UNIVERSITY OF CALIFORNIA, SANTA BARBARA
GRADUATE SCHOOL OF EDUCATION

UCSB MISC Program Evaluation Summary 1994–2000

Santa Barbara County

Multiagency Integrated System of Care

Family–Community Collaborative Serving Youth with Emotional and Behavioral Disorders

Information collected through June 2000

UCSB-MISC Evaluation Summary 1994-2000

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Local Heroes

MISC would not have been possible without the vision and leadership of the County Board of Supervisors, the Department Directors, and the cooperation of the County's school districts.

Board of Supervisors:

Naomi Schwartz, 1st District
Susan Rose, 2nd District
Gail Marshal, 3rd District
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Charlene Chase, Social Services
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Myrna Gaskin, Public Health

County Superintendent of Schools:

Bill Cirone, Santa Barbara County Superintendent of Schools

This project was completed as part of the evaluation of Santa Barbara County's Multiagency Integrated System of Care (MISC). MISC was originally funded by a grant (No. 6-HS5SM51592-01) from the Centers for Mental Health Services, a principal operating component of the Substance Abuse Mental Health Services Administration, within the U.S. Department of Health and Human Services. Its contents are soley the responsibility of the authors and do not necessarily represent the official views of the Centers for Mental Health Services or Santa Barbara County Alcohol, Drug, and Mental Health Services.

Forward

In the Spring of 1994, Dr. Todd Sosna came to UCSB seeking support for the development of a grant proposal to the federal Center for Mental Health Services to implement a cross agency service program for youth with emotional and behavioral disorders and their families. Having previously worked as a school psychologist in special classes for students with emotional disturbance, Dr. Furlong had an immediate interest in this exciting possibility. Dr. Casas, having served on the County Mental Health Commission, also recognized the need to improve and expand mental health services to youth. What seemed like a long-shot at the time became a reality. The influx of federal support to implement a system of care model started a process that has resulted in fundamental structural changes in the way that youth and their families are served in Santa Barbara County. This, of course, has become known as the Multiagency Integrated System of Care (MISC) program.

When MISC began in the fall of 1994, it seemed that the end of the grant cycle was far off. Now some six years later, it all seems too brief. Despite the many challenges that remain, these six years have changed the way that agencies work together, fund services, and think about service planning. Most commendable to the many managers and treatment staff: MISC is not going away. There is a continuing desire to develop and implement more meaningful and relevant services to youth with emotional and behavioral disorders and their families. Equally encouraging, MISC and the system of care, family-friendly, strength-based model have been embraced by other youth-serving efforts in the County. Building upon and enhancing the MISC model, County Juvenile Probation has secured two substantial grants to serve youth who have a need for their services.

It has been our distinct honor to have been a part of MISC. We express our appreciation to all of the UCSB staff who helped implement the evaluation component of MISC. We especially acknowledge the leadership, passion, and creativity that Dr. Michelle Woodbridge provided during the critical first three years of the project. We can never say thank you enough or express the esteem in which we hold her and her efforts for MISC.

We also want to express our recognition of Dr. Todd Sosna for the vision and passion that he gave to the MISC federal grant from its inception to its completion. His efforts truly helped change the possibilities for every youth with emotional and behavioral disorders in Santa Barbara County.

We do not have the space to thank all people who contributed to the MISC evaluation. The esteem we have for the managers, care coordinators, assessment staff, and other service providers and support staff is immense. They made MISC work. MISC would not have flourished and survived without the commitment of public and private agencies, administrators and staff, who do the important work of MISC. A special thanks for putting up with all of the fiscal management of MISC is extended to Rae Miesbauer, Anotina Gauer-Stupak, Paula Ryan, and Michael O'Neil for their friendly and invaluable support. Finally, we want to thank Dean Jules Zimmer and Chancellor Henry Yang for their recognition of MISC as a valuable university-community collaboration and by helping to make UCSB's resources available for this project.

Michael J. Furlong
J. Manuel Casas

Santa Barbara County MISC

Multiagency Integrated System of Care

What is MISC?

The Multiagency Integrated System of Care (MISC) began as a federally-funded youth mental health collaborative in Santa Barbara County.

How did MISC come about?

Santa Barbara County applied for and received competitive funds from the Center for Mental Health Services in 1994, which provided resources to fully implement cross agency services to youth and their families. In Fiscal Year 2000, MISC will be a fully sustained service system.

Who does MISC serve?

MISC serves youth with serious emotional and behavioral disorders and their families who need services from two or more agencies. Enrollment into MISC is through the primary participating agencies: Child Welfare Services; Alcohol, Drug, and Mental Health; Probation; Public Health; Guadalupe School; and Santa Maria High School. When MISC began, approximately 200 youth were referred for mental health services. Six years later, more than 1000 youth and their families are being served.

What makes MISC unique?

Interagency Collaboration
Collocated Staff
Parents as Partners
One-Stop Services
Flexible, Individualized Services
Single Assessment and Service Plan
Focus on Strengths
Culturally Competent Services
Primary Care Coordinator
Systemic Outcome Evaluation
Services in Home/School

UCSB MISC Evaluation Team

The evaluation of the MISC project was organized by researchers from the Graduate School of Education at the University of California, Santa Barbara in cooperation with the MISC agencies and participating families.

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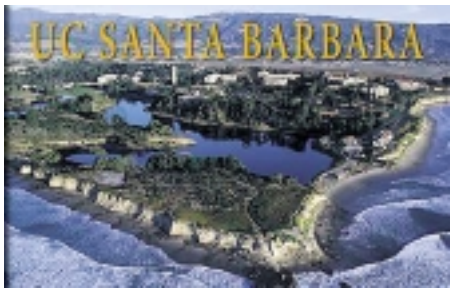

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UCSB

Introduction

Purpose

The purpose of this MISC Evaluation Report is to compile information that informs Santa Barbara County and others about the status of the MISC after six years of implementation.

Procedure

This MISC Evaluation Report is a collaboration between the UCSB MISC evaluation team, MISC partner agencies, MISC service partners, and MISC parents.

Why System of Care?

Jane Knitzer's (1982) groundbreaking publication, *Unclaimed Children*, revealed that, at that time, approximately two million of the three million children with serious emotional disturbance in the United States received no treatment at all, and many others received excessive and inappropriately restrictive care. Problems have been identified in the literature emphasizing the need to create a children's mental health system that would be more responsive to children and families in need. For many children and families, traditional outpatient and inpatient care are ineffective for a variety of reasons. These families may require assistance with the demands of daily life, including school problems, housing problems, economic hardships and many other survival-based needs (Knitzer, 1993). Overwhelmingly, the consensus is that it is necessary to develop coordinated systems of care to provide the essential range of services to effectively meet the needs of these youth and their families who are falling through the cracks in the existing fragmented mental health system.

Introduction to Systems of Care Concept

In response to the above-mentioned inadequacies, a national movement arose in the children's mental health field. This action has been the federally-supported development of child-centered, family-focused, community-based and culturally competent systems of care for youth with emotional and behavioral disorders (EBD) and their families. These systems of care consist of continuums of treatment with arrays of services offered in various settings (Stroul & Friedman, 1986). Through the Federal government's establishment of the *Child and Adolescent Service System Program* (CASSP) in 1984, awareness and understanding of the needs and strengths of these youth and families increased substantially. CASSP was created by Congress under the belief that the current mental health service system for this population was inherently fragmented and ineffective—children received services from a number of disparate agency providers including the departments of mental health, special education, child welfare, and juvenile justice. Furthermore, youth with the most severe problems were usually being served under one roof instead of by multiple agencies, which their needs dictated (Lourie & Katz-Leavy, 1992). CASSP's primary goal was to improve the way in which multi-service options were offered and made available to youth and their families with or at-risk of emotional and behavioral challenges.

A system of care was originally defined as being a comprehensive spectrum of mental health and other necessary services, which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with EBD (Stroul & Friedman, 1986). In addition to being a theory of service provision, the system of care concept is an implicit ecological theory of change. It is embedded within a larger social systems change theory that emphasizes the need to address context and environment in order to achieve desired therapeutic outcomes (Flam 1999).

Stroul and Friedman (1986) pioneered the movement towards integrating services for youth with EBD. These authors presented a conceptual framework for a comprehensive system of care that encompassed the full range of services and the mechanisms necessary to ensure their appropriate delivery. This framework has served as the "philosophical blueprint" for the national

Adobe building, La Purisima Mission, Lompoc

reform of mental health services for children, adolescents, and their families (Henggeler, 1994). Stroul and Friedman's (1986) original definition of a system of care is as follows:

A system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of severely emotionally disturbed children and adolescents. (p. 3)

System of Care Philosophy

Stroul and Friedman (1986) envisioned systems of care as emphasizing comprehensive and individualized services provided within the least restrictive environment, full participation of the families involved, and coordination among all agencies and programs serving youth. The system of care concept, therefore, represents not just a network of coordinated services, but rather a philosophy about how services should be delivered to youth and their families. This philosophy was predicated upon specific core values, which call for developing service systems that are child-centered, family-focused, community-based, and culturally competent, as shown in Table 1 (Stroul & Friedman, 1986). In addition, the concept of systems of care extends beyond the concept of a continuum of services (Stroul, 1993). It also includes specific mechanisms, structures, and the processes necessary to ensure that services for youth are provided in a coordinated, cohesive, comprehensive manner, such as through interagency case review, case management, and system-level coordination of services. These are also shown in Table 1 (see page 8).

There are several components and specific characteristics that have been articulated to define systems of care for youth with serious emotional disturbances as described by Stroul and Friedman (1986). The following section describes these components and characteristics further.

Family Participation

Research demonstrates that family involvement is critical to successful outcomes for children, and system of care efforts recognize the valuable resources that families can bring to service delivery. The principle of family participation focuses on the system's responsiveness to families and family members' authentic involvement in service delivery and planning demonstrated by: (a) respect for families, (b) recognition of family strengths, (c) involvement of families in setting priorities, and (d) centering service delivery on the holistic, ecological needs of families. In addition, systems of care are intended to empower families, to be flexible to their changing needs, to utilize informal support networks, and to be culturally competent in their delivery of services to family members.

Integration and Coordination of Services

The system of care model was originally organized in a framework consisting of seven major dimensions of services. Each dimension represents an area of need for youth and their families. This framework includes these services: mental health, social, educational, health, vocational, and recreational. Children and adolescents with emotional disorders are often embedded in several of these service systems for support, guidance, and in some cases, mandated rehabilitation and treatment (Stroul, Pires, Katz-Leavy, & Goldman, 1994).

The system of care model was intended to be "function specific" rather than agency specific (Stroul & Friedman, 1986), therefore, each of these dimensions addresses a set of functions that must be completed in order to provide truly comprehensive services to meet the presenting needs of families. Accordingly, the original model does not specify which agency is expected to fulfill any specific functions or needs. Certain functions are more likely to be provided by particular agencies, such as educational services that are provided in schools. However, many services, such as mental health services, can often be provided by non-typical, and non-traditional sources such as community organizations like the Boys or Girls Clubs.

Increasing interagency coordination and collaboration in the planning, developing, and delivering of ser-

vices is a fundamental aspect of the system development initiative. The goal is to reduce the fragmentation that typically characterizes child and adolescent mental health services. Ideally, agencies and systems share responsibility for serving troubled youth for several beneficial purposes, including: (a) more comprehensive service planning and development, (b) joint financing and a reduction in service cost, (c) reduction of replication and increased coordination at a system level, and (d) collaborative problem solving and interagency treatment planning (Stroul, 1993).

A Continuum of Community Care

A critical structural component of systems of care is the development of broad continuums of community-based services for youth with emotional disturbance and their families. Many communities have designed innovative services such as intensive nonresidential and residential components that better address the needs of the youth and families they serve (Stroul, 1993). In this respect, such systems of care have been able to serve the needs of the youth and families within their home communities rather than sending the youth to out-of-home or out-of-county placements. This broad range of treatments has been termed a "continuum of care" (Stroul & Friedman, 1986) and is considered to be an essential aspect of a system of care. The continuum of care is intended to deliver needed services on an individualized basis and in a coordinated manner, using case management and interdisciplinary teams to integrate treatment programs and to facilitate transition between services (Bickman, 1996).

As indicated above, reducing the use of restrictive treatment environments and out-of-home placements is a critical goal of system development (Stroul & Friedman, 1986). There has been a clear historical pattern of over-utilization of costly and restrictive inpatient and residential treatment settings for youth with EBD (Sondheimer, Schoenwald, & Rowland, 1994). Attempting to create a wide array of services, which are intensive and community-based, allows communities to divert many youth from restrictive environments to services within their own communities, or better yet, within their own homes!

Partner Agencies

These agencies form the backbone of the MISC services:

Families
Schools
Alcohol, Drug & Mental Health Services
Child Welfare Services
Probation
Public Health
Community Action Commission
Child Abuse Listening & Mediation
Council on Alcoholism & Drug Abuse
Family Service Agency
Santa Maria Valley Youth & Families

Strength-Based, Individualized Services

As all of the preceding discussion indicates, providing flexible, individualized services that are tailored to meet the unique needs of each child and family is a primary value and a broadly defined goal in system development. Developing systems of care can provide individualized services is a concept that has continued to evolve and expand from within the initial framework of "systems of care" set forth by Stroul and Friedman (1986). The philosophy and values of current individualized services are similar to the original conceptualization of systems of care; however, there are several unique aspects to Santa Barbara's System of Care. Youth with EBD are considered eligible for services no matter how serious, complex, or difficult the problems may be. In addition, once youth are found

Rustic gardens, Lompoc

to be eligible for services, a commitment is made that s/he will be terminated from services as a result of challenging or problematic behaviors. This commitment to unconditional care often can break the cycle of rejection that many of these troubled youth experience (Burchard, 1988).

Individualized services draw upon all available resources for youth and their families: formal and informal, traditional and nontraditional (e.g., enlisting family members or friends as "service providers"). The process of individualizing services entails a thorough, ecological assessment, completed by the case manager and interagency team that identifies strengths and needs of the youth and families in all life domains. This precedes and facilitates the development of a comprehensive individualized service plan, or wraparound plan, which reflects the specific needs and strengths of the youth and family (Clarke et al., 1992).

System of Care Program Goals

Better Child and Family Outcomes

Embedded in the overall guiding philosophy of systems of care are specific goals intended to address outcomes, such as family and child functioning in several life domains and cost effectiveness. Outcome evaluation studies have become a major investment of recent federal efforts to assist states and communities to develop systems of care. The Child, Adolescent and Family Branch of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) has played a significant role in financially supporting the development and evaluation activities of emerging systems of care. All systems of care that were funded in the same cycle with Santa Barbara County were required to complete a comprehensive and longitudinal evaluation of child and family outcomes. The outcome evaluation studies include the following: (a) methods that were approved by Congress and intended to be child-centered and strength-focused, (b) national evaluation of these sites with MACRO, International leading the efforts as the consultants in Atlanta, Georgia, and (c) data collected at intake, six months, and then yearly throughout the duration of the five-year projects. The evaluation efforts gathered information in the following domains: (a) child and family demographics and risk factors, (b) juvenile justice and educational performance indicators, (c) mental health and behavioral outcomes, (d) youth and family satisfaction, (e) service provider and staff satisfaction, (f) family empowerment, and (g) restrictiveness of placement.

Cost Effectiveness

In addition to improving behavioral outcomes, systems of care are intended to be designed to achieve these outcomes in a cost-effective manner. Containing and reducing costs for services have been demonstrated by such strategies as reallocating existing funds from expensive out-of-home care to in-home and prevention-oriented services (Meyers, 1994). In 1987, three California counties were legislatively enabled, via Assembly Bill 377 (AB377) to replicate an innovative system of care model implemented in Ventura County, California. These three California counties (San Mateo, Santa Cruz, and Riverside) are collectively referred to as the "AB377 counties." In a preliminary evaluation of the AB377 counties' systems of care, Rosenblatt and Attkisson (1993) found that foster home and state hospital utilization and overall expenditures were lower for the counties replicating the innovative system of care than for the state of California as a whole. However, only one county, Santa Cruz, actually reduced their overall expenditures whereas the other two counties expenditures remained approximately the same. This may, however, be a result of communities identifying and serving more youth with EBD. Furthermore, in preliminary cost studies of the system of care in Santa Barbara County, findings demonstrated reductions in per capita group home expenditures with total estimated cost savings of approximately $3.4 million.

Table 1: System of Care Values

Core Values for the System of Care

1. The system of care should be child-centered, with the needs of the child and family dictating the types and mix of services provided.

2. The system of care should be community-based, with the locus of services as well as management and decision-making responsibility resting at the community level.

Guiding Principles for the System of Care

1. Children with emotional disturbance should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.

2. Children with emotional disturbance should receive individualized services in accordance with the unique needs and potentials of each child and be guided by an individualized service plan.

3. Children with emotional disturbance should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbance should be full participants in all aspects of the planning and delivery of services.

5. Children with emotional disturbance should receive services that are integrated, with linkages between child-caring agencies and programs and mechanisms for planning, developing, and coordinating services.

6. Children with emotional disturbance should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.

7. Early identification and intervention for children with emotional problems should be promoted by the system of care in order to enhance the likelihood of positive outcomes.

8. Children with emotional disturbance should be ensured a smooth transition to the adult service system as they reach maturity.

9. The rights of children with emotional disturbance should be protected, and effective advocacy efforts for emotionally disturbed children and youth should be promoted.

10. Children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Note. From Stroul, B., & Friedman, R. (1986). ***A system of care for severely emotionally disturbed children and youth*** *(Rev. ed.). Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center.*

Water fountain, La Purisima Mission, Lompoc

Contemporary Systems of Care

The need for systems of care for emotionally disturbed youth was initially documented over a decade ago, yet only recently have local system of care programs been documented that combine existing community-based services, case management, and interagency collaboration (Behar, 1992; Vermont, 1993). These systems of care are being supported by the Federal, State, and private provisions of funding mentioned previously that have been made available specifically to facilitate this systems change process.

Target Population

In current systems of care, most communities target children and adolescents who are considered to be most in need of services (Stroul, 1993). The three California AB377 counties mentioned earlier defined their target population by both clinical severity and risk status, other system of care programs, such as the *Oregon Partner's Project,* prioritized youth whose emotional impairments put them at immediate risk of placement in a restrictive environment (Stroul, 1993).

The System of Care theory, as presented by Stroul and Friedman (1986), moved toward an ecological approach to serving youth with EBD. In addition to calling for structural changes, such as a continuum of care and integrated, coordinated services, they articulated the need for services to be provided with: (a) the close involvement of family members at all points in the process, and (b) the development of individualized and culturally competent treatment plans that are based on strengths of the youth and family as well as on their needs. In addition, they emphasized the need for services to be provided in an integrated, comprehensive, and holistic manner (Stroul & Friedman, 1986). Thus, this theory encourages service systems to open their doors to family members, to redefine strengths and needs, and to restructure their service approach—all requiring extensive systems change and adaptation.

The purpose of these principles was to provide general guidelines for communities nationwide to consider in developing service delivery mechanisms appropriate to the needs of children and families in their respective communities.

Santa Barbara County's Multiagency Integrated System of Care

Santa Barbara County's Multiagency Integrated System of Care (MISC) was established in 1994 upon receiving a federal grant from the CMHS. It was selected as one of more than 50 sites nationwide to implement this innovative service delivery model for youth with emotional and behavioral disorders and their families. At its onset, MISC consisted of county mental health, public health, child welfare services, probation, public schools, county drug and alcohol program, families, and other community-based liaisons (e.g., recreation). Staff from each of these partner agencies have been redirected as MISC personnel and serve as service providers (e.g., caseworkers, assessment coordinators, therapists) for this project. Consistent with Stroul and Friedman's (1986) premises, the mission of this interagency endeavor is to provide coordinated and comprehensive community-based services appropriate to the individual needs of youth and their families in the least restrictive setting possible.

MISC Youth Demographics—An Overview

The following section presents demographic information for MISC youth: age, gender, and ethnicity compared *by time frame*. That is to say, two groups are represented in each of the following graphs: (a) youth first enrolled between 1994 and 1998 (i.e., under the federal evaluation period), and (b) youth first enrolled between 1999 and June 2000 (i.e., under the current state evaluation—referred to as 1999-Present in this report).

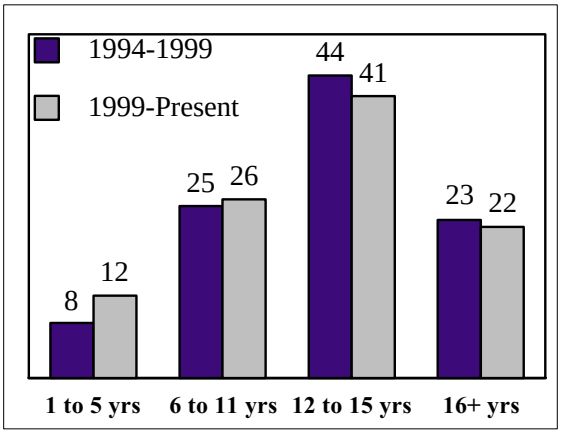


FIGURE AGE. *Percent of youth, by time frame, in age category at time of intake.*

Age

The average age of youth for both groups (i.e., 1994-1998 and 1999-Present) was about 12 years (total number reporting = 840 and 681, respectively). As seen in *Figure Age*, the largest proportion of youth from each group entered MISC between the ages of 12 to 15 years. In contrast, the smallest proportion of youth from each group entered MISC between 1 to 5 years of age. In considering the gender breakdown, the between group similarities continue: 66% male and 34% female (1994-1998) and 64% male and 36% female (1999-Present).

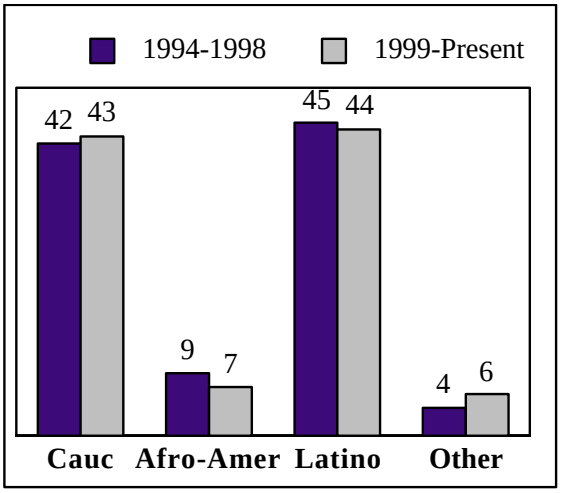


FIGURE ETHNICITY. *Percent of youth, by time frame, in ethnicity category at time of intake.*

Ethnicity

The population of children living in Santa Barbara County is made up of 45.2% Caucasian, 47.2% Latino, 2.6% African American, 4.5% Asian/Pacific Islander, and 0.5% Native American youth. These county figures are similarly reflected in the MISC youth for both the 1994-1998 (total reporting = 797) and the 1999-Present groups (total reporting = 747) with Caucasian and Latino youth comprising the bulk of these respective groups. *Figure Ethnicity* summarizes each MISC group.

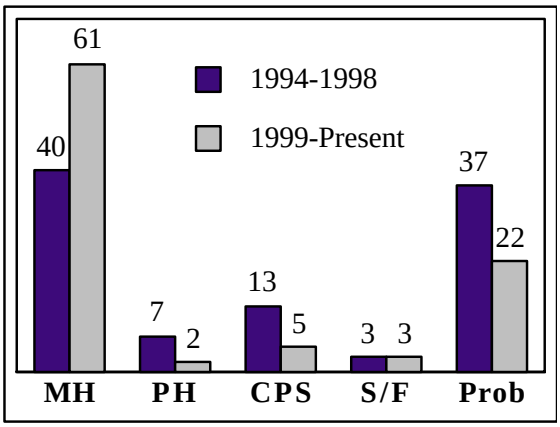


FIGURE GATEWAY. *Percent of youth, by time frame, in gateway category at time of intake.*

Gateway

Although all clients in MISC are open to mental health services, only some youth are primarily referred to MISC via Mental Health (i.e., some clients enter MISC through probation or social services). *Figure Gateway* presents the percent of MISC youth (for each time frame group) who enter MISC, by gateway. For the 1994-1998 group, 398 youth are represented; for the 1999-Present group, 219 youth are represented. Note that abbreviations in the graph are: MH = Mental Health; PH = Public Health; CPS = Child Protective Services; S/F = School or Family Program; Prob = Probation.

In 1998, MISC identified the following goals:

Healthy Youth

All youth will have access to health care and all health conditions will be managed to the extent possible. Treatment and medical guidance follow-through are a priority.

Safe Youth

All youth will live in safe homes and communities. Children will not be victims of child abuse (sexual, physical, or neglect). Improved judgement of youth living in high crime areas will be increased so that crimes related to sexual harassment or date rape will be reduced.

Residing with Family

All children will live with their family or extended family.

Learning in School or Working

All youth will attend school and will benefit from attendance. Knowledge will increase. If working, youth will have regular attendance and find some enjoyment from their job.

Abiding by the Law

Youth will not violate the law. If they violate the law they will respond favorably to probation interventions.

Supportive Relationships with Others

All youth will have the skills necessary to develop healthy, mutually supportive relationships with others. They will not be involved in unhealthy, exploitive relationships.

To monitor these goals, MISC has created coordinated service delivery, provided a continuum of local service options, and evaluated the process and outcome of the project.

MISC Cornerstones

Interagency Collaboration in a System of Care

Collocation of public and private service staff

Single point-of-contact case management

Shared treatment planning and resources

Family Participation

Family mentors collocated at MISC sites

Mandatory staff training on family strengths conducted by family members

Family membership on the MISC Advisory Council

Flexible, Individualized Services

Single, individualized, cross agency service plan

Strength-based assessment

Access to school-based and home-based services

Systematic Outcome Evaluation

Integrated clinical assessment and outcome evaluation

Longitudinal collection of data

Results of outcome evaluation used to improve service delivery and manage cost

Description of MISC Assessments

Instruments Completed by the Caregiver

1. Child Behavior Checklist (CBCL)

The CBCL is designed for children aged 4 to 18, and is given to parents to complete (Achenbach, 1991a). The instrument is comprised of two sections. The Competence section measures a child's social competence by asking the parent(s) to provide information about the activities in which their child most enjoys participating. The Problem Behavior section is comprised of 113 items that assess the extent of behavioral and/or emotional problems. Parents respond to questions on a three-point scale (from "0" if the item is not true of their child, to "1" if the item is sometimes true, to "2" if the item is very or often true of their child). The CBCL profile provides nine syndrome scales (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Sex Problems, Delinquent Behavior, Aggressive Behavior) as well as an Internalizing Score (sum of Withdrawn, Somatic Complaints, Anxious/Depressed), and Externalizing Score (sum of Delinquent Behavior and Aggressive Behavior), and a Total Problem Scale (sum of all scales).

2. Family Satisfaction Questionnaire (FSQ) and Client Satisfaction Questionnaire (CSQ-8)

The FSQ measures family satisfaction with services. This instrument also measures the family's perception of involvement in their child's care and the unconditional nature of the services provided. The second section focuses on the parent or caregiver's satisfaction with specific characteristics of treatment and with specific services received. Items are based on a combination of three- and five-point Likert type scales. The CSQ-8 (similar in form and content to FSQ) replaced the FSQ when a statewide evaluation was mandated in California (April, 1998).

3. Family Empowerment Scale (FES)

The FES is a 34-item questionnaire designed to measure parent/caregiver perceptions of roles and responsibilities within their local service systems and their ability to advocate on behalf of their child(ren) with emotional or behavioral problems. All questions are on a five-point Likert scale (ranging from not true to very true). Three subscales are produced yielding information on Family (perceived ability to take care of family), Systems (perceived ability to navigate local systems), and Community/Political (perceived ability to influence quality of care in the community).

Instruments Completed by the Staff

1. The Client Information Worksheet (CIW)

The CIW asks the staff to provide information on four domains: Child and Family Descriptive Information, Service Utilization, Educational Attendance and Performance Indicators, and Juvenile Justice and Law Enforcement Indicators.

2. Child and Family Risk and Resiliency Index (RRI)

The RRI is designed to measure the historical occurrence of child and family risk factors. The clinician is asked to indicate the current negative impact of that risk factor on the client's current functioning (mild/none, moderate, or severe). In addition, the current school performance, educational placement and characteristics of home environment (number of adults, children, bedrooms and bathrooms in household) are assessed. The clinician is also asked to measure how much certain resiliency factors are a strength or resource that aid in the child's current functioning.

3. Child and Adolescent Functional Assessment Scale (CAFAS)

The CAFAS (Hodges, 1994) is designed to rate how well children and adolescents are functioning in different life domains (ages 6 through 17 years). These domains include Role Performance at Home, School and in the Community; Behavior Toward Others; Moods/Self Harm; Substance Use; and Thinking (ability of youth to use rational thought processes). A clinician rat-

ing in each area indicates severity of impairment. Category ratings are totaled for each domain to produce a Total Dysfunction Score from 0 to 150 (based on 5 scales, 0-30 for each scale). The clinician rates the most severe impairment in each domain over the past three months on a rating system with 30 being equal to severe impairment, 20 being equal to moderate impairment, 10 being equal to mild impairment, and 0 being equal to minimal or no impairment.

4. Residential Living Environment and Placement Stability Scale (ROLES)/Client Living Environment Profile (CLEP)

The ROLES rates the types and restrictiveness of a youth's current living environment and produces a mean restrictiveness score for previous placements. This measure lists a variety of potential placements and living environments, and the restrictiveness of each setting is measured on a scale ranging from 0.5 to 10. A score of 0.5 represents the least restrictive setting (i.e., independent living) and 10 represents the most restrictive setting (i.e., adult correctional facility). The stability of placements is assessed by the number of days spent in each residential setting and the number of total placement changes over the same specified measurement. The CLEP (similar in form and content to ROLES) replaced the ROLES in the California statewide evaluation study (implemented in April, 1998).

La Purisima Mission, Lompoc

Instruments Completed by the Youth

1. Youth Self Report (YSR)

The YSR is based on the CBCL. It is filled out by youth ages 11 to 18 as a measure of their perception of functioning on several dimensions (Achenbach, 1991b). Like the CBCL, the YSR is divided into two sections. The Competence Scales section is comprised of two sets of items, resulting in an Activities Scale score and a Social Scale score. This measures their perception of their participation in activities, social support, and performance in academic subjects. The Total Problem Scales section consists of eight scales (Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior).

An additional syndrome scale that is scored only for boys on the YSR is designated as Self-Destructive/Identity Problems. The YSR also provides an Internalizing, Externalizing and Total Problem Score.

2. Youth Satisfaction Questionnaire (YSQ)/YSQ-5

The YSQ assesses the youth's satisfaction with services, perception of involvement in treatment planning, and perception of unconditional care within the system of care. Another section focuses on youth's satisfaction with specific characteristics of treatment and with specific services received. A shorter version,YSQ-5, replaced the YSQ in the California statewide evaluation study (implemented in April, 1998).

3. MISC Local Supplement

This instrument (for youth ages 11-18) measures the frequency of substance use in the past six months.

The Likert scales reange from "never" (1), "a few times" (2), "once a month" (3), "every week" (4), to "once a day or more" (5). These items were taken from California's Student Survey of Adolescent Substance Use.

Instrument Completed by the Teacher

1. Teacher Report Form (TRF)

The TRF is also based on the CBCL. This measure is designed to obtain teachers' perceptions of the adaptive strengths and weaknesses of their students (ages 6 to 16; Achenbach, 1991c). The instrument provides an efficient means for comparing children's school functioning as perceived by their teachers. The TRF is also comprised of two sections. The first section entitled "Academic and Adaptive Functioning Scales" asks the teacher to rate the child's performance in academic subjects. The second section entitled "Syndrome and Total Problem Scales" asks the teacher to identify the incidence(s) of problem behaviors that tend to occur together as syndromes. The TRF contains the same eight scales as the Youth Self Report.

Summary of MISC Instruments Required by California Deparment of Mental Health (1999-Present)

1. The caregiver completes the: Child Behavior Checklist (CBCL) and the Client Satisfaction Questionnaire (CSQ-8)

2. The provider completes the: Child and Family Risk and Resiliency Index (RRI), the Child and Adolescent Functional Assessment Scale (CAFAS), and the Residential Living Environment and Placement Stability Scale (ROLES)

3. The youth completes the: Youth Self Report (YSR), and the Youth Satisfaction Questionnaire (YSQ-5)

Summary of MISC Instruments Required by CMHS (1994-1998)

1. The caregivers completed the: Child Behavior Checklist (CBCL), the Family Satisfaction Questionnaire (FSQ), and the Family Empowerment Scale (FES)

2. The provider completed the: Client Information Worksheet (CIW), the Child and Adolescent Functional Assessment Scale (CAFAS), and the Residential Living Environment and Placement Stability Scale (ROLES)

3. The youth completed the: Youth Self Report (YSR), the Youth Satisfaction Questionnaire (YSQ), and the MISC Local Supplement

4. The teacher completed the: Teacher Report Form (TRF)

MACI Analysis

As discussed earlier, MISC assessments completed, both under the federal evaluation and through the present (under the California State requirements), are largely ratings of youth behavior (e.g., the parent-rated CBCL and youth-rated YSR) or youth functioning (e.g., the clinician-rated CAFAS). Such measures give a variety of information on each youth, but they reveal little insight into overall personality structure or aid in the process of differential diagnosis, case conceptualization, and service planning. In contrast, personality assessments, such as the *Millon Adolescent Clinical Inventory* (MACI; Millon & Davis, 1993), yield such information and lend themselves to clinical practice, yet are not considered compulsory. The MACI, for example, has a unique configuration where separate scales assess more acute and transient clinical syndromes associated with Axis I disorders and more stable personality patterns associated with Axis II disorders. Similarly, the MACI can be computer scored and, in turn, generates a "clinician-friendly" report that details interpretive considerations, personality patterns, youth expressed concerns, clinical syndromes, and diagnostic hypotheses.

In this section, MACI data (available for a subset of MISC youth) are presented along with their youth and family risk factors (see pages 20-21 for detailed information on risk factors). This section concludes with, what the authors consider to be, broad implications for the incorporation of personality instruments into the overall existing assessment requirements.

MACI Data

Of the scales that comprise the three major domains of the MACI (Personality Patterns, Expressed Concerns, and Clinical Syndromes), those tapping affective and externalizing areas and self/other relationships were most frequently clinically prominent or present for MISC youth. For example, Family Discord (Expressed Concerns), Depressive Affect, Delinquent and Impulsive (all from Clinical Syndromes), and Unruly (Personality Patterns) were elevated for between 34% and 49% of the sample. *Figure MACI Scales* summarizes the elevated scales.

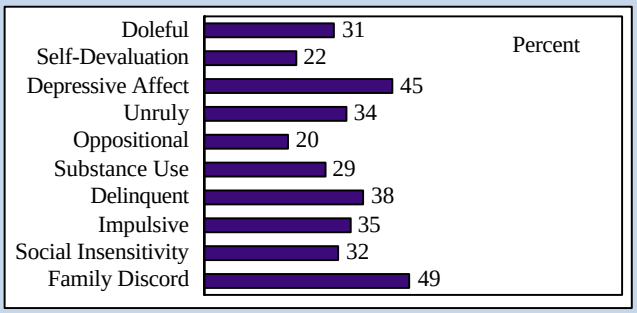


FIGURE MACI SCALES. *Percent of youth with elvevated MACI subscale scores.*

The range of youth and family risk factors that are prominent for MISC youth are numerous and, in fact, mirrored by information produced by the MACI. Suicide attempts (a youth risk factor) and history of substance abuse among family (a family risk factor) are present in 37% and 71% of the current sample, respectively. *Figure Child Risks* and *Figure Family Risks* summarize the family and youth risk factors for youth with MACI data.

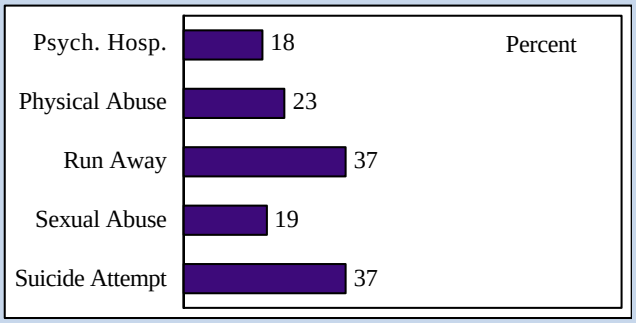


FIGURE CHILD RISKS. *Child risk factors.*

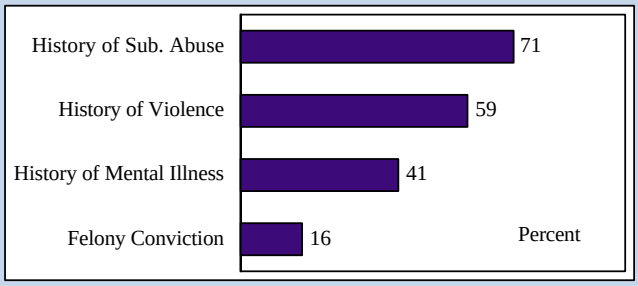


FIGURE FAMILY RISKS. *Family risk factors.*

Implications of Outcome Trends

The results of this preliminary analysis suggest that the risk factors present in the lives of these youth are mirrored by the MACI profiles. They are experiencing such troubling events as sexual and physical abuse, and a family history of mental illness, violence and substance abuse. Given that the highest mean scores from the MACI were on scales that correspond to such concerns (i.e., Family Discord and Delinquent Predisposition), the MACI scores seem to reflect well the genuine distress of these youth.

Examining the unique clinical profiles generated by such measures may help tailor specific treatment strategies to clients with particular characteristics within systems of care (i.e., a "precision of fit" or "best practices" approach). For example, are the differences in the treatment or services for youth who score high on Family Discord and Depressive Affect different from those who score high on Unruly and Family Discord? And will the different interventions have an impact on outcomes?

From a pragmatic perspective, broadening the scope of clinical assessments may have a differential impact on data collection and specifically, the problem of missing data. That is to say, while many factors contribute to the overall problems in obtaining state required assessments (e.g., families move, clinicians are overwhelmed with large amounts of paperwork), perhaps one important factor is that of their perceived utility and the associated clinician "buy-in." Clinicians may not see the intuitive use of Achenbach reports, for example, but may prefer the more "clinician-friendly" MACI computer-generated report. From this perspective, more research tapping into clinicians' perceptions of state-required assessments and their respective utility could inform administrators in their choice of instruments. For example, although the state may require CBCL data to be collected annually, if the clinician does not see this as a priority, these data may not be collected.

Dolphin sculpture at Stern's Warf

Data Collection Procedures

As data are the backbone of evaluation efforts at MISC, an efficient and effective data management system was created to enter, integrate, store, and manipulate data from multiple sources. This system has undergone several revisions and, as of June 2000, was transferred from UCSB to the County Alcohol, Drug and Mental Health Program for their independent use. The section that follows details the initial systems created for the UCSB office to interface with MISC sites.

At the time of intake, consent forms and intake assessments were completed on site. These documents were sent to the UCSB evaluation office and represent the beginning point of entry into the data collection system. Client demographic information along with the presence or absence of intake instruments was then entered into a FileMaker Pro database system (termed Client Datalog). This initial step enabled the evaluation office to track assessments received (and subsequently data entered) as well as track missing or uncompleted instruments (reports of missing/uncompleted instruments were easily generated in the Client Datalog and sent to the respective sites).

In addition to notification of missing instruments, the evaluation office notified each care coordinator as to what assessments were due (by time frame). That is to say, each month, care coordinators at each site received a report of (a) what client was due for an assessment, (b) the time frame of the assessment (e.g., six-month, one year, two year, etc.), and (c) a complete packet of instruments for youth, family, and staff to complete. In an effort to maximize the data collected, the process of assessment completion was created in a flexible nature (e.g., forms could be mailed to the client's home to be completed and mailed back; Spanish forms were available for those who were not native English speaking). Youth and family were paid $15 for completing the six-month assessments.

In sum, the use of the Client Datalog allowed the UCSB office to track (a) clients as they entered the system, (b) instruments completed by youth, family, and staff, and (c) missing or uncompleted instruments. Monthly reports generated from this database helped MISC staff at each site manage their assessment schedules and track missing instruments.

The following section turns attention to how instruments are processed once received in the UCSB office as well as the nature of the system ("RAIN") created to manage the data.

RAIN (information management)

To meet the demand for a high quality and efficient system, the UCSB evaluation team computer programmer, Prashant Rajvaidya, developed a new software program called RAIN. RAIN is a complete, standalone system designed for ease-of-use for evaluation staff.

RAIN has multiple functions, such as entering or editing data, creating custom reports, processing current data, and more. It is a multi-user networkable program, allowing users situated on different terminals to simultaneously work with the system. Specifically, RAIN is used to:

1. Manually input data or edit data previously entered for any assessment at any time frame.
2. Integrate and process the Mental Health billing and service data to create a variety of custom reports (these data are accessed directly from the Alcohol, Drug, and Mental Health Services Department).
3. Integrate and process probation data to create a variety of custom reports (as data are accessed directly from the Probation Department.
4. Create and electronically transfer the mandated Federal and State reports.
5. Cross-reference client identification numbers with the Client Datalog.
6. Prepare a complete and integrated data set for analysis in SPSS.

The primary data analysis software used is the Statistical Package for the Social Sciences (SPSS). SPSS is a program to generate statistical information based on a particular dataset. RAIN was created to convert all

data into a predetermined format and then merge these converted files into an SPSS dataset.

The hours involved in the creation of RAIN have greatly assisted the day-to-day operation of the evaluation effort. RAIN has been demonstrated at various meetings and conferences. As the federal evaluation period has ended, changes were made to RAIN to comply with California state requirements as well as changes to MISC.

The New System Begins

The original grant funding from the CMHS was for a five-year period, ending in August 1999. The MISC evaluation team used the last period of the grant to alter the system to continue evaluation for the California State Department of Mental Health Services (DMH).

On January 1, 1999 MISC stopped processing the assessment forms required by the federal grant and began collecting the data designated by the California Department of Mental Health. There are 7 forms in the California system, compared to the 10 forms previously used in the federal grant. These new forms are familiar– some have remained the same (CAFAS, YSQ, CBCL, and YSR), while the others are comprise of abridged versions of the old forms, streamlined to just the essential data (the Risk and Resiliency Index is a two-page replacement for the lengthy Client Information Worksheet). This makes the process of entering, analyzing, and filing data more effortless.

To facilitate the data system, the majority of the state required instruments were recreated with *Teleform*®. Teleform is a three-part software program that combines machine readable form design, form entry, and form verification and storage. Teleform facilitates rapid and accurate data entry.

Another step in the creation of the California data reporting system was overhauling RAIN. The State system has new requirements, so RAIN was revised to address these requirements and to offer more ease of use. New functions and features included data backup and retrieval, improved service data handling, easier data entry and editing controls, and a log system that tracks all the important actions enacted while in RAIN.

In May 2000 the California data management system was transferred to Santa Barbara County's Alcohol, Drug, and Mental Health Services central office, which now handles the data entry, tracking, and storage.

For information about MISC-RAIN please contact Prashant Rajvaidya: prash@cs.ucsb.edu

State Street, Santa Barbara

Goals and Outcomes

MISC's unique interagency structure and focus on family collaboration are reflected in the agency's goals. The breadth of perspectives in these goals encouraged a look beyond traditional mental health outcomes to instead capture functioning in multiple areas. Established in 1998 by the Santa Barbara Cross Agency Council, these goals represent the vision of MISC families and administrators and as such, do not necessarily parallel federally-required outcome assessments. In an effort to tie more closely program goals and various outcomes, the RRI was developed by the MISC evaluators to enhance the state required instruments. The RRI addresses both the risks and strengths of the youth and family as determined by clinician ratings. Preliminary results from the Risk and Resiliency Index (RRI) will be highlighted in this report (see page 25). In this section we (a) address the currently available outcomes associated with each MISC goal and, (b) present graphs to illustrate selected outcomes.

MISC Goals and Outcomes

Safe children

Residing with family in the community

Learning in school or working

Supportive relationships with others

Abiding by the law

Safe Children

MISC youth are often at risk for a number of negative life circumstances such as physical and sexual abuse, runaway episodes, and suicide attempts. Similarly, the family as a whole may be at risk for such events as psychiatric hospitalization, felony conviction of a caregiver, history of mental illness, family violence, substance abuse, or suicide attempts. *Figures Child Risk 94-98 through Family Risks 99-present* illustrate the percentage of youth and families with risk factors at intake. Based on this information, it becomes clear that drug and alcohol abuse, suicide attempts, physical abuse and run away behavior are of significant concern in their lives. These statistics are consistent with the direct service staff members' concerns that this population is at risk for a multitude of problems.

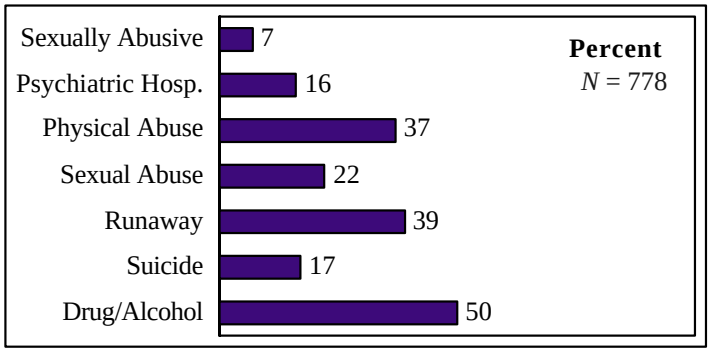
Residing with Family in the Community

Providing community-based services and striving to keep children placed at home are overarching goals of MISC. Though youth may at times be out of home, (e.g., in juvenile detention, foster care, or the hospital) the time there is minimized. At intake, 84% of youth are served either in the community or their own homes rather than out of the home, community or even out of the county. Not only does serving youth within the home or county work to contain costs, it also respects the importance of family in service delivery.

Learning in School or Working

The school environment provides youth with opportunities to learn academic material, socialize with peer groups, and gain a sense of mastery from various activities. MISC care coordinators tracked youth academic performance and school attendance over time. When compared to intake, the majority of MISC youth improved their academic performance after one year of services. Fifty-four percent of youth at one year (as compared to 41% at intake) were at an average or above average level. *Figure Academic* (p. 22) compares the level of academic performance attained by youth at the time of their intake and one-year follow-up time point. Based on this information, fewer youth are performing below average after one year in MISC.

FIGURE CHILD RISKS 94-98. *Child Risk Factor Data from 1994-1998*



Case files indicate that MISC youth have a history of numerous risk factors in their lives.

FIGURE CHILD RISK 99-PRESENT. *Child Risk Factor Data from 1999-present*

Drug and alcohol abuse continues to be a challenge for these youth. Additionally, both graphs represent high percentages of suicide attempts, physical abuse, and run away behavior.

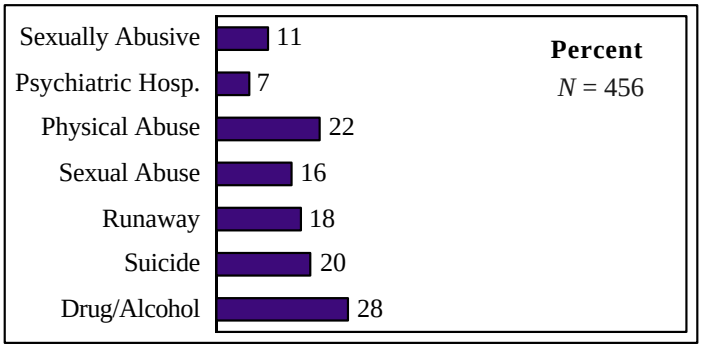
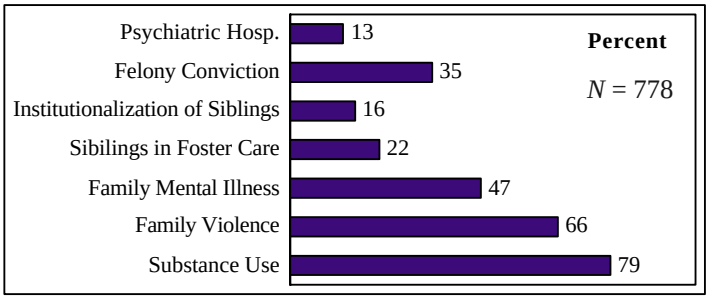


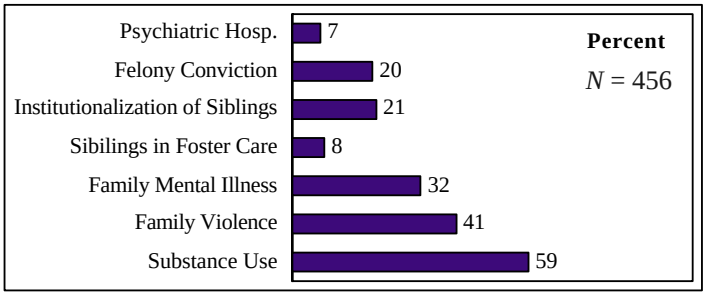
FIGURE FAMILY RISKS 94-98. *Family Risk Factor Data from 1994-1998*



Families have histories of numerous risk factors prior to participating in MISC. Substance abuse and family violence are particularly prevalent.

FIGURE FAMILY RISKS 99-PRESENT. *Family Risk Factor Data from 1999-present*

The majority of families have histories of substance abuse, and many have experienced domestic violence. In addition, more than one third of the caregivers have a history of mental illness.



Academic performance information was collected for the 201 youth that had intake and one year CBCL data. From this sample, data were available for 108 youth enrolled in MISC for one year. These data indicate that a larger percentage of youth are performing average in school since receiving MISC services. The variety of opportunities and services available through MISC may be positively impacting the academic performance of these students.

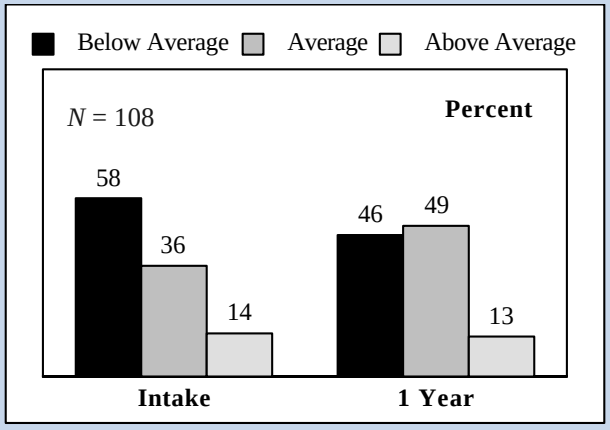


FIGURE ACADEMIC. *Academic outcomes over time.*

What Does the Offense Information Reveal?

Increases in "violations" during the MISC program represent probation violation referrals, not new offenses. This occurred at least in part due to the increased level of supervision made possible by the assignment of a case manager to each MISC youth. The actual number of new arrests decreased and 42.5% of the MISC youth had no new offenses or violations during months 7-12 of service.

By reviewing Santa Barbara County's Probation data, it was possible to track the number of probation referrals and sustained petitions that occurred during the first year of MISC participation and the number of sustained petitions before MISC enrollment. Data for 447 youths were available. The Pre-MISC (i.e.,12 months before MISC entry date) reflects sustained petitions. The 0-6 month and 7-12 month time periods reflect both sustained petitions and referrals. The graph indicates that the mean number of new referrals to probation of MISC youth decreased from 1.53 (before entry to MISC) to 1.37 (after one year of receiving MISC services).

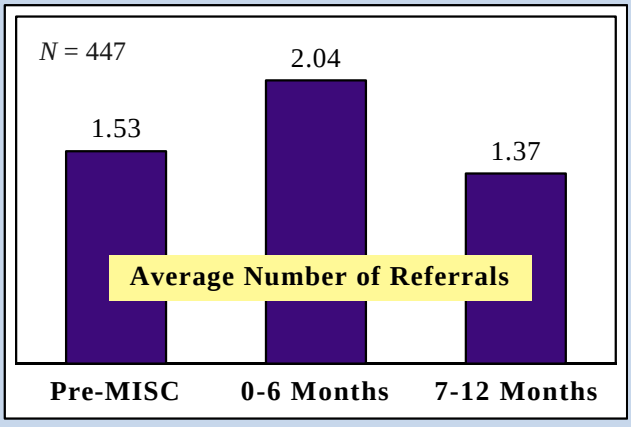


FIGURE PROBATION REFERRALS. *Mean number of referrals over time.*

Abiding by the Law

MISC's collaboration with the juvenile justice department has provided a unique opportunity to track youth involvement in the criminal justice system. Participation in MISC positively affected the rate of criminal behavior for youth involved in the project. The average number of offenses committed by youth during the year before entering MISC was 1.53; after 6 months, that number rose to 2.04, and during the next six months of service the average number of referrals decreased to 1.37. In addition to the number of referrals decreasing, the severity or the nature of the referrals lessened as well. For example, before entrance into MISC, 92% of the referrals of these youth were for felonies or misdemeanors. At the six-month follow-up point only 45% of the referrals were for felonies or misdemeanors and this fell to 32% at the one-year follow-up point. *Figures Probation Referrals and Crime Severity* present these data.

These data represent criminal referral patterns over time, specifically changes of MISC client's criminal records. All offenses decreased while clients received services from MISC. The number of felonies, the most severe offense, decreased from 22.4% of all pre-MISC referrals to only 9.2% after a year of receiving services. Figure Crime Severity also illustrates an increase in the number of no rerferrals from 26.4% during the first six months of receiving services to 42.5% after one year.

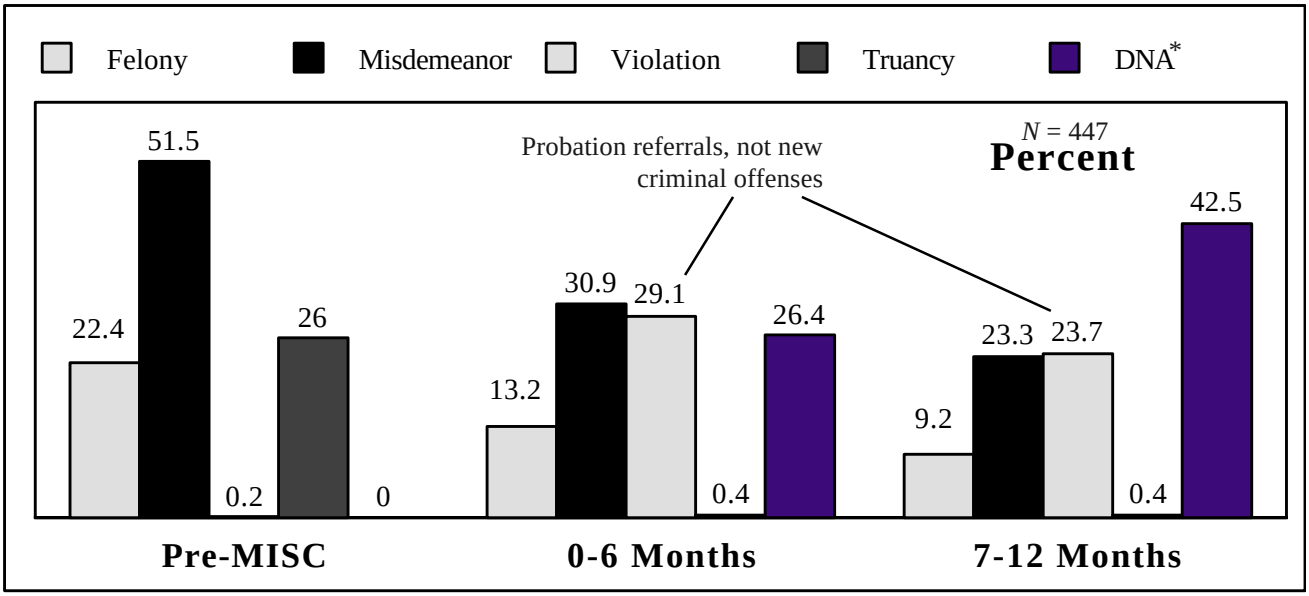


FIGURE CRIME SEVERITY. *Percent of MISC youth with new referrals by type of crime and by time of referral.*

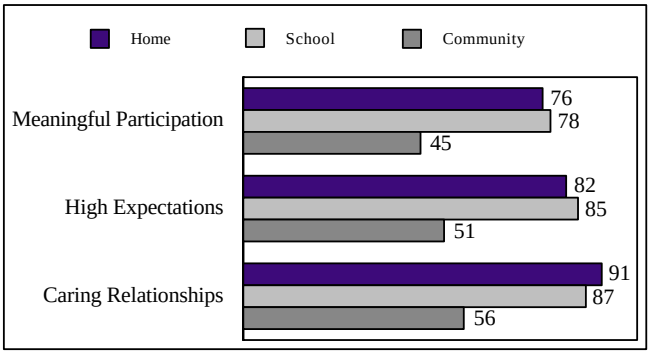


FIGURE RRI. *Percent of MISC youth with resiliency factors (Meaningful Participation, High Expectations, and, Caring Relationships) present.*

Supportive Relationships with Others

Caring relationships, a sense of belonging to one's cultural community, and one's behavior toward others are all factors that relate to the relationships in one's life. MISC clinicians rated youth resiliency factors relative to: (a) caring relationships, (b) high expectations, and (c) meaningful participation in activities and relationships utilizing the Risk and Resiliency Index.

In rating the presence of various strengths or resiliency factors in one's life, clinicians indicated the majority of MISC youth have multiple and positive influences in their lives. Within their homes, schools, communities, and peer groups, many youth have important relationships, messages of optimistic success, and opportunities for participation in fulfilling activities. This information helps to develop stregnth-based support plans and to monitor progress toward enhancing youth resliency. *Figure RRI* presents the percentages of MISC youth for whom these resiliency factors are present (total reporting = 456).

71.6% of enrolled youth had a Total CBCL score in the clinical range at Intake to services. This decreased to 57.7% after one year of services.

Other Available Outcomes

In addition to information relating directly to MISC's goals and mission, the federal and state evaluation mandates included using the *Child Behavior Checklist* (CBCL). *Figure CBCL* presents information on change in youth CBCL scores over time.

Data were collected and analyzed from caregivers of youth enrolled for one year in MISC on the CBCL. For 201 youth whose caregivers completed both intake and one-year assessments, there was a decline in the percentage of Total, Internalizing, and Externalizing Problem scores in the clinical range from intake to one-year follow-up. These results indicate improvements for many of the MISC youth in terms of their behavioral and emotional functioning.

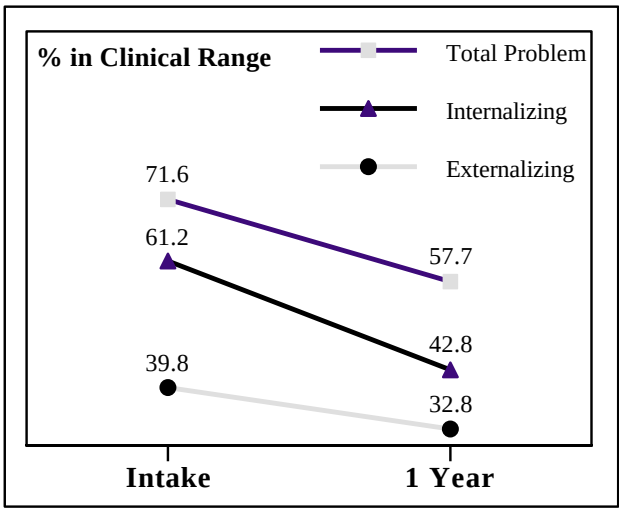


FIGURE CBCL. *Child Behavior Checklist scores*

Risk & Resiliency Index

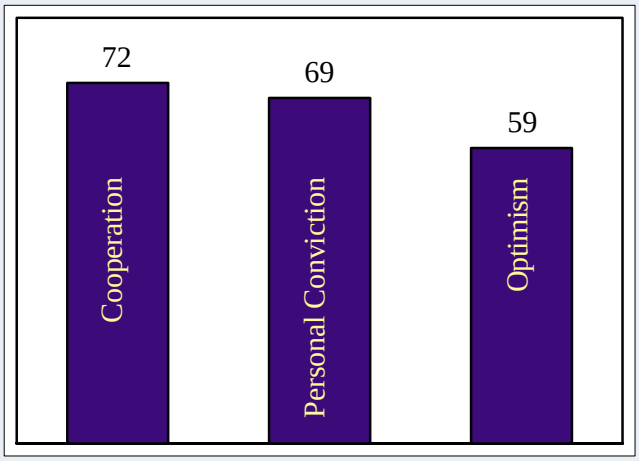
The Child and Family Risk and Resiliency Index (RRI) was designed by the MISC evaluation team to supplement the California Department of Mental Health evaluation data requirements. The importance of addressing strengths as well as weaknesses in youth with emotional and behavioral disorders is well documented in the literature and provides an important alternative way to conceptualize the youth and his or her family. The goal in developing the RRI was two fold: (a) to help clinicians explore resiliency factors in lives of MISC youth and their family, and (b) to evaluate resiliency factors of youth at intake into the system of care.

The format of the RRI includes items on youth and family risk factors, educational performance and placement, characteristics of the home environment (e.g., number of adults, children, and bedrooms in the household), and a series of youth resiliency factors. Resiliency items were adapted from the California Healthy Kid's Survey (see www.wested.org/hks).

Six strength-based areas comprise the Child Resiliency portion of the RRI: (1) *Caring Relationships*–items here query for the presence of individuals in the youths' lives (specifically at home, school, community, and peer group) who model or support healthy development and learning; (2) *High Expectations*–questions in this area tap the presence of consistent communication (specifically from home, school, community, and peer group) of both formal and informal messages that the youth will succeed; (3) *Meaningful Participation*–items here check for the involvement of the youth in relevant, engaging, and responsible activities with opportunities for responsibility and contribution; (4) *Social Competence*–these questions tap the ability to communicate effectively and appropriately (e.g., via cooperation and communication skills) and to demonstrate caring, flexibility, and responsiveness in social situations (e.g., via empathy, respect for diversity, and problem solving skills); (5) *Autonomy and Sense of Self*–items here query as to one's sense of personal identity and power (e.g., via personal conviction, self-efficacy, internal locus of control, self-awareness, and appearance), and finally; (6) *Sense of Meaning and Purpose*–items here query for the knowledge that one's life has coherence and makes a difference (e.g., via optimism, goals and aspirations, achievement, motivation, and intellectual ability).

The graph below presents data on the latter three personal resiliency factors. As seen in Figure RRI-2, clinicians rate the majority of MISC youth as being cooperative (Social Competence), having personal conviction (Autonomy & Sense of Self) and optimistic (Sense of Meaning & Purpose). Personal resources such as these are an important part of creating positive, strength-based support plans.

FIGURE RRI-2. *Percent of MISC youth (as determined by clinician) with resiliency factors present in their lives.*



VOICES FROM WITHIN

Interviews with Program Managers

Burt Romotsky, MSW
Program Manager of Santa Barbara site

Mary Jane Alumbaugh, Ph.D.
Former Program Manager of Santa Maria site

Bob Richey, Ph.D.
Former Program Manager of Lompoc site and current Program Manager of Santa Maria site

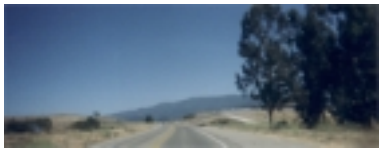
To gain a full perspective of how MISC functions, we interviewed the Program Managers from each site. These individuals are in charge of the management and supervision of staff, some direct service, and administrative duties such as disseminating the MISC protocols, providing consultation to partner agencies, ensuring professional standards are maintained, and improving programs.

Bob Richey, while at Lompoc, noted that working for MISC is fundamentally different because of the collocation component. "This changes the focus tremendously because we can work with families in a holistic way" stated Richey. In addition, the lines are blurred when working with the different agencies. Richey said, "working with CPS and Probation has increased my skills because we need to work through problems and be aware of the different cultures that exist." In commenting on his perceptions of differences, Burt Romotsky, of Santa Barbara felt that, "Resources are utilized more quickly here because it is all one program. All agencies have input in the progress of a case. It is not just your traditional outpatient therapy."

Mary Jane Alumbaugh, of Santa Maria, views the huge expansion of services as a strength of MISC and the overall system of care model. Also, the staff make-up (e.g., diversity and collocation) and the total number of staff members is a benefit of this model. This has allowed MISC to serve more clients in a broader way. Romotsky feels that the strengths include both collaboration among staff and avoidance of duplication of services. The interagency team approach is another strength. The agencies are working together to provide information that are not otherwise known to each other. Richey feels that a strength is working with so many different individuals with a variety of experiences. In addition, Richey noted that, "much of our work takes place in the field, home and community. I view this as best practice and enjoy working within this type of environment."

Finally, Richey noted that the cross-training component is "crucial to our success. By having staff collocated, agencies do not shift responsibilities back and forth and ping-pong families from one agency to another. There is less diffusion of responsibility and families are treated holistically."

However, it has not been easy to establish this infrastructure. Alumbaugh noted that all agencies were not equally prepared for MISC and things happened quickly. According to Romotsky, the challenges include, "a lack of documenting things appropriately, the large amounts of paperwork, understanding each other's roles among staff, a high turnover rate and a need for consistent training so that staff can provide the right level of service for each client." Additionally, collaboration with schools was a concern. He related that, "Our outcomes are directly connected with progress in school, and this relationship is critical to our success." Schools are sometimes suspicious, he noted, and MISC needs to have them as partners working together to move children to the least restrictive environment. In addition, Richey stated that, "We need to have behaviorally-based services that are collocated. We also need to resolve the challenges that are associated with working with paraprofessionals." He continued to relate that many of the paraprofessionals are contracted through CBOs (community based organizations) and collaboration, monitoring, and training are more difficult as a result. There is a lack of vocational services for MISC youth, especially those referred from probation. The therapeutic foster care system should have been implemented earlier in MISC to provide a smooth transition for youth



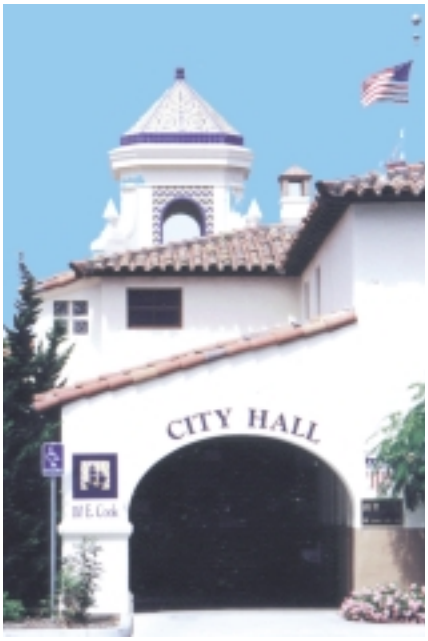
coming back home. Finally, Richey concludes, more assessment staff need to be allocated to the agencies.

These program managers spoke very highly of their staff, "these people do amazing work and get good outcomes too," stated Alumbaugh. Romotsky said that, "The teamwork approach of the staff, bringing together of clients and families for the Recreation programs and at holiday events like the Christmas party, and working together with families and including them in the process are things of which I am most proud."

"Lompoc clients are very challenged and our outcomes are great," stated Richey. He is also proud of how collaboration, quality of services, assessments and professional standards have greatly improved.

It won't be an easy road as MISC transitions from federal funding to being self-sufficient. Alumbaugh has concerns that without grant funding, some agencies won't keep up the devoted positions. She worries that people will say they are committed to the collaboration/collocation, but that ultimately agencies will have other concerns and not follow through. Some of Romotsky's concerns are that staff know how to bill and document correctly and that they keep the philosophy of MISC fresh. In addition, it is important to teach the staff MISC ideals and philosophies on an ongoing basis so that staff don't revert back to the traditional way of service provision. Romotsky stated that he is concerned that departments will be pulled to act upon their own interests and there will be less collaboration. He is also concerned that the planning process will be too small of a focus. He hopes that MISC can continue benefiting clients without diluting any of their services. Finally, he is concerned that data management and evaluation are handled efficiently and are accessible. He stated that, "Our association with the UCSB evaluation team has been beneficial, and I hope this integral relationship continues."

These Program Managers have extensive knowledge to offer future sites. Alumbaugh suggests that new sites visit existing sites and learn from their mistakes and good fortune. She views an existing infrastructure as an important concern. Also, she feels that it is important for the front line staff to receive early training. Romotsky suggested allowing enough preparation time to get everything set up and have a succinct training manual that staff can access on an ongoing basis. It is important to have policy and procedures set and ready to go and make sure that management is hired soon enough to implement programs. Richey suggested creating a "super-agency" that handles administrative and organizational details. He stressed the importance of collocation, collaboration, working in-vivo, and creating positive relationships with the schools.



Santa Maria City Hall

Vista of Channel Islands National Park

Interviews with Care Coordinators

Dorothy Groce
Care Coordinator of Lompoc site

Cheryl Poirer
Care Coordinator of Santa Maria site

Deborah Nichols
Care Coordinator of Santa Barbara site

Care coordinators are on the front line of service management and delivery for MISC families. We asked one care coordinator from each MISC site to share their experiences and perspectives in working for MISC. These individuals were kind enough to volunteer their opinions.

What is a care coordinator and who are these professionals? They are responsible for brokering and providing access to services in addition to monitoring the clients' progress toward goals. They are part of the client's treatment team and help to ensure families get the services they need. As Dorothy Groce, a care coordinator from Lompoc MISC, states, "I am a liaison between families, community and agencies, and a communicator." Their broad range of responsibilities often involve working within the community and schools, as Deborah Nichols of Santa Barbara points out.

Although the three MISC sites share many similarities (e.g., collocation of staff and integrated service plans), each has its own unique characteristics. Cheryl Poirer, from Santa Maria MISC, points out that, "[we] have the highest number of direct service hours [relative to] other sites," while Groce notes the high crime rate, low socioeconomic status, and drug related problems of their clients lead to especially intense case loads that require "more services." In Santa Barbara, Nichols considers interagency collaboration and effective communication as the hallmarks of her site. The care coordinators we interviewed unanimously agreed that hard working staff and administrators are what ultimately help their respective sites run smoothly.

Given their close involvement in family's lives as well as the MISC milieu, care coordinators have a unique perspective on ways to improve or change the system after its first five years of implementation. Poirer witnessed the success of more "nontraditional" services such as Equestrian Therapy and would like to see more of these programs instituted. All care coordinators echoed the concern that more educational programs for families be instituted such as parenting skills, transition/independent living skills, and job readiness curriculum. Nichols would like to see the issue of staff turnover addressed and, as she puts it, "it takes a long time to get acquainted with cases...[and when a staff member leaves] it takes a long time...to learn the cases."

Clinical and personal success stories such as handling difficult clients in a respectful manner, effectively training new staff members, or getting children placed in an appropriate educational setting can help care coordinators feel effective in their jobs as well as overcome inherent job challenges. Groce, along with the other care coordinators, noted that large caseloads can be "overwhelming [as there are] no caps on our caseloads, so I have from 35-40 cases at a time." Though it is obvious there is no shortage of business for these professionals, it is equally apparent how vital their services are to Santa Barbara County families.

Interviews with Families

We have heard from those in the role of serving MISC families. However, it is clear that how families perceive the role of MISC may provide a critical piece of information on MISC's effectiveness and give clues to how it may continue to improve.

Rosa is the mother of three children, Benito,* Maria,* and Juanita,* (ages 14, 12, and 8, respectively) who are enrolled in Lompoc MISC. The family is typical of many families in MISC who present with a number of problems such as poverty, substance abuse, and physical and sexual abuse. "I left my husband because he was molesting my children and physically abusing

** Actual names have been changed.*

all of us," said Rosa. "We had to move into a poor neighborhood as a result. I was on welfare for two years right after our divorce, but am off it for good right now." In addition, Benito had trouble in school both academically and socially. He had "terrible angry outbursts, was starting to use drugs" and was hurting himself, said Rosa. She states that as a result of the neighborhood in which they resided, her son would get "jumped" by gang members on his way to and from school. She also reported that her daughter Maria had "terrible anger problems" and a history of suicide attempts between the ages of 9 and 11. Rosa reported that she couldn't leave her daughter alone in our house "for fear that she would kill herself."

Along with Rosa's help and willingness, MISC staff began to tackle the multitude of problems one by one. First, MISC "gave us financial support to get involved with programs at the YMCA so my son could get off the streets and channel his anger into something positive," said Rosa. Both the son's and daughter's anger problems led to the utilization of emergent concern services "almost every day," said Rosa. The emergent concern staff "would intervene when my son got angry by teaching him safe ways to calm down and express his feelings," she stated. MISC also began the process of placing her daughter in temporary foster care to help her with her problems while the family became more stabilized. "MISC kept things calm. If we didn't have them, we wouldn't be okay," she noted.

Adobe building, La Purisima Mission, Lompoc

Her son's academic problems were next on the agenda for MISC staff. The family was not receiving consistent mental health services, and when they were enrolled in MISC, her son received a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). MISC staff spoke to his teachers and "even went to IEP (Individualized Education Plan) meetings with us to be our advocates and help us through the process," Rosa stated. She also noted that currently, counselors from MISC are helping her son "stay away" from drugs.

Beyond surviving the troubled times, Rosa indicated that her children seem to be thriving now, with both of them developing hobbies and interests. She was happy to report that she is now able to spend more time with her youngest daughter, Juanita, even taking a tae-bo class with her, because the crises with her older children had decreased. Benito is now taking a diving class through the YMCA and has expressed a desire to play high school football. He has also begun work at a church child care and is "wonderful with the children," said Rosa.

Reflecting back on the progress the family has made while in MISC, Rosa said "our family has utilized every service possible." And while she admitted that things aren't perfect with her family, she stated that "we are doing so much better—I'd like to say thank you to MISC for all of their support."

Other families have experienced similar successes through MISC. Laura*, a 40-year old mother who currently resides in Santa Barbara with her six year-old son Keith*, also described the numerous challenges that her family has had to overcome to achieve the stability and closeness they now feel.

"Keith has always been a real hyperactive boy," she said. Laura also described her son as someone who was very impulsive and aggressive and would often act out. "He would kick and scream and it was hard to calm him down or handle him," she said. With the help of MISC workers, they had a behavioral specialist who worked with them at home to help Laura manage and respond to her son's outbursts. In addition, emergent

concern services were available to the family to deal with crisis moments at home.

Laura, Keith, and his older half-sister Lisa,* have remained an intact family now for several months. Laura states that she is very "bonded" with Keith and that he is "close" with his older sister. "It's nice now for all of us to be together because we weren't for a long time," said Laura. Keith was first referred into MISC because he was a CPS (Child Protective Services) case. At the time, both his mother and father were about to serve prison sentences.

Since her release from prison, Laura has retained full custody of her son. Although she did not have a permanent home and stayed at Bethel House with Keith, she began to tackle her problems and work towards obtaining a stable home for herself, Keith, and her daughter. "I really wanted to get cleaned up and start being positive when I got out of prison," she said. Laura has dedicated herself to maintaining her sobriety from alcohol dependence. She has also been attending summer school and now has a part-time job as a nursing assistant at a home for the elderly and hopes to eventually obtain a license as a nurse's assistant so she can get a full-time job.

In the spring, through the help of MISC providers, particularly the care coordinators, Laura was able to apply for housing through a program called Project Recovery, which seeks to keep high-risk families unified by assisting with low-income housing. "We got the apartment because we were a CPS case and because we had all been separated for a long time," said Laura. "Everybody at MISC really helped us out there. They helped us get an extension on the application deadline and told us about Project Recovery."

Mission era adobe building

With a stable home, the family could turn their focus toward getting more intensive help for Keith. He has been able to see a neurologist, who has diagnosed Keith as having significant psychomotor deficits. "At first, everybody thought he had FAS (fetal alcohol syndrome) because it was hard for him to learn and he couldn't do things physically," reported Laura. Now, with regular medical treatment, Keith is slowly tackling these obstacles. He is currently on the medication Ritalin for his hyperactivity and is enhancing his psychomotor skills with regular physical therapy. Care coordinators from MISC have also attended IEP and SST (Student Study Team) meetings at Keith's school to help inform the school personnel about his specific neurological deficits and their impact on his academic and social functioning.

In addition, MISC helps the family by providing recreational services such as the Boys & Girls Club over the summer and coordinating childcare services for the family. Keith also has continued Wraparound services, and his care coordinators have worked hard to keep all of his family members involved, including his father. Both his father and mother have pledged to continue with family therapy and work out their differences. "We have been working real hard in therapy, and Keith's father and I are trying to help Keith," said Laura. "For a long time Keith's dad was not involved in the process with us, and now he is getting more into it and getting more involved," she said.

"We really try to use every service that's available to us, and we wouldn't be here if it wasn't for MISC and everybody who was working with us to help us," said Laura. She noted that it was "still real hard" for a single-parent family to deal with a child like Keith who has numerous mental, emotional, and behavioral challenges. Nevertheless, she stated with optimism, "Compared to last year, we are doing real good. We have a house, we are together, I'm clean, in school, I have a job, Keith isn't acting out as much and doing better now." She added, "We just really want to thank MISC for being there and helping us."

Beyond the Gateways

Interview with Family Mentor Program Coordinator

Antoinette Billington
Family Mentor Program Coordinator

The Family Mentor Program, under the auspices of Community Action Commission (CAC), provides information and guidance to families involved in MISC. Given the value that MISC places on family involvement in treatment, this agency provides an invaluable service to the collaborative. Billington spoke with us about the Family Mentor Program and the role that it plays in MISC.

The Family Mentor Program is unique among MISC partner agencies for many reasons, most notably because staff members are parents themselves whose children have some sort of disability. Further, these parents have had experience and skill in negotiating social service and other related agencies (e.g., Child Welfare Services, Juvenile Justice, and public school systems). Billington considers these families as "thrivers" rather than survivors: parents who have been through a crisis with their child and have successfully navigated through their respective systems. Their program currently has nine total staff (both full- and part–time positions) and has served 121 families thus far.

The Family Mentor Program staff has a special connection with MISC families and are often viewed as less threatening than their companion agencies. Entering a new system of care can be overwhelming and scary for parents who are already dealing with many problems. "We know what it's like," said Billington. She acknowledges that each family is different and that "it is a different journey for each parent, and we want to meet them where they are."

As Billington points out, the Family Mentor Program provides a host of services for MISC families. As part of the collocated MISC team, they provide direct services to families on site, hold monthly "network meetings," (part information sharing and part support group), maintain a resource library at each site, and raise parents' consciousness about the political process to foster activism and empowerment in their communities.

The Family Mentor Program staff have access to client records, write progress notes, and bill for services. As the federal grant funding has expired, the Family Mentor Program has become self-sustained and bill for their services through MediCal. Families access the Family Mentor Program through their care coordinator, but as Billington notes, it is one of the few services that families can access *before* a formal treatment plan is created.

During her time in this position, Billington has had the opportunity to see areas in need of improvement as well as areas of success. The "family friendly" policy of CAC allows their staff to have flexibility in their schedules for child-related issues, and Billington has "never seen the policy abused…it works well for everyone." Additionally, she views the collocation of her staff along with other MISC staff as "very important," but notes that each of the three sites has utilized the Family Mentor Program differently over time. Antoinette would like to see the pay scale for these positions increased (especially in light of housing and cost of living in Santa Barbara) given the fact that Family Mentor Program staff are often the primary bread winners of the family. Also, office space and related materials are often hard to come by, and Billington would like to see this addressed for her staff.

School mural, Santa Maria

Promoting the Goals of MISC: Partner Agency Interviews

Alex Brumbaugh
Director of Project Development at the Council on Alcoholism and Drug Abuse

Tara Dooley
South County Operations Manager of Family Service Agency

Anna Kokotovic
Executive Director of Child Abuse Listening and Mediation

Jeannie Mitchell
Program Services Officer for Community Action Commission

In addition to the integrated services provided by the collaboration of Probation, Mental Health, Public Health, and Social Service agencies, several community-based organizations have joined MISC to provide additional ongoing therapeutic, recreational, emergent, school, and home-based services to MISC families.

Care coordinators assess whether a family with particular risk factors or issues, such as substance or child sexual abuse, may be helped by the specific services provided by these partner agencies and refer them to these organizations. Because the services provided by these agencies match the goals of MISC, these agency staff were eager to collaborate.

Brumbaugh, the Director of Project Development, at the Council on Alcoholism and Drug Abuse (CADA) which provides substance abuse counseling and recreation services, stated that CADA became a partner agency because "we knew that substance abuse issues would impact large numbers of MISC families, so it was consistent with our mission."

Likewise, Dooley, South County Operations Manager for Family Service Agency (FSA), stated that because FSA "is very committed to community issues [and] serving children and families," the goals and mission of MISC fit with those of FSA. The organization provides family and child therapy for the greater Santa Barbara community. FSA provides two in-school therapists who work in special education classes, one family therapist, in addition to several intensive in-home therapists to work with MISC families. They provide consultation in the schools, assist families in coping with children's behavioral problems, make in-home assessments, and provide counseling and referrals to other agencies or services.

Moreover, some partner agencies already had a long history of collaboration with state and county agencies such as Child Welfare Services and Probation. Both the Child Abuse Listening and Mediation (CALM) and Community Action Commission (CAC) agencies felt their participation in MISC was a natural extension of the work they were already doing in the community. In addition, Kokotovic, Executive Director of CALM, noted that, "child abuse treatment services are really not offered elsewhere in the community, so it made sense that CALM would play a role." CALM provides three main direct service provisions to MISC as network providers: (a) intensive in-home therapy to prevent institutionalization, (b) therapeutic foster care services, and (c) as a referral source for any child referred into MISC.

Mitchell, the Program Services Officer for CAC, reported that her agency's collaboration with MISC came about through years of building a partnership with County Children's Mental Health. CAC is Santa Barbara County's largest nonprofit social services agency and provides the Family Mentor and Therapeutic Aide Programs to MISC families. The Family Mentor Program functions to help other families successfully navi-

Probation Department, Santa Barbara

gate social service systems, serves as a source of parent information-sharing, forms support groups, and facilitates parent activism and family empowerment around community and policy issues.

Fundamental to each agency's decision to collaborate with MISC was their support of the system of care model of service delivery. "We believed in the concept," stated Mitchell. The integrated approach to service delivery and treatment were commonly cited by the agency spokespersons as reasons for the gains made by the families. Dooley, who primarily oversees administrative operations, stated that, "I know that improvements may have taken place because we have the advantage of providing services in nontraditional ways. Therapeutically, there have been very strong breakthroughs. I know that from listening to the clinicians. Many of the Clinical Supervisors I know have success stories to talk about...and have made tremendous strides with the kids [they] have worked with in the schools."

Sterns Wharf and the Santa Ynez Mountains

MISC families have also been helped through the opportunity to serve the community themselves as employees of the agencies who had helped *them*. "Many have been hired by our agency to become employed partners/professionals, and families have been assisted in successfully navigating services," said Mitchell. She reported that since MISC family members had been through the system themselves, CAC decided to employ several of them to work as Family Mentors so that other families may benefit from their experiences. Brumbaugh also recalled a particular family in which the father was struggling with severe alcoholism dependence. Through the intensive treatment provided by MISC and CADA, his substance use decreased, and the family situation stabilized. Additionally, Kokotovic credits the "highly trained and highly effective" staff members and service providers who are the "strength of CALM" as most responsible for the gains MISC families have made.

Several agency representatives described their agencies' experience in working with MISC families as positive, challenging, and rewarding, but difficult. The main reasons that working with MISC have posed unique challenges for the agencies are the multitude of special needs and services the families require. Mitchell states that CAC "carr[ies] the single most family-driven program and is the piece of the overall collaborative effort, which links families with the system of care. It has worked well, is evolving, but has not been without stumbles and lessons learned." She further states that the "intense level of need and functional deficits" that are characteristic of MISC families are definitely formidable, and that the "families have a great need for information, support, and assistance in advocating for their children in a productive manner."

Dooley also noted that it has not always been easy to serve a population of families who frequently deal with major disruptions in their lives that result in appointment cancellations and breaks in treatment and service. She stated that this is perhaps the "greatest challenge" for their agency but hopes to "get the families to the point of not always being in crisis mode, where there is more stability."

More than most, MISC clients in particular constitute "high numbers of multiproblem families that not only have child abuse issues, but substance abuse, poverty, and other problems such as transportation and housing," said Kokotovic. Brumbaugh stated that in his experience, MISC families often have needs that are "beyond" that which traditional case management can solve. He stated that family members "often need new skills and ideas about how to relate more effectively" with each other and the larger social service systems. The difficulty comes in helping the families "change patterns of behavior that do not work." Brumbaugh also

noted that "coordination of various services and trying to break the cycle of crisis" have been the most challenging for his agency and staff.

Overall, the representatives felt that the collaboration between MISC and partner agencies has been effective and smooth. However, there were several suggestions to improve the collaboration. Dooley noted that "moving toward bringing all the partner agencies together and getting their input from the beginning" is important, and added that under the direction of Todd Sosna (MISC Director 1994-2000), partner agencies have began to play an increasingly bigger role in MISC. "Involve the CBOs (community based organizations) and providers more in the process from the start in developing new proposals and evaluating progress of the program," she suggested. Brumbaugh would like to see "a formal process for using feedback and what was learned to improve service design and delivery," in addition to "ongoing training/retraining of all staff" as a means for enhancing the partnership.

More specific suggestions for improvement included a request for more Wraparounds, a greater emphasis on family involvement, as well as having a clearer focus for the MISC Advisory Council earlier on in the program.

Both Dooley and Kokotovic emphasized the critical role played by the care coordinators as doorways to the partner agencies. They see the care coordinator's ability to assess and refer the youth and families to the specific and appropriate services provided by the organizations as the key component that determines the effectiveness of the collaborative. Kokotovic likened the care coordinators' role to that of "mini-managed care brokers who determine what services will be made available to youths and families." Thus, care coordinators are entrusted with the arduous task of correctly identifying the particular needs of a family and also being familiar with the appropriate community resources available to meet those needs. Dooley noted that it would take a considerable amount of a time for anyone to know: (1) the various dimensions of service that each of these community organizations provides, and (2) how to utilize them accordingly. Hence, both stressed the necessity of greater ongoing and intensive training for Care Coordinators and other staff to recognize and match family needs with the right services (and agencies).

While the core agencies of MISC—Probation, Mental Health, Public Health, Schools, and Social Services—are responsible for the initiation of these youth and families into a managed and integrated system of services, the partner agencies play the significant role of extending the continuum of care so that the goals of MISC can be met: healthy kids who are safe, residing with families, learning in school, abiding by the law, and forming supportive relationships with others.

Historic El Paseo

Cultural Competence and Santa Barbara County MISC

The demographic make-up of the United States has been steadily changing. Between 1970 and 1997, the percent of individuals who identify as non-Anglo-European descent more than doubled (12% versus 30%; Hanson, 1998). Estimates for 2050 indicate that Caucasians will make up about 53% of the U.S. population (Singh, 1998). Of the 90,000 youth currently between the ages of 0 and 17 in Santa Barbara County, 45.2% are Caucasian, 47.2% are Latino, 2.6% are African American, 4.5% are Asian/Pacific Islander, and 0.5% are Native American. This dramatic shift in the local and national cultural make-up has set the stage, in part, for recognizing and appreciating cultural differences in mental health service delivery.

One of the three core values for a system of care is concerned with "the system of care [being] culturally competent, with agencies, programs, and services [being] responsive to the cultural, racial, and ethnic differences of the population they serve" (Stroul & Friedman, 1996; p. 6). The Santa Barbara County MISC, with professionals from outside the mental health system, has been concerned with the issue of culture. What does being culturally competent mean on both an agency or system level and an individual level? What would this look like, what are the standards we should adhere to, and how would we measure this? What is the impetus for valuing culture and delivering services in a manner congruent with the client's own cultural values?

Background and History

Culture, for the purpose of this discussion, is considered to be "the shared values, traditions, arts, history, folklore, and institutions of a group of people unified by race, ethnicity, nationality, language, religious beliefs, spirituality, socioeconomic status, social class, sexual preference, politics, gender, age, disability, or any other cohesive group variable" (Singh, 1995 as cited in Singh, 1998). Mental health professionals' training has traditionally been based solely on European-American middle-class culture. Problems are frequently encountered when this framework is applied to a client whose cultural experiences are not European-American and/or middle-class. As Isaacs-Shockley, Cross, Bazron, Dennis, and Benjamin (1996) state, ". . . children and adolescents of color often do not get their needs met in the present system…[and] the data are clear: Current systems of care provide differential [i.e., worse] treatment to children of color" (p. 24). The process of recognizing and respecting other cultures and providing services in a way congruent with that culture entails *cultural awareness*, *sensitivity*, and *competency*.

Cultural awareness means an understanding of differences within and between cultures, while cultural sensitivity represents a step beyond awareness: not attributing positive or negative values to the differences within and between cultures. This non-judgmental perspective sets the stage for cultural competence, or the possession of skills and knowledge necessary to work with individuals from different cultures in a manner congruent with their values. Stated differently, a culturally competent counselor does not force an Anglo framework on a non-Anglo client.

Cultural Competence and Santa Barbara County MISC

Evelyn Schladweiler, the Cultural Competency and Training Director for Santa Barbara County Alcohol, Drug, and Mental Health Department spoke with us to share her perspectives on working with culture. Trained as a registered nurse, Schladweiler comes most recently from University of California, Los Angeles where she directed a research project studying Latina and non-Hispanic white women's experiences with arthritis and quality of life. Her background in community health, her experiences with diverse populations, and her own bicultural identity combined with a deep belief in appreciation and celebration of diversity appear to give

her abundant fuel for her work during her year and one half tenure in the position.

In addressing how to introduce cultural sensitivity and training to a myriad group of adults, youth, and service providers, Schladweiler states that "training on a department-wide basis and integrating cultural competence for everyone" from clerical to direct service staff is the imperative. Schladweiler credits the medical director, Dr. Nicholson (current MISC Director), as helping to advocate for her own work and notes that "leading by example" is, for her, one of the most important things.

What are the tools of the trade for this position? Schladweiler described developing training seminars and focus groups; creating policies and procedures across departments; utilizing client satisfaction data; and attending conferences to continually work toward making diversity part of the "culture of the mental health system." In sum, Schladweiler is quick to point out her belief in "defining culture and diversity broadly: gay and lesbian, geriatric, religious beliefs" among many other groups and subgroups of people who, together, form the "quilt" of the United States.

Art murals, a Lompoc tradition

Chumash

The indigenous people of Santa Barbara were the Chumash. They had a vibrant and rich culture that included one of the highest population concentrations in North American prior to the arrival of the Europeans. Their culture included rich artisitic traditions in addition to the technology needed to build ocean-worthy vessels (tomols).

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MISC Publications

The dissemination of findings from the MISC evaluation has been an important role for the UCSB Evaluation Team. Student dissertations, published conference proceedings, as well as theoretically- and empirically-based journal articles are represented in this dissemination process. Here, we have included citations, abstracts, and key findings from published projects.

Casas, J. M., Furlong, M. J., Alvarez, M., & Wood, M. (1997)

Qué dice? Initial analyses examining three Spanish translations of the CBCL. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 10th Annual Research Conference Proceedings. A System of Care for Children's Mental Health, Expanding the Research Base* (February 23 to February 26, 1997) (pp. 459-464). Tampa FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

This paper describes three initial analyses that are part of a research effort to examine the validity and utility of three Spanish versions of the CBCL with Latinos from diverse national and linguistic subgroups. These analyses encompass the following respective components: (a) the identification of Spanish items that had structural or conceptual differences from the English version; (b) the item translation preference ratings of bilingual experts, and (c) the comparison of the CBCL syndrome and composite scores for Latino parents completing the Spanish forms with those of Latino and Anglo parents who responded to the English version. The results suggest that additional research is needed to refine the Spanish version of the CBCL, at least for Spanish-speaking population in the southwestern United States.

• 48 Spanish CBCL items had structural/conceptual differences from the corresponding English versions.

• Existing translations of standardized scales (such as the CBCL) may not be universally appropriate and that ad hoc translations do not necessarily result in more acceptable items.

Casas, J. M., Pavelski, R., Furlong, M. J., & Zanglis, I. (in press)

Addressing the mental health needs of Latino youth with emotional and behavioral disorders: Practical perspectives and policy implications. *Harvard Journal of Hispanic Policy.*

Children and adolescents of color are often underserved or inappropriately served by public and private sector mental health agencies in the United States. A service delivery model, referred to as "systems of care," has been proposed as a promising way to expand and improve mental health services to all children and adolescents who have serious emotional disorders. Because the system of care paradigm emphasizes cultural competence in service delivery, it also provides a promising mechanism through which to assume the responsibility of meeting the mental health needs of Latino youths and their families. This article reviews the inequalities that exist for Latino and other minority youth in obtaining mental health services, outlines trends and themes present in previous research on this topic, and highlights key policy-related elements of systems of care to consider when serving Latino youth and their families. In this discussion, we draw extensively on the experience of staff and researchers working in the Santa Barbara County Multiagency Integrated System of Care (MISC), a collaboration among family members, health and safety net agencies, education, and community-based organizations.

• Discusses inequalities that exist for Latino and other minority youth in obtaining mental health services

• Considers how systems of care a) may function to better serve such groups and b) can impact policies to benefit traditionally marginalized groups.

Flam-Decker, C., Woodbridge, M. W., & Furlong, M. J. (under review)

Measuring the integrity of systems of care (MISC):

Want access to MISC reports? See: www.education.ucsb.edu/~sbmisc or www. education.ucsb.edu/~schpsych

Preliminary development of the MISC scale. Manuscript submitted for publication.

A review of the literature in the field of system of care service delivery for youths with serious emotional disturbances (SED) does not reveal empirically derived definitions or instruments to assess indicators of promising practices. This study provides a rationale and procedure for the development of a scale to evaluate the processes of wraparound service planning. Through the documentation of indicators of best practices as prescribed by national experts in system of care services, a preliminary *Measuring the Integrity of Systems of Care (MISC) Scale* is developed that can assess the integrity of the wraparound service planning processes within and among service delivery sites. The *MISC Scale* measures the perceptions of front line staff and family team members and has utility in large-scale evaluation projects to assess whether systems of care are implementing practices consistent with wraparound principles.

• Based on a survey of experts in the field and statistical analysis, two instruments were developed to assess caregivers' and service providers' perceptions of fidelity to the wraparound process.

• These instruments, comprised of five domains, have practical implications for service providers and their agencies. More broadly, program evaluators may benefit from these instruments as a method to make standardized comparisons between and among programs.

Woodbridge, M. W., Furlong, M. J., Casas, J. M., & Sosna, T. (in press)

Santa Barbara's evaluation principles, practices, and products. In M. Hernandez & S. Hodges (Eds.), *Tools, case studies, and frameworks for developing outcome accountability in children's mental health.* Baltimore, MD: Brooks.

This chapter presents the developmental process of establishing a meaningful local evaluation of child and family outcomes in community-based services, and it delineates the practical methods used to effectively manage longitudinal, interagency data. The information is based on the work of the Santa Barbara County Multiagency Integrated System of Care (MISC) Evaluation Team supported for five years, in part, with funds from the Center for Mental Health Services

Although federal funds expired in the summer of 1999, the system of care and its evaluation project have been sustained. The collaboration between the University of California, Santa Barbara and local public and private agencies on the evaluation of outcomes of their services is one of the cornerstones of MISC, and it has been one of the hallmarks of the program's success. This chapter illustrates the purposes, principles, and practices of the evaluation with an emphasis on the: (a) human resources needs, (b) technical resources utilized, (c) challenges recognized and overcome, and (d) innovative products developed.

• Timely and continuous feedback to clinicians and administrators from the evaluation staff helped to shape and guide service delivery.

• Communication between families, agencies, and the evaluation staff helped to create a culture supportive of evaluation that allowed all parties to grow and evolve.

• The emphases on client care and best practices allowed for a smooth transition between federal funding and self-sustained funding.

Furlong, M. J., & Wood, M. (1998).

Review of the Child Behavior Checklist. In J.C. Conoley & J. C. Impara (Eds.), *The Thirteenth Mental Measurements Yearbook*, (pp. 220-224). Lincoln, NE: The Buros Institute of Mental Measurements.

The Child Behavior Checklist (CBCL/4-18), a general measure of child and adolescent emotional and behavioral problems, is designed to be

completed by parents and parent surrogates (including adoptive parents, foster parents, or other adults who live with the child such as care workers in residential settings). The CBCL/4-18 is part of an integrative web of assessment tools including (a) the preschool version CBCL/2-3; (b) the Teacher Report Form (TRF); (c) the Youth Self-Report (YSR); (d) the Direct Observation Form (DOF); and (e) the Semistructured Clinical Interview for Children (SCIC).

• Strengths of the CBCL include its extensive history as an assessment and research instrument as well as its ease of use.

• Areas of concern include its lack of a strengths based approach and lack of items geared to detect social desirability sets or lying.

Pavelski, R., Woodbridge, M. W., & Flam, C. (1999)

Evaluating the adherence to service delivery planning in a system of care. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings. A System of Care for Children's Mental Health. Expanding the Research Base* (February 21 to February 24, 1999) (pp. 16-17). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Before outcomes of system of care approaches can be measured, an instrument is needed to asses the degree to which emerging models of systems of care for youth actually implement service delivery planning with integrity to the guiding theory. This study a) determines and operationalizes empirically valid indicators of best practices within a system of care and b) discusses the instrument that was developed based on these indicators.

• A scale, *Measuring the Integrity in Systems of Care Scale* (MISC Scale) was created and includes a family and care coordinator form (each with 22 items forming five subscales).

• Santa Barbara County care coordinators (n = 4) and primary caregivers (n = 22) completed the MISC Scale. Results indicate Santa Barbara County may have been successful in its attempts to implement a theoretically sound system of care.

Robertson, L. M., Bates, M. P., Wood, M., Rosenblatt, J. A., Furlong, M.J ., Casas, J. M., & Schwier, P. (1998)

The educational placements of students with emotional and behvioral disorders served by Probation, Mental Health, Public Health, and Social Services. *Psychology in the Schools, 35*, 333-346.

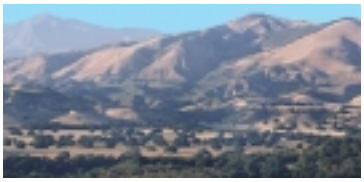
The present study examined child and family risk factors and behavioral indices of youths with emotional and behavioral disorders to determine critical factors that predicted the restrictiveness of their educational placements. Placements were defined on a broad continuum which ranged from general education classrooms to residential treatment and incarceration facilities. Results indicated that a discriminate function model which incorporate age, Caucasian identification, juvenile justice involvement, CAFAS score, family history of mental illness, substance use and school attendance indices correctly classified the placement of 53% of the students. Variables of student behavior, severity of behavior, and risk factors such as abuse and out-of-home care were not reliable predictors of placement. These findings are discussed in the context of system of care efforts to reform service system response to youths with special education and mental health needs and their families.

• Age of the youth moderates the level of restrictiveness of placement (younger youth were more likely to be placed in less restrictive environments).

• A history of family mental illness discriminated between students placed in different educational settings (e.g., speical ed, corrections).

Rosenblatt, J. A., & Furlong, M. J. (1998)

Outcomes in a system of care for youths with emo-



tional and behavioral disorders: An examination of differential change across clinical profiles. *Journal of Child and Family Studies, 7,* 217-232.

We assessed the utility of an empirically-derived classification system for youths with emotional and behavioral disorders in a system of care with a strong representation of juvenile delinquents. Eighty-seven youths served in a system of care were categorized by variables related to past history, current behavioral functioning, and current psychological functioning into four clinical clusters. We evaluate preliminary clinical outcomes after six months of interagency involvement for youths within each cluster and across the four clusters. Results indicated that youths in different clusters improved significantly in need-specific areas. Trends in our data indicated differential change in clinical outcomes across clusters. The findings are discussed within the context of emerging outcomes of youths involved in comprehensive community-based programs, and implications for outcome research, treatment of juvenile delinquents, and mental health policy are considered.

• Youths with differing profiles (based on past history and current behavioral and psychological functioning) demonstrate differential improvement on outcomes.

• A clustering procedure appears to have utility as a classification procedure and relates to understanding youths' improvement.

Rosenblatt, J. A., Robertson, L. M., Bates, M.P., Wood, M., Furlong, M. J., & Sosna, T. (1998)

Troubled or troubling? Characteristics of youth referred to a system of care without system-level constraints. *Journal of Emotional and Behavioral Disorders, 6,* 42-54.

The characteristics of 128 youth with emotional and behavioral disorders referred to a system of care were investigated according to agency referral, behavioral and emotional issues, and risk factors. The referral process in this system of care was unique, with each agency referring youth deemed to need multiagency services. The primary analysis used a two-step clustering procedures to examine characteristic profiles, and results produced evidence of four types of referral profiles: Troubled, Troubling, Troubled and Troubling, and At Risk. It was found that youth with various impairments and corresponding needs were referred by different agencies (e.g., troubling youth were most likely to be referred by juvenile probation, but all agencies referred youth across the four clusters. The results of this study are examined with respect to the long-standing policy debate regarding which youth with emotional and behavioral disorders should be given priority to receive services.

• Meaningful differences in characteristics of youth referred by different agencies were found.

• Implications for system of care evaluation include the fact that different types of children and their families may be more successful in community-based, collaborative efforts.

Turner, J., Casas, J. M., & Furlong, M. J. (1999)

Unique evaluation outcome features: Santa Barbara County MISC. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings. A System of Care for Children's Mental Health. Expanding the Research Base* (February 21 to February 24, 1999) (pp. 12-13). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Recipients of the Center for Mental Health Services (CMHS) funds are required to report outcome data based on the Child Behavior Checklist (CBCL; Achenbach, 1991), Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1995), and other measures from their system of care demonstration project. This article details some of the unique ways that the Multiagency Integrated System of Care (MISC) in Santa Barbara County, California, chose to analyze

Santa Maria Air Museum

these data as well as describe alternate sources of data we have accessed. Specifically, this paper describes one of the frameworks used to view outcomes from Santa Barbara County (i.e., the construction of "Improver" and "Deprover" categories) and present outcomes we have found useful.

• Youths who improve and "deprove" in the system of care tend to have some overlapping as well as unique risk factors.

• Youth who "deprove" tend to use more services than their improving peers.

Wood, M., Chung, A., Furlong, M. J., Holbrook, L., & Richey, R. (1998)

What works in a system of care? Services and outcomes associated with a juvenile probation population. *Journal of Juvenile Law and Policy, 2,* 63-71.

In order to provide comprehensive data about the profiles and behavioral outcomes of juvenile probationers participating in a system of care for youths with emotional and behavioral disorders, descriptive statistics and six-month outcomes were explored. Within and between group differences were documented in the context of two distinct outcome groups: (1) "Improvers"—whose behavioral indices were rated above clinical range at intake and then improved (to below clinical range) after sic months in the system of care; and (2) "Deprovers"— whose behavioral indices were rated below clinical range and then declined (to above clinical range). The services delivered to the youths in each outcome profile are presented, identifying the impact that various types of services may have had on the youths' internalizing and/or externalizing problems. Differences between the services received by the outcome groups may lend evidence to what works in a system of care and how to serve probationers better in a precision-of-fit, collaborative model of service delivery.

• An examination of the risk factors, behavioral ratings, and presenting problems of the early Probation referrals show significant impairment that threaten their well-being and the security of their community.

• In looking at outcome profiles, it was found that more services do not necessarily lead to better outcomes.

Wood, M., Furlong, M. J., Casas, J. M., & Sosna, T. (1998)

A system of care for juvenile probationers. *Journal of Juvenile Law and Policy, 2,* 5-9.

The Multiagency Integrated System of Care (MISC) of Santa Barbara County is a partnership between families, mental health, probation, child protective services, public health, schools, and private community-based organizations to serve youths with emotional and behavioral disturbances and their families. This mutually-beneficial, precision-of-fit service delivery system is supported, in part, by a grant from the Center for Mental Health Services (CMHS). The MISC is demonstrating the way in which juvenile probationers can be more effectively served within a community-based system of care. Probation and MISC cross-agency staff have collaborated to support crisis intervention programs, local group homes, family mentorship services, placement review committees, counseling and education centers, and interagency teams to tailor services to meet the individual strengths and needs of the probation department's clientele. The cross-agency, interdisciplinary partnership of the MISC is instrumental in more effectively meeting the needs of juvenile offenders and their families.

• Parents of youths report fewer internalizing and externalizing concerns after integrated care in MISC. Also, clinical coordinators report less severe impairments in youths' functioning.

• School performance for probation-referred youth show similar, positive increases.

Wood, M., Furlong, M. J., Rosenblatt, J. A., Robertson, L. M., Scozzari, F., & Sosna, T. (1997)

Understanding the psychosocial characteristics of gang-involved youths in a system of care: Individual, family, and system correlates. *Education and Treatment of Children, 20(*3), 281-294.

In order to provide comprehensive data about the profiles and risk factors of gang members participating in a system of care for youths with emotional and behavioral disorders (EBD), descriptive statistics were explored. Results indicated that gang-involved youths are represented in all ethnic and gender groups, experience multiple child and family risk factors, present mental health-, substance abuse- and academic-related problems, and often socre within clinical ranges on behavioral and emotional indices. In addition, a multivariate analysis (MANOVA) using gender, ethnicity, and gang-affiliation as independent variables indicated that non-Latina, gang-involved females present significantly more internalizing and externalizing disorders than any of the other ethnic or gender groupings. Implications for the social and mental health services delivered to youths with EBD affiliating with gangs are discussed in the context of a system of care.

• Gang-involved youths are represented in all ethnic and gender groups and experience multiple risk factors, mental health, substance use, and academic-related problems.

• Non-Latina gang-involved females present more internalizing and externalizing than any other ethnic/gender grouping.

Wood, M., Rosenblatt, J. R., Furlong, M. J., Robertson, L. M., Bates, M. P., & Casas, J. M. (1997)

Evaluating system of care clinical outcomes by youth risk profiles. In C. Liberton, K. Kutash, & R. Friedman, (Eds.), *The 10th Annual Research Conference Proceedings. A System of Care for Children's Mental Health, Expanding the Research Base* (February 23 to February 26, 1997) (pp. 407-414). Tampa FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Specifically defining the characteristics of the target populations served in system of care has been recognized as a vital preliminary step in empirically determining the most effect interventions. The present study, therefore, sought to determine: (a) if youths referred to a system of care present differing profiles of impairment and corresponding needs; and (b) whether differential clinical outcomes may be associated with these specific profiles of sociodemographic and behavioral characteristics.

• A cluster analysis using child and family risk factors, behavioral consequences, and clinician-and parent-rated measures yielded four profile types: Troubled, troubling, troubled and troubling, and at-risk.

• Six-month outcome data indicated that different profile types are associated with more significant impairment.

Wood, M., Rosenblatt, J. A., Robertson, L. M., Sosna, T., Gaskin, M., Terrell, E., & Thompson, M. (1996)

Precision of fit or one size fits all? Wrapping and tailoring to the needs of the community. In C. R. Ellis & N. N. Singh (Eds.), *Children and adolescents with emotional and behavioral disorders: Proceedings of the sixth annual Virginia Beach Conference.* Richmond, VA: Commonwealth Institute for Child and Family Studies, Medical College of Virginia, Virginia Commonwealth University.

Santa Barbara County is one of 22 sites nationwide to receive a federal grant from the Center for mental Health Services to develop and evaluate a Multiagency Integrated System of Care (MISC) serving families and their children with severe emotional and behavioral disturbances. The MISC is based on a set of principles that guide the coordination of services for children among their families, County Mental Health, Social Services, Public Health, Probation, Drug and Alcohol Programs, public schools, and private counseling agencies. Unique approaches to evaluation and service delivery will be presented. Innovations such as blended resources, streamlined paperwork, simultaneous assessment and care coordination, centralized service plans, and a deduction of duplication will be shared and evaluated. This

presentation will examine agency referral criteria, the population of youths served, structural system changes incorporated to accommodate for multiagency integrated service delivery, and intensive caseload management in the context of an outcome-based community partnership. We will discuss multigated assessment and its integration with the evaluation process. Variable levels of school involvement in the system, and the precision of fit model of service delivery are just a few of the unique attributes of this innovative program that will be addressed.

Zanglis, I., Furlong, M.J., Wood, M., Casas, J.M., & Blake, K. (1998)

Opening the floodgates? The influence of a system of care on referrals to special education. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 11th Annual Research Conference Proceedings. A System of Care for Children's Mental Health, Expanding the Research Base* (March 8 to March 11, 1998) (pp. 106-111). Tampa FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

The purpose of this paper is to examine the rates of SED identification in one community operating a system of care to determine the service system's influence on special education referrals. The historic pattern of SED identification in the community, child and family risk factors of children served, and behavioral and emotional indicators are examined to address the growing concerns of local school districts regarding service delivery and shared accountability to SED students and their families.

• The number of youths identified as SED rose over 44% after the implementation of MISC in Santa Barbara County. Factors proposed to explain the rise in SED are discussed.

Zanglis, I., Furlong, M.J., & Casas, J.M. (in press)

A case study of a community mental health collaborative. Impact on identification of youths with emotional disturbance. *Behavioral Disorders.*

The participants in Santa Barbara County's Multiagency Integrated System of Care (MISC) have serious emotional and behavioral disorders that require collaboration among family members, health and safety-net agencies, education, and community-based organizations. This investigation compares the characteristics of students referred to school-administered special education services due to emotional and behavioral disorders (EBD) prior to initial opening into the system of care and those identified as EBD after the initial opening into MISC. At the time this study was conducted serious emotional disturbance was the term use in California; however, to reflect current terminology the term EBD is used throughout this article. The purpose of this study is to: (a) investigate the influences of cross-agency coordinated service delivery on the frequency of special education eligibility both locally and statewide (California); examine the psychosocial histories, presenting problems, and diagnostic information of EBD-identified students in the MISC program; and (c) examine issues related to concerns that the implementation of collaborative systems of care will increase EBD identification rates. During the implementation of a cross-agency, co-located service delivery system, the number of county youths who were eligible for public mental health services in Santa Barbara County increased from 956 to 1,826. At the same time, the number of youths residing in the county who were eligible for special education EBD services increased from 101 to 204. Whether these youths with EBD, who were identified by the schools after the system of care was in place, represent a distinct group is explored. Issues related to the interpretation of findings and for improving understanding of identification patterns for students with EBD are offered.

• A community mental health collaborative (relative to school professionals) may identify ED youth at a younger age and thereby intervene before problem behaviors take place or worsen.

• Contrary to community concerns, the implementation of a system of care does not open a "floodgate" of ED cases into mental health systems. Rather, rising ED rates are attributable to multiple causes (e.g., community awareness and commitment to treatment).

Zanglis, I., Furlong, M. J., Casas, J. M., & Chung, A. (1999)

Accessing and using juvenile probation data to evaluate outcomes: Santa Barbara County MISC. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings. A System of Care for Children's Mental Health. Expanding the Research Base* (February 21 to February 24, 1999; pp. 14-16). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Juvenile probation data was collected as part of the national evaluation of system of care. Santa Barbara County accessed local probation data that provided important information. This paper presents the framework that was developed to code the type and severity of juvenile probation referrals for each MISC youth for three time periods. The elements needed for collaboration between County Probation and County Mental Health to obtain this detailed information are examined.

• The number of sustained petitions (equivalent to a conviction for an adult), in general, decreased across time (i.e., pre-MISC referral, first six months in MISC, seven to twelve months in MISC).

• Similarly, the severity of the crimes committed (e.g., felony, misdemeanor, probation violation) decreased over time.

Zanglis, I., Pavelski, R., Furlong, M. J., Casas, J. M., & Sosna, T. (under review)

Enrollment in an established system of care: A replication and extension of clinical profiles at service intake. Manuscript submitted for publication.

This study replicated Rosenblatt et al.'s (1998) cluster analysis of intake profiles of youths enrolled in a system of care program. The characteristics of a unique sample of 275 children and adolescents with emotional and behavioral disorders who participated in the Santa Barbara County Multiagency Integrated System of Care (MISC) program were examined. A two-step clustering procedure (hierarchical and K-means) was used to evaluate subtypes of youths who were opened to MISC after it had become a stable youth-service program. The results of the Rosenblatt et al. (1998) study were replicated with four identical clusters emerging: Troubled, Troubled and Troubling, Troubling, and At-Risk. Two additional clusters emerged: Moderate Troubled, and Moderate Troubled and Troubling. Comparisons across these six clusters show distinct profiles of youths with emotional and behavioral disorders. Implications of these findings for developing appropriate service plans and for evaluating systems of care outcomes are discussed.

• Distinct groups of youth were found using cluster analysis. While some clusters of youth had been identified in prior research, two new groups, specifically at-risk youth, emerged here. This points to differences in client type over the course of enrollment in a system of care.

• The creation of youth typologies has implications for how cases are conceptualized as well as what types of services should be prioritized and delivered.

Granada Theater, Santa Barbara

MISC Publications and Conference Presentations Through July 2000

Casas, J. M., Pavelski, R., Fulong, M. J., & Zanglis, I. (2000). Addressing the mental health needs of Latino youth with emotional and behavioral disorders: Practical perspectives and policy implications. *Harvard Journal of Hispanic Policy*.

Furlong, M. J., Casas, J. M., Woodbridge, M. W., & Sosna, T. (2000). Santa Barbara's evaluation principles, practices and products. In M. Hernandez & S. Hodges (Eds.), *Tools, case studies and frameworks for developing outcome accountability in children's mental health.* Baltimore, MD: Brooks.

Zanglis, I., Furlong, M. J., & Casas, J. M. (in press). A case study of a community mental health collaborative: Impact on identification of youths with emotional disturbance. *Behavior Disorders.*

Turner, J., Casas, J. M., & Furlong, M. J. (1999). Unique evaluation outcome features: Santa Barbara County MISC. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings, A System of Care for Children's Mental Health, Expanding the Research Base* (February 21 to February 24, 1999) (pp. 12-13). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Zanglis, I., Furlong, M. J., Casas, J. M., & Chung, A. (1999). Accessing and using juvenile probation data to evaluate outcomes: Santa Barbara County MISC. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings, A System of Care for Children's Mental Health, Expanding the Research Base* (February 21 to February 24, 1999) (pp. 14-16). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Pavelski, R., Woodbridge, M. W., & Flam, C. (1999). Evaluating the adherence to service delivery planning in a system of care. In C. Liberton, K. Kutash, & R. Friedman (Eds.), *The 12th Annual Research Conference Proceedings, A System of Care for Children's Mental Health, Expanding the Research Base* (February 21 to February 24, 1999) (pp. 16-17). Tampa, FL: University of Southern Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

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Zanglis, I., Pavelski, R., Furlong, M. J., Casas, J. M., & Sosna, T. (under review). *Enrollment in an established system of care: A replication and extension of clinical profiles at service intake.* Manuscript submitted for publication.

CONFERENCE PRESENTATIONS (most recent to past)

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Pavelski, R., Turner, J., Zanglis, I., & Furlong, M. J. (2000, April). *Outcomes in a cross agency collaborative for youths with emotional and behavioral disorders: An examination of service utlilization.* Paper to be presented at the National Association of School Psychologists (NASP) Convention, New Orleans, LA.

Pavelski, R., Turner, J., Zanglis, I., & Furlong, M. J. (2000, March). *What youths with emotional and behavioral disorders tell us about transitioning to adulthood.* Paper to be presented at the California Association of School Psychologists (CASP) Convention, Monterey, CA.

Zanglis, I. & Pavelski, R. (1999, April). *Who are these kids?: Analyzing the risk factors of youths referred to a community mental health collaborative.* Paper presented at the National Association of School Psychologists (NASP) Convention, Las Vegas, NV.

Zanglis, I. & Furlong, M. J. (1999, March). *A community mental health collaborative: Impact on identification of youths with emotional disturbance* Paper presented at the California Association of School Psychologists (CASP) Convention, Pasadena, CA.

Furlong, M. J., & Casas, J. M. (1999, February). *Holy MACRO: Lessons learned from evaluating a center for mental health services-funded program.* Paper presented at the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, Tampa, FL.

Rajvaidya, P., & Woodbridge, M. W. (1999, February). *Managing evaluation data in a system of care: Barriers and solutions.* Paper presented at the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, Tampa, FL.

Woodbridge, M. W., & Flam, C. (1999, February). *A scale to evaluate the integrity of wraparound service planning.* Paper presented at the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, Tampa, FL.

Zanglis, I., & Chung, A. (1999, February). *Using juvenile probation data to evaluate outcomes in a system of care*. Paper presented at the Research and Training Center for Children's Mental Health, Florida Mental Health Institute, Tampa, FL.

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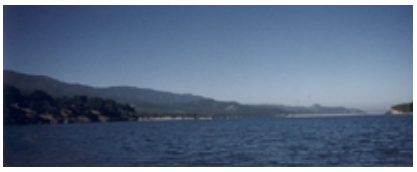

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Wood, M., Rosenblatt, J. A., Robertson, L. M., Bates, M. P., & Furlong, M. J. (1996, October). *Precision of fit or one size fits all? Wrapping and tailoring to the needs of the community.* Paper presented at the 6th Annual Virginia Beach Conference, Virginia Beach, VA.

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Related On- line Resouces

California Department of Mental Health.
URL: http://www.dmh.cahwnet.gov

California Healthy Kids Survey.
URL: http://www.wested.org/hks

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Journal of Emotional and Behavioral Disorders *(M. Epstein, and D. Cullinan, Editors). Austin TX: Pro-Ed.*
URL: http://www.proedinc.com/

Knowledge Exchange Network (KEN).
URL: http://www.mentalhealth.org

National Association of School Psychologists.
URL: http://www.naspweb.org

Portland State Research and Training Center
URL: http://www.rtc.pdx.edu/

Robert Wood Johnson Foundataion.
URL: http://rwjf.org

Substance Abuse and Mental Health Services Administration (SAMHSA).
URL: http://www.samhsa.gov

University of South Florida: Louis de la Parte Florida Mental Health Institute.
URL: http://www.fmhi.usf.edu/

Other Resources

For those interested in further reading on topics discussed in this report, we have included a bibliography below.

SYSTEM OF CARE

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CHILD BEHAVIOR CHECKLIST (CBCL)

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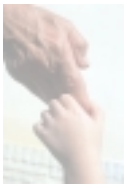

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Celebrating student success at Santa Maria High School

Many individuals contributed to the development and success of MISC

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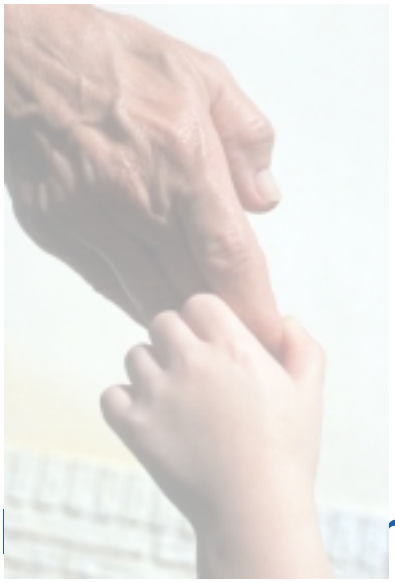
MISC's Vision

All Children and Families Flourishing



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