and parent advocate will take the following preliminary steps:

- Assess strengths (assets or talents that can be mobilized to ameliorate or counteract the impact of problems or adverse circumstances);
- Identify the members of the team;
- Clarify the roles of worker, advocate, and family;
- Sign the interagency release, which gives family members permission to sit at the table to make a plan for the child and family;
- Arrange a meeting date and location; and
- Invite team members, the individuals identified to provide support to the child and family (e.g., representative from social services).

The SPOA/A Team. The SPOA/A team reviews and evaluates the initial level-of-care decision with the family and child. Depending on their unique needs, this deci-

sion could possibly include various levels of mental health treatment, case coordinator services, residential or living arrangements (i.e., home with parents, kinship, family foster care, therapeutic foster care, residential programs, inpatient treatment), and the use of other nontraditional support services such as mentoring, in-home family supports, or community supervision.

The SPOA/A director is designated as the responsible individual for monitoring progress and evaluating outcomes. SPOA/A establishes, implements, and monitors a universal intake process that includes all single points of access and residential treatment facility (RTF) referrals. The elements of this process comprise a dataset, a CANS assessment with needs, concerns, and strengths identified, an action plan or SPOA/A committee disposition, and the party responsible for ensuring implementation. To ensure coordinated care across the four system partners, CANS assessment units for the various systems include:

1. *Mental health:* Any mental health provider. If none, the Tier I clinician/parent advocate team will administer the CANS;
2. *Child welfare:* Any program or service supported by the Department of Social Services (DSS). This could be the county caseworker or private provider staff;
3. *Juvenile justice:* Probation officers or juvenile justice liaisons;
4. *Educational system:* District liaison or CANS district evaluator; these are typically psychologists, school social workers, guidance counselors, nurses.

These units ensure that the universal assessment tool (dataset & CANS assessment) will be administered at intake, at the 60-, 90-, and 180-day intervals until discharge, and at discharge to monitor for progress. The C-Info database assists in this aspect of the process. The SPOA/A process also has a utilization review system for families to evaluate outcomes and present findings to the SPOA/A oversight committee.

SPOA/A Oversight Committee. An SPOA/A oversight committee includes commissioners of mental health and social services, the Board of Cooperative Educational Services (BOCES), district superintendents, the senior family court judge,

See CHILD-SERVING SYSTEMS, page 74

From the Literature: What's Hot ... What's Not

by Lorraine Dubuisson*

Mental Health & Chronic Physical Conditions

Do Mental Health Problems in Childhood Predict Chronic Physical Conditions Among Males in Early Adulthood? Evidence From a Community-Based Prospective Study

Goodwin, R.D., Sourander, A., Duarte, C.S., Niemelä, S., Multimäki, P., Nikola-karos, G., Helenius, H., Piha, J., Kumpulainen, K., Moilanen, I., Tamminen, T., & Almqvist, F.

Psychological Medicine
39:301–311, 2009

Using data from the 15-year follow-up study of Finnish males, "From Boy to Man," this study examines the ways in which mental health problems present in childhood are related to physical disorders in adulthood. Chronic physical conditions such as diabetes are reaching epidemic levels among a much younger demographic than before. Because these conditions are considered to be in many ways preventable, discovering early predictors is key. Previous studies have suggested that chronic physical conditions and mental health are linked, but these links are still not fully understood.

At age eight, the mental health of the males in the sample was evaluated by their parents and teachers using the Rutter questionnaire, which contains questions about attributes such as shyness, aggression, and short attention span. The children also self-reported their mental states using the Children's Depression Inventory (CDI).

Information about the males' adult physical conditions was obtained through the Finnish national military register at ages 18 to 23. Military service is compulsory in Finland, and a medical examination is required at age 18 before service begins. The study concluded that severe conduct and hyperkinetic problems in childhood were associated with both obesity and atopic eczema in adults. Childhood emotional problems and depressive symptoms were linked with epilepsy and asthma in

adults. Although researchers offer some educated guesses about the nature of these relationships, further study is necessary to determine why asthma, and epilepsy in particular, are linked to certain childhood mental health issues.

Screening vs. School Professional Identification

School-Based Screening to Identify At-Risk Students Not Already Known to School Professionals: The Columbia Suicide Screen

Scott, M.A., Wilcox, H.C., Schonfeld, I.S., Davies, M., Hicks, R.C., Turner, J.B., & Schaffer, D.

American Journal of Public Health
99:334–339, 2009

Are school professionals accurately identifying students at risk for suicide? How much overlap exists between screen-

Results suggest that although both screening and school official identification are flawed, both are necessary in terms of detecting suicidal students. Screening produced fewer false positives, and although school professionals did not identify some students with severe problems, the small number identified by school professionals alone was significant, considering the permanent nature of suicide.

Predictors of Adult Psychopathy

Amygdala Hypoactivity or Fearful Faces in Boys With Conduct Problems and Callous-Unemotional Traits

Jones, A.P., Laurens, K.R., Herba, C.M., Barker, G.J., & Viding, E.

The American Journal of Psychiatry
166:95–102, 2009

This study examines neural response to emotional stimuli using functional MRI.

Are school professionals accurately identifying students at risk for suicide?

ing and school professional identification? As part of the Columbia Suicide Screen (CSS), this study focuses on a sample of 2,858 high school students in New York in the early 1990s. The CSS asked students whether they have entertained suicidal thoughts during the past three months, made previous suicide attempts, suffered from three or more severe mental health issues during the past three months, or requested help in any of these areas. Students who answered yes to any question were considered positive screens for the purpose of this study. Positive screens were then further evaluated using applicable sections of the Diagnostic Interview Schedule for Children (DISC 2.3).

Researchers next contacted school professionals (including administrative staff, nurses, guidance counselors, and social workers) concerning their impressions of the suicide risk potential of the students who screened positive. To preserve participant confidentiality, teachers were excluded from this study, even though they might be the school professionals in the best position to accurately identify students at risk for suicide.

Seventeen boys with conduct problems and higher levels of callous-unemotional traits such as lack of guilt and empathy were compared to a control group of 13 boys. Callous-unemotional traits are associated with psychopathy in adults. When presented with blocks of neutral or fearful faces, the group with higher levels of callous-unemotional traits manifested lesser right amygdala activity to fearful faces. The study anticipated this finding because the popular model of psychopathy in adults suggests that individuals with higher levels of callous-unemotional traits do not process visual and auditory presentations of fear and sadness.

Even though this model is generally accepted, only one previous study has been conducted on the relation between the amygdala and callous-unemotional traits. Amygdala functioning is associated with, and may be responsible for, the ability to empathize. This study concludes that antisocial behavior is largely heritable and that psychopathy is a developmental disorder that can be diagnosed in children, even if such a diagnosis may prove unethical. ■

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CHILD-SERVING SYSTEMS, from page 72

a family advocate, the probation director, a representative from the New York State OMH, the RTF administrator, and the SPOA/A director. It is the SPOA/A team's job to resolve any issues presented, implement services, and manage any follow-up. If the team is unable to resolve issues at the table or has exhausted all services/resources, or if its recommendation was to make an RTF referral, the oversight committee steps into the process.

CANS Readministrations/Follow-Up. CANS assessments are readministered only for those children identified as high risk and high need. If a child who was originally deemed low risk demonstrates decompensation, the CANS will be readministered. Readministrations occur 60, 120, and 180 days after initial assessment until discharge, and at discharge. This is an SPOA/A process of monitoring progress and evaluating care effectiveness. More specifically, the SPOA/A will:

- Maintain continuous utilization review of cases for program efficacy (readministrations of the CANS);
- Complete quarterly reports on capacity expansions (reporting to the state);
- Use a performance management system via readministrations of the CANS;
- Monitor inpatient utilization and hospitalization slots, and manage RTF slotted beds;
- Collaborate with the OMH on screening and level of care determination tools and

receive technical assistance in piloting the single point of access;

- Use outcomes evaluation and management;
- Access web-based clinical and administrative decision support via the C-Info database;
- Actively use evidenced-based practices; and
- Oversee satisfaction surveys administered to the child and family.

Impact of the Initiative

As envisioned, SPOA/A and the use of the CANS assessment can potentially have several significant impacts upon all services offered to the community. The first significant impact will be a reduction in the demand for institutional level-of-care beds. As the partnerships evolve, a stronger trust will develop among families, providers, and governmental purchasers of services. This will be supported by more focused, individualized services rather than the current one-size-fits-all approach to program delivery.

At the local level, the System of Care values and principles will be the guiding force to assist the partners and providers in changing the focus from control to one of a supportive movement to ensure a brighter and more productive future. We can begin to create an environment that promotes and supports change. Youths and families will begin to feel secure and connected with the partners and providers to achieve the goal of community connection and support required to maintain the same.

At the state level, with the systematic and regulatory reform changes made, partners and providers can begin to open up different, nontraditional ways to deliver services. This can create an energy that may motivate other communities to make changes in these types of services. Replication is a strong possibility as we begin to demonstrate how change can better assist our families, children, and communities from both a quality-of-life and a fiscal point of view.

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IMPROVING OUTCOMES, from page 68

Other programs have also been influenced by Wraparound. California Assembly Bill 1453, Residentially-Based Services (RBS), passed in 2007, authorizes the implementation of alternative program and funding models to transform residential care from long-term placements to planned, short-term, and individualized interventions. These interventions combine needs-specific treatment with integrated "follow-along community-based services" to reconnect youth with their families, schools, and communities. Assembly Bill 1453 was influenced by Los Angeles County's Residential/Wraparound pilot program

in 2003 that infused Wraparound with residential care.

Thus, Wraparound principles and practice will soon influence the nature of residential care in Los Angeles County. RBS will focus on youth who are currently in or identified for high-level residential care placements (i.e., RCL 12 or 14). The residential care providers selected for the demonstration project will integrate the principles and practices of family finding, family engagement, and Wraparound within their residential care programs to increase the effectiveness and reduce the length of residential stays. The integration of Wraparound into residential care will help complete the transformation already underway in many residential care programs

in Los Angeles County from a deficit-based, facility-driven model to a strength-based, family-driven model functioning largely within the community. The lessons learned from the RBS demonstration project will inform planning for statewide implementation of RBS reform that is due to the California Legislature in 2011.

Conclusion

Wraparound is providing promising options for service delivery that supports youth with high level needs in Los Angeles County. Our study has shown improved outcomes in maintaining youth with their families and in their communities and in

See IMPROVING OUTCOMES, see next page

IMPROVING OUTCOMES, from page 74

helping assure their safety, permanency, and well-being. Wraparound has also reduced the costs associated with providing this level of care in the community rather than in a residential setting.

The results of this study build upon the existing, and rapidly expanding, Wraparound research base concerning placement outcomes. It is essential that we conduct rigorous evaluations of Wraparound services in Los Angeles County, the largest and one of the most urban settings in California, and we are currently planning such an evaluation.

In addition, the integration of the Wraparound model into residential care has far-reaching implications in the training of children's social workers in Los Angeles County and the transformation of the very nature of residential care in California. Wraparound has the potential to play an even more important and expanding role in the field of child welfare in delivering services to vulnerable populations, including youth with complex emotional and behavioral needs.

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CALENDER, from page 76

- 13** **Responding to the Workforce Crisis in Child Welfare Supervision for Success.** Nashville, TN. Sponsor: Child Welfare League of America (CWLA). Website: www.cwla.org
- 14** **Responding to the Workforce Crisis in Child Welfare Supervision for Success.** Thomasville, NC. Sponsor: Child Welfare League of America (CWLA). Website: www.cwla.org
- 15–18** **The Division for Early Childhood (DEC) 25th Annual International Conference on Young Children With Special Needs and Their Families.** Albuquerque, NM. Sponsor: Division for Early Childhood (DEC). Website: www.dec-sped.org
- 25–29** **21st Annual National Dropout Prevention Network Conference.** San Antonio, TX. Sponsor: National Dropout Prevention Center. Website: www.dropoutprevention.org
- 27–Nov 1** **56th Annual Meeting of the American Academy of Child & Adolescent Psychiatry.** Honolulu, HI. Sponsor: American Academy of Child & Adolescent Psychiatry (AACAP). Website: www.aacap.org
- 28–31** **83rd Annual American School Health Association Conference: Healthy Kids, Healthy Lives, Healthy Futures.** Denver, CO. Sponsor: American School Health Association (ASHA). Website: www.ashaweb.org/i4a/pages/index.cfm?pageid=3315

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- 2–5 **23rd Annual Conference on Treatment Foster Care.** Atlanta, GA. Sponsor: Foster-Family Based Treatment Association. Website: www.ffa.org
- 3–6 **School Health Interdisciplinary Conference (SHIP): Charting the Course for Our Children's Future.** Ellicott City, MD. Sponsor: Center for School Mental Health. Website: http://csmh.umaryland.edu/conf_meet/ship/index.html
- 6–9 **117th Annual Convention of the American Psychological Association.** Toronto, CAN. Sponsor: American Psychological Association (APA). Website: www.apa.org
- 11 **Responding to the Workforce Crisis in Child Welfare Supervision for Success.** Nashville, TN. Sponsor: Child Welfare League of America (CWLA). Website: www.cwla.org
- 12 **Responding to the Workforce Crisis in Child Welfare Supervision for Success.** Thomasville, NC. Sponsor: Child Welfare League of America (CWLA). Website: www.cwla.org
- 19–22 **National Association of Counsel for Children 32nd National Juvenile and Family Law Conference.** New York, NY. Sponsor: National Association of Counsel for Children. Website: www.naccchildlaw.org/?page=National_Conference

September

- 21–24 **2009 National Alliance for Drug Endangered Children Conference.** Spokane, WA. Sponsor: National Alliance for Drug Endangered Children (NADEC). Website: <http://www.nadec-conf.org/>

October

- 8–10 **21st Annual CHADD International Conference on AD/HD.** Cleveland, OH. Sponsor: Children and Adults with ADHD (CHADD). Website: www.chadd.org/Content/CHADD/Conferences_Training/Calendar_of_Events/default.htm

see CALENDER, page 75

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