Collaborative Initiatives to Develop Integrated Services for Children and Families

A Review of the Literature

Revised March, 1996

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SECTION ONE

OVERVIEW

This review of the literature is intended for use by organizations and agencies who are working collaboratively to improve outcomes for children and families by developing integrated services in their communities. The factors outlined in this review have been identified by researchers, experienced service practitioners and organizational theorists as key components in designing, implementing and evaluating the impact of collaborative initiatives to develop integrated services. The information is organized in a framework that reflects primary areas of importance in evaluating the implementation (or processes) and impact (or outcomes) of collaborative initiatives focused on service integration. The framework includes four broad categories:
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Context:	The background factors that may influence or be influenced by service integration initiatives.
Barriers and facilitators:	The factors that either enhance or inhibit the collaborative process.
Key elements:	The activities that describe the implementation process of a service integration initiative.
Outcomes:	The observable effects of the collaborative initiative and the indicators used to substantiate these outcome claims.

This framework corresponds with the model used to develop broad evaluation questions for Minnesota's Children's Initiative Partners, Children's Mental Health Collaboratives and Family Services and Community-Based Collaboratives. These evaluation questions are presented in Attachment A.

This literature review is based on an examination of documents from various service sectors (i.e., education, mental health, health, social services and economic security). We found that it was necessary to include documents from the various sectors in order to obtain a comprehensive perspective on issues related to the evaluation of integrated services for children and families. Depending on the focus of a particular community initiative, some factors across the framework will be more relevant than others.

A distinction is made in this review between collaboration, which is a process or tool for integrating services, and service integration, which is the intended result of collaborative initiatives. Although the two

concepts are related, making a distinction between them in planning and evaluating collaborative initiatives may improve our understanding of how each is related to improving outcomes for children and families.

The documents that have been reviewed reflect a combination of empirical research findings, recommendations based on multiple practitioners' experiences, theoretical perspectives, and analysis of existing programs. Because not all of the factors identified here are based on empirical research findings, to a large degree, their validity and usefulness must be determined by the collaborative initiatives who use this document. A listing of all references reviewed is presented in Attachment B. Additionally, selected references for each framework category are included at the end of the corresponding section.

As state and local-level collaborative efforts at service integration are increasingly examined and evaluated, more and more information will become available about the contextual factors that shape the initiatives, the factors that enhance or inhibit collaborative processes, and the implementation strategies that lead to improved short and long-term outcomes for children and families.

How to Use this Report

This document is intended as a resource for local collaboratives as they design, implement and evaluate their initiatives. The information should be useful in conceptualizing a variety of evaluation approaches: evaluation of context, evaluation of barriers/facilitators, process evaluation and outcome evaluation. Table 1 summarizes the characteristics of these evaluation approaches in terms of proposed objectives, data collection methods and how the data may be used by decision makers.

The major sections of this document have been organized to correspond to the broad framework categories and to the "theory of action" for the collaborative initiatives (Figure 1). A theory of action illustrates the relationship among the framework categories. Section Two emphasizes the contextual factors that may shape service integration initiatives. In Section Three we summarize the factors that may facilitate or impede the collaborative process itself. Sections Four and Five crystallize the key elements that are part of a collaborative initiative to develop integrated services for children and families. In Section Six we identify an array of outcome claims that service integration initiatives may make about positive impacts on children and families and the system as a whole. This section also includes a compilation of intermediate and long term indicators that might be used to substantiate these outcome claims.

Figure 1: Theory of Action

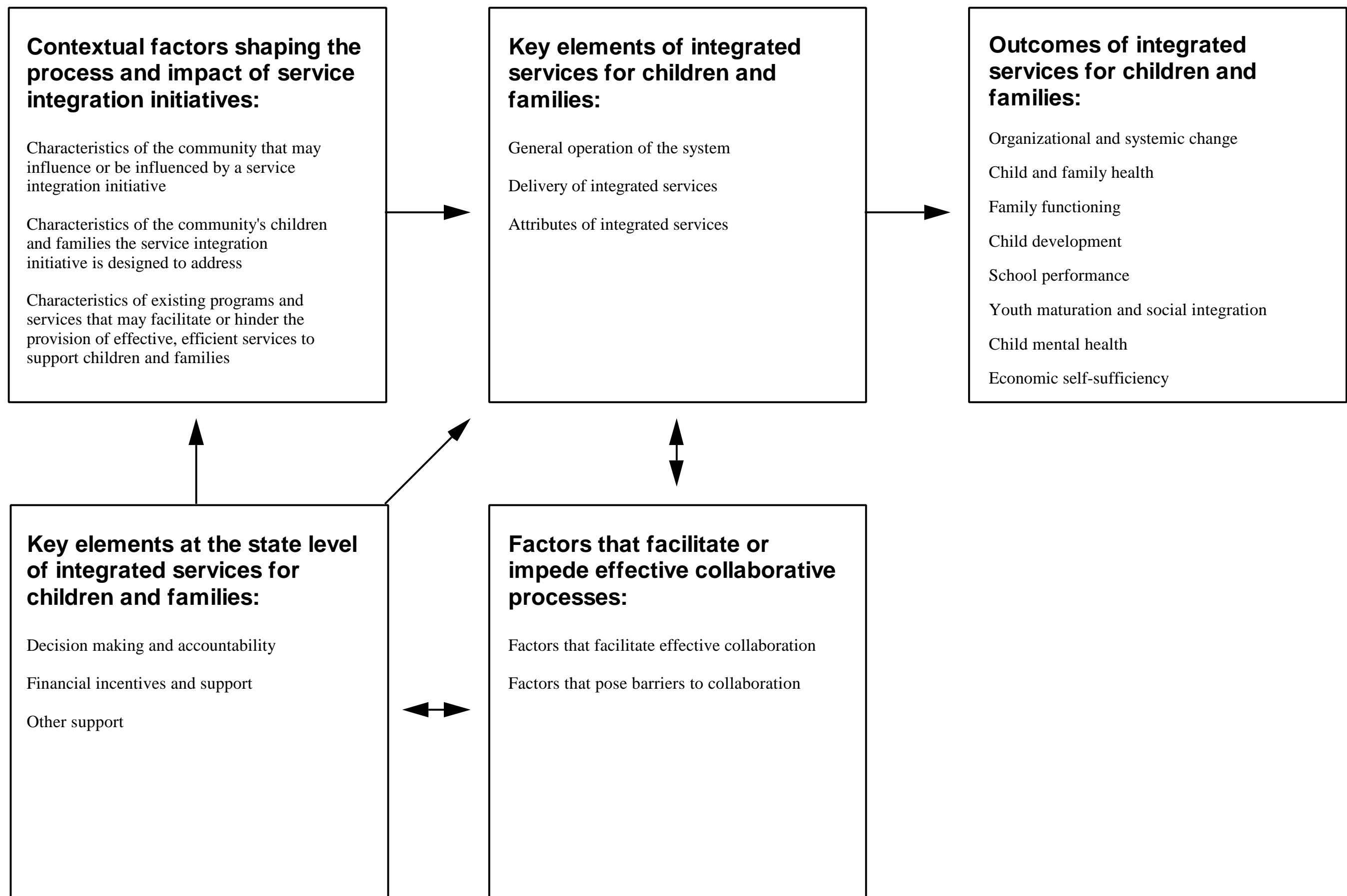

TABLE 1: **Evaluation Approaches**

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	Context Evaluation	Evaluation of Barriers/ Facilitators	Process Evaluation	Outcome Evaluation
Objective	To identify the target population To assess strengths and needs	To identify and assess system capabilities in terms of collaborative barriers and facilitating factors	To identify strengths and weaknesses of procedural design	To identify outcome claims and corresponding indicators To relate indicators to
	To identify opportunities to address needs and build on strengths		To record key elements and procedural events	organizational and community context factors and key program elements

	To diagnose problems underlying		To assess relevance of key	
	identified needs		process elements to community needs	To interpret value of the program
	To judge whether proposed objectives are sufficiently responsive to assessed strengths and needs		To assess level of involvement in collaborative processes and decision making	
			To assess the quality of collaborative processes	
Data Collection Methods	System/community analysis Surveys Document review Interviews Diagnostic tests	Surveys Interviews Observation Document Reviews	Structured observation of collaborative practices Document review Process descriptions Interactions with project staff	Document and record reviews Surveys Assessment instruments (vary greatly by identified indicators)
How Data May Be Used by Decision-Makers	Deciding upon the geographic setting to be served Determining program goals associated with meeting needs or capitalizing on opportunities Establishing the objectives associated	Identifying sources of collaborative support Developing barrier reduction/ removal strategies Structuring change activities	Implementing and refining program design and procedures Interpreting outcomes	Deciding whether to continue, terminate, modify, or refocus collaborative activities Presenting a clear record of effects (intended and unintended, positive and negative)
	with solving problems Planning needed changes			
	Establishing a basis for judging outcomes			

SECTION TWO

CONTEXTUAL FACTORS SHAPING THE PROCESS AND IMPACT OF SERVICE INTEGRATION INITIATIVES

Context includes a variety of background factors that may influence or be influenced by an initiative to develop integrated services for children and families. Some factors may be the focus of the change

initiative's policies, programs and activities. Other factors may be outside the control of the system change planners, but have either facilitating or inhibiting effects on the initiative process and impact.

The contextual factors presented in this section include characteristics of the community as a whole; characteristics of the community's children and families that the initiative is designed to address; and characteristics of existing programs and services to support children and families. Depending on the focus of the initiative, particular contextual factors will be more or less relevant. It is important for planners of service integration initiatives to obtain and periodically review existing information and data related to contextual factors that are particular to their community.

Characteristics of the community that may influence or be influenced by a service integration initiative

The demographic profile of the community

Population growth rate

Population distribution by age

Racial/ethnic/cultural characteristics

Occupational profiles

Home ownership and general housing patterns

Educational attainment

Number of people with disabilities

Changing structure of the family (divorce rate, out-of-wedlock births, teenage pregnancy)

Prevalence of teenage suicides

Prevalence of children in single parent homes, before reaching adulthood

Economic status of families

Prevalence of violent behaviors

Number of children with severe emotional disturbances and severity of disorders

Prevalence and severity of mental health and substance abuse disorders in adults

Prevalence of co-occurring disorders among children and adults

The community's beliefs, values, attitudes, and norms

Cultural beliefs

Cultural practices

Cultural celebrations and other traditions

Approaches to family issues and to child rearing

Value placed on normalization for people with mental disorders

Parents' sense of security

Connections among families, neighbors, and community members

The community's geographic boundaries

Definition of the community to be served geographically (as the city, county, school district, etc.) will help to align the structures and operations of decision-making bodies, the location of services, and the characteristics of the population.

Existence of cohesive, readily identifiable catchment areas (e.g., clearly rural, urban, etc.)

The community's leadership

Local business representatives

Clergy and other representatives of religious congregations and agencies

Culturally specific organization representatives

Elected officials

Leadership of collaborative projects

Advocacy and volunteer organization representatives

Philanthropists

Health, human service, and educational service providers

Higher education representatives

Characteristics of the community's children and families the service integration initiative is designed to address

Planners can take either an asset based approach or a deficit based approach in developing their system change efforts. Depending on the issues most relevant to their target population, individual initiatives will focus on a unique set of outcomes and indicators in the areas listed below. See Section Six of this review for a listing of specific outcome claims and indicators in these areas.

Child and Family Health

Family Functioning

Child Development

School Performance

Youth Maturation and Social Integration

Child Mental Health

Economic Self Sufficiency

Characteristics of existing programs and services to support children and families that may facilitate or hinder effective, efficient programs and services for children and families

Funding

Size of budgets for a continuum of child and adolescent programs from prevention to treatment

Maintaining a balance between the immediate needs of children and families with serious problems and the long-term need to support children and families to prevent development of so many inter-related problems

Disincentives for local/home based care:

-cost of home and community-based systems must be absorbed locally but out-of-home and out-of-community placements are covered by higher levels of government

-greater portion of the cost for some services paid by the county

-services, such as state-operated institutions and hospitals, provided at state expense with referrals made by community agency personnel

Fragmented service delivery system

Federal funding streams, differences in eligibility and federal categorical programs

Multiple agencies, each having its own funding stream to provide specific services to a population that meets a highly targeted eligibility criteria

The agency that has access to the child does not have access to all of the resources theoretically available in the system

Agencies are restricted by how much money they can spend and by eligibility criteria that restrict how they can use available dollars.

Many families with private insurance have mental health coverage that is inferior to that available to public assistance clients

Attitudes and knowledge

"We can only fill the available slots" mentality of service providers

Inflexible family preservation policies

Least restrictive setting mandate limits treatment options - a child is forced to fail at one level of treatment before he is permitted to receive the level of treatment that would be most effective

Parents' unwillingness to label children sometimes can delay treatment

Little scientific information available concerning the efficacy of alternative treatment for emotional disorders in children and adolescents

Lack of trained personnel -- both a lack of trained child and adolescent mental health professionals (child psychiatrists, child and/or developmental psychologists, and clinical social workers specializing in children and adolescents) and a lack of less highly trained personnel who could staff community-based services

Parents play opposing roles in the system. Some serve as de facto case managers for their children's treatment but parents can also be part of the problem, creating unhealthy or dangerous environments that cause or contribute to children's illnesses

Lack of public support for addressing the needs of children and adolescents with severe emotional disturbances; negative attitudes and/or lack of awareness

Services are driven by the constraints of the service system instead of being designed to support and strengthen families or to promote the ability and opportunity for parents to make informed choices

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Selected references for contextual factors

General references

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SECTION THREE

FACTORS THAT FACILITATE OR IMPEDE EFFECTIVE COLLABORATIVE PROCESSES

Collaboration is a process where organizations and people unite for the purpose of achieving common goals that could not be accomplished by any single organization or individual acting alone. In contrast to cooperation or coordination, collaboration involves more intensive action in which the parties share common goals, mutual commitments, resources, decision making, and evaluation responsibilities.

Collaboration is frequently a tool or process used in system change initiatives that seek to develop comprehensive, integrated service systems. Collaboration can take many different forms from collaboration among government agencies, to collaboration among service providers to collaboration among service providers and recipients of those services. Although collaboration represents the means rather than the end of a system change initiative, the success of the collaborative process can influence the achievement of service integration.

The purpose of this section is to describe factors that facilitate or impede effective collaborative processes. Awareness of these factors may assist participants in reflecting on their collaborative processes in order to build on strengths and to implement strategies to overcome barriers.

Conditions that tend to facilitate effective collaboration include factors surrounding the attitudes, values, and perceptions of collaborating partners. These are called *interpretive* facilitating factors. *Contextual*

facilitating factors include structural components such as technology, organizational complexity, and economic patterns.

Barriers include the obstacles, both interpretive and contextual, that exist within systems that block or hinder implementation of collaborative initiatives and the achievement of the collaborative's goals.

Factors that facilitate effective collaboration

Interpretive facilitating factors

Perceived need for collaboration

Perceived benefits to organizations and families outweigh the perceived costs

Positive staff/administrator attitudes favor collaboration

Consensus between administrators and staff about program goals and activities

Agencies see others as being a valuable source of resources

Perceived ability to maintain program identify/prestige/power in the collaborative relationship

Reward system for staff reinforces group-centered approaches and collaboration

Accessibility to other organizations

Positive evaluations of other organizations and their staff

A level of similarity or overlap in resources, goals, and needs across organizations

Shared common commitment to initiative's main goal

Organizations share common definitions/ideologies/interests/approaches

Perceived partial interdependence among organizations

A history of good relationships between organizations

Relationships among participants built on trust, respect, and mutual understanding

Flexibility and adaptability

Outcome orientation and accountability for achievement of results

An environment that encourages honesty about individual agencies and turf concerns

Degree of independence that local professionals feel from their state supervisors

Clear and open exchange of information between families and professionals

Contextual facilitating factors

Needs/benefits actually exist (for certain types of families, or resources to better serve families)

Scarce resources

Prevailing organizational/environmental norms value innovation through collaboration

Standardization of procedures has taken place (referral procedures, scheduling of activities)

A level of occupational diversity among staff that is complementary

A broad range of services are offered by organizations

Leadership styles of organizational management favor collaboration

Regular opportunities exist for informal contact/exchanges of information/resources across organizations

Geographic proximity among organizations

Staff are specifically assigned to boundary-crossing roles

Similarity in organizational structures, supply capabilities, needs, and services

Chances exist for voluntary association of staff across organizations (leading to a reduction of misconceptions and hostilities and the development of a common ground for discussion)

Core staff responsible to the collaborative as a whole

Formal and informal structures and processes for resolving communication problems and turf conflicts

Clear lines of communication and clear roles

Process for recognizing and celebrating collective achievements and individual contributions

A participatory decision-making system that is accountable, responsive, and inclusive.

Experience with prior system-development efforts

Support from the top

A tradition of an active state-level role in developing and improving services

State agencies allocating funds to an entity that serves a geographically defined area instead of contracting directly with providers

Investment of agency resources through contribution of time, personnel, materials or facilities

Joint evaluation and judgment of the effectiveness of the project and the quality of the collaborative

Factors that pose barriers to collaboration

Interpretive barriers

Sense of competition for resources or clients among organizations

Organizations perceive a loss of program identity

Organizations perceive a loss of prestige or role as "authority"

Organizations have differing levels of service effectiveness

Alienation of certain types of families by some organizations

Differing leadership approaches/authority among organizations

Differing professional backgrounds of staff

Disparities in staff training across organizations

Different program priorities, ideologies, outlooks, or goals for families

Lack of a common "language" among organizations and differing professions

Internal norms among staff do not favor cooperation or collaboration

Negative evaluations of other organizations and staff

Lack of knowledge and skills among agency/organization staff

Poor historical relations between organizations

Perceived sanctions by peers or higher authorities

Inertia of existing service system

Contextual barriers

Costs (in terms of resources or staff time) outweigh the actual benefits

Lack of communication among higher level staff

Bureaucratization that inhibits internal as well as external communication

Centralization of authority causing large amounts of "red tape"

Little staff time devoted to boundary crossing roles

Structural differences (scheduling, pay structures, contract agreements, standards of service, funding mechanisms)

Differences in organizational priorities, goals, or tasks

High staff turnover within organizations

Other organizations/agencies having little to offer

Lack of geographic proximity

Professionalization of staff roles limits flexibility

Inadequate cross-agency monitoring and evaluation practices for decision making

Ineffective community decision-making structures

Categorical funding requirements, confidentiality strictures, and other statutory and regulatory barriers to coordination

Lack of resources/insufficient funds

Lack of trained personnel

Absence of clear responsibility for providing an integrated and comprehensive package of services and supports

Lack of coordination by advisory bodies

Families' past negative experiences with professionals

Inherent power imbalance between professionals and family members

Professionals' beliefs that families cause children's disorders

Selected references for factors that facilitate or impede effective collaborative processes

General references

Amherst H. Wilder Foundation. (1992). *Collaboration: What makes it work.* St. Paul, MN: Amherst H. Wilder Foundation.

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SECTION FOUR

KEY ELEMENTS OF INTEGRATED SERVICES FOR CHILDREN AND FAMILIES

There are two major types of elements, or activities, related to an integrated service system for children and families:

A) activities related to the general operation of the system, including those related to planning, decision-making, funding, information management and communication

B) activities directly related to providing integrated services; these include intake and assessment, case management/service coordination, case review and quality assurance and integration of services.

In addition to these key elements there are also system attributes that describe how the elements are operationalized. These attributes include: family-focused/individualized; culturally competent; community based and comprehensive. The key elements and attributes are not necessarily mutually exclusive, but they have been separated here for discussion purposes. Collaboratives may want to examine their implementation process in terms of these elements.

A. GENERAL OPERATION OF THE SYSTEM

In this section, key elements related to the general operation of an integrated service system are described. Some of these elements may be more relevant at start-up, some may be ongoing functions that need to be done within the system.

Planning

Planning should be a collaborative, multidisciplinary, multiagency effort that involves all relevant parties, public and private. Key characteristics and steps include:

Initial planning

Establish a definition for the target population that is agreeable to all agencies in system

Assess the characteristics and service needs of the target population

Examine the match between range of services offered and the needs/assets of the target population

Examine the degree to which services/supports offered are actually used by the target population

Define the nature and components of the desired system of care

Establish clear goals and a clear value statement that reflects the basic values that motivate, drive, and define the system of care

Examine the collaborative "infrastructure" (e.g. administrative and decision-making structures, use/integration of funds, facilities utilization, staff training and career development)

Examine the extent to which service delivery practices inform subsequent decision making practices

On-going planning

Conduct an annual comprehensive process evaluation that focuses on the following: (1) reviews program philosophy, administration and operation, documentation, and facilities; (2) interviews with clients in the program and program staff; and (3) surveys of the members of the client's service planning team (including the legal guardian) to assess their level of satisfaction with the services of the provider

Develop a strategic planning process that includes: a reevaluation of the agency mission, vision, and tenets; a stakeholder analysis; assessments of the external and internal environments; a review of service accessibility, and client progress and consumer satisfaction measures

Strive for developing additional services based both on the needs of clients and on those of the existing service system. Create, stimulate, or otherwise derive and access new services when and as needed by clients, regardless of how new or demanding of the system

Establish a sound client-information database that can identify critical characteristics and trends in the population, track client services, and point to service development needs

Decision-Making

Creation of decision-making structures

Partner organizations must commit to operate under a particular decision making structure. Alternatives include:

Interagency agreements

Human Services Board

Joint Powers Authority

Development of a new Non-Profit Agency

Informal Governing Board

Participation in decision-making

Determination of who (by role and affiliation) participates

Determination of the extent to which decision making authority is distributed and shared

Determination of who (by role and affiliation) assumes leadership responsibility within the decision-making structure

Role of the decision-making body

Set collaborative agenda and priorities

Develop strategies

Coordinate and distribute resources

Maintain accountability

Distribute authority

Empower others to act on behalf of the collaborative

Establish formal and informal structures and processes for resolving communication problems and turf conflicts

Serve as autonomous entity to administer system of care rather than administrator affiliated with a mental health or social service agency that provides direct service

Facilitate community agreement on problems

Purchase individualized services from a variety of public and private providers

Create alternative organizational structures for service delivery

Alternative structures include:

Consolidated: all services are provided by one agency using case managers at the clinical level

Quasi-consolidated: almost all services are provided by one agency, but typically responsible for certain services, such as mental health, is divided between two agencies

Single or lead agency management: cooperating agencies in each community form agreements detailing the roles each plays in the planning and provision of services, using case managers across agencies. Legal, executive, or court mandate may also be used to define roles

Multiple agency management: agencies establish formal agreements detailing the roles of each agency in the planning and provision of services, consistent communication and coordination, joint funding of case managers, and ready, periodic review for problem solving, fine tuning, and evaluation

Factors that influence success

Regular and willing coordination among all concerned at all levels of responsibility

Management system should be most visible and functional at the local community level

Management works in partnership with state government to create an effective delivery system. The partnership with the state government is imperative to gain access and support from all child-serving agencies at the state level and to prevent the local authority from becoming dominated by special interests or becoming an overly politicized decision-making entity

Neighborhood decision-making boards strengthen the role of neighborhood leaders in serving local residents

Funding

Establish integrated funds. Alternatives include:

Integration of funds from multiple sources (including local, state, and federal funding streams)

Joint budgeting, cost sharing among public agencies who share responsibility in service delivery (or sharing costs with families)

Joint purchase of services

Wrap-around funds that permits case managers/direct service providers to "wrap services around" the needs of children and families rather than requiring families to fit into existing services or programs

Obtain additional funding/ find new uses for existing funds

Obtain Medicaid reimbursement for in-home, targeted case management and other nontraditional services

Re-deploy inpatient hospital funds to support community-based services

Use resources in a needs-determined manner where funding is flexible and can be used for experimentation, creating pilot programs, staff incentives, training and technical assistance

Information management and communication

Information maintained and shared across collaborative partners

Service provider information

-Agency Goals

-Service eligibility, accessibility, and current availability

-Array of services provided

-Contact person

General collaborative/organizational information

-Organizational updates (upcoming events, new funding sources)

-Training opportunities

-Educational materials or resources

-Exchange of knowledge or experiences
-Research findings
-Review of debated issues

Service Recipient information
-General individual/family demographics
-Individual/family strengths and needs
-Identification of array of services currently being received
-Case management or service coordination plans
-Case manager or key case contact
-Individual or family plans/goals
-Dates of service provision
-Documentation of progress toward goals
-Measures of identified outcomes and indicators
-Follow-up information

Modes of communication across collaborating organizations

Informal phone conversations
Formal or informal meetings
Electronic communication (E-mail, Internet)
Accessing a uniform, unified, cross agency data and information system

Levels of communication across collaborating organizations

Direct service staff
Administration/management
Policy makers/decision makers

Uses of information

Communicating the collaborative's work, methods, results, problems, etc. throughout the system
Assessing client needs, progress, and outcomes
Providing a strong basis for rational data-based decision making

Facilitating research activities

Staff training and support

Transfer staff across agencies/organizations

"Loan" administrators across agencies/organizations

Cross train staff from multiple agencies/organizations

Offer incentives for continuing education

Train staff for boundary crossing roles (i.e., understanding the functions and working of other agencies and departments)

Offer intensive training and compensation for required skills

Educate key groups in the system on alternative ways of providing services. The recipients of this training and consultation should, on the one hand, be planners and administrators, and on the other hand the actual line workers who provide service.

Train more mental health professionals who specialize in the treatment of children and adolescents

Provide continuing education opportunities to existing mental health professionals to keep them abreast of current developments in the care of children and adolescents with severe emotional disturbances

Train both professionals and paraprofessionals who can provide the in-home and community-based services that are being promoted

Develop training curricula for existing case managers that address services and systems issues specific to children and adolescents

Include family input in the education of mental health care professionals

Provide intensive training to prepare case managers for job duties not taught in formal education

Provide technical assistance and special program development strategies to new providers who are expected to serve difficult, acting-out clients with a philosophy of "no reject/no eject"

Public awareness and advocacy

Special events sponsored by the collaborative

Contact with legislators and state administrative staff

Media coverage of collaborative activities

Establishment of a collaborative newsletter

Remove shame and blame

Remove stigma from mental illness

Increase the general knowledge of mental health disorders

B. DELIVERY OF INTEGRATED SERVICES

Intake and assessment

Provide a universal point of service contact, a single point of entry into the service system

Coordinate comprehensive interagency intake and assessment practices that have capability of assessing and identifying all the strengths/needs of referred or inquiring children and families, across or in spite of traditional disciplines

Evaluate the child/family needs and strengths in the context of his or her community

Assessment should be individualized and include child/family strengths and needs in at least eight major life domains: 1) family or surrogate family; 2) residence (a place to live); 3) social (friends and contact with others); 4) educational/vocational; 5) medical; 6) psychological, emotional, and behavioral; 7) community (recreation, transportation, legal, etc.); and 8) safety (the need to be free from harm)

Develop an individual service plan with goals, time lines, and descriptions of specific services, with clear delineations of responsibilities by all concerned.

Case management/service coordination

Establish interdisciplinary services teams (IDTs) which include, at a minimum: 1) the parent and/or the surrogate parent; 2) the appropriate representative of the state (if child is in custody); 3) lead teacher and/or vocational counselor; 4) counselor or therapist (if child is in mental health treatment); 5) a case manager or services coordinator (responsible for ensuring that the services are coordinated and accountable); 6) an advocate of the child and/or parent; and 7) any person influential in the child's or parent's lives, who may be instrumental in developing effective services, such as a neighbor, a physician, a relative, a friend, etc.

Case manager or service coordinator coordinates interagency assessment of needs, brokering the needed services, and linking those agencies that should be involved (including the schools), regardless of type of system management employed

Determine eligibility, economic and therapeutic analyses, resource commitment, and provide referral to appropriate services. Other roles include monitoring and tracking of services, advocating for families, and a modicum of shoring up and hand holding, throughout the process.

Case review and quality assurance

Establish a clearly definable structure with uniform but flexible procedures and quality standards

Establish multidisciplinary or interagency case review committees

Provide supervision and consultation to support front-line case managers and service planning teams

Provide continual monitoring of the progress of youngsters who have been placed in very restrictive settings.

Establish a process for resolving disputes amicably including: basic due process and fairness, prior notice, an opportunity to argue before an objective arbiter, and recorded dispositions are recommended

Maintain the privacy of children and adolescents with SED

Provide continual monitoring of the progress of youngsters who have been placed in very restrictive settings

Link case managers with case review or other service planning committees for interdisciplinary input regarding the planning of services, the rights of the clients, and the progress and appropriateness of services

Present case review or other service planning committees as sharers in the responsibility of decision making about the lives of clients, locally, or as watchdogs, advisors, and strategists to the system at the state level. One caveat is to ensure that equal treatment, protection of rights (e.g., least restriction), and family and community-based values and philosophies are reasonably uniform across such committees, regardless of which clientele they serve

Ensure that system functions are implemented in conformity with the key values and philosophy of individualized, family-focused, community-based, and least restrictive service planning and provision

Provide periodic quality assurance review and evaluation of client progress and outcomes

Integration of services

Coordinate delivery of services* across an array of community-based entities (e.g., housing, transportation, public safety, parks and recreation, health, mental health, vocational, child care, education, human services)

Provide a single point of decision making, monitoring, and facilitation (e.g., empowered case management)

De-emphasize service categories, in favor of creating and wrapping services around each client

Offer creative, flexible, accountable, wrap around interventions in at least three life domains

Plan and provide services through collaborative multidisciplinary, multiagency efforts

*See Attachment B for listing of discrete services that are part of an integrated service system.

C. ATTRIBUTES OF INTEGRATED SERVICES

The goal of the collaboratives is to improve outcomes for children and families by developing integrated services. There are six attributes of quality services for children and families that are important.

Family-focused

In a system that is family-focused, parents and family members will be involved in all aspects of the system. Indicators of a family-focused system of care:

Family members are included in individual case planning

Parent support networks are developed

Parent advocacy for children's mental health exists in the region and the state

Parent representation exists on planning and advisory groups

Conferences and workshops for family members are provided

Training and technical assistance is routinely provided to parent groups

Financial support is provided to developing parent groups

Work with existing state parent advocacy organizations

Service plans include a family component in service plan (i.e., family participation in services) and provide rewards and sanctions for families that fulfill contract

Individualized

In a system that provides individualized services, the needs of the child dictate the mix of services provided rather than the needs or availability of the system. Indicators of individualized services:

Service provision is guided by an individualized service plan developed in accordance with unique needs and potentials of each child (and family)

Services are provided within the least restrictive, most normative environment that is clinically appropriate

Culturally competent

A system that is culturally competent is composed of agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve. Indicators of cultural competency:

Include minority group members on state planning and advisory groups

Establish special task forces and committees to address minority issues

Hold workshops and conferences

Provide special training on minority issues

Produce media products and materials specifically for or about minority populations

Hire bicultural or bilingual staff to address ethnic and cultural issues

Mount special data collection or needs assessments to identify the needs

Target high minority communities for parent support activities, local service demonstration, or information dissemination

Establish formal curricula, courses, or certificate programs in universities for community-based service delivery to children and adolescents

Assure that procedures for identifying and providing services to target populations are equitable

Community based

In a community based service system, services are planned, devised, integrated, and implemented at the local level. Indicators of a community based system:

De-centralize responsibility for planning and control over resources so that greater control is exercised at the community and neighborhood level

Allocate resources at the local level

Move locus of services as well as management and decision making responsibility to the community level

Comprehensive

Indicators of a comprehensive service system:

Provide services at varying levels of intensity and restrictiveness

Include prevention and early intervention services

Provide services to address the physical, emotional, cognitive, spiritual and social needs of the child and the family

Accessible

Indicators of an accessible system:

Services are co-located

Family resource centers or other "one stop shopping" models are provided

Flexible transportation services, ensuring availability of public transportation to service site

Home visits are provided

Service delivery hours are expanded to match the schedules of targeted users

Drop-in services are offered

Additional staff are available during "peak" hours

Intake locations have been established that are:

-physically accessible - nearby, co-located, served by public transportation, conveniently available before and after traditional working hours, present no barriers to the handicapped or to those who do not speak English

-psychologically accessible - clean, comfortable, hospitable, respectful, individualized environments

-functionally accessible - no theoretical or other artificial barriers such as new or previous labels that might restrict services

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SECTION FIVE

KEY ELEMENTS AT THE STATE LEVEL OF INTEGRATED SERVICES FOR CHILDREN AND FAMILIES

In addition to activities at the community level, service integration initiatives often involve activities at the state level.

Decision making and accountability

De-centralize responsibility from the state level to the local level

Move accountability for achieving particular outcomes to the local level

Establish standards for communities to meet in developing services

Monitor and evaluate the performance of communities

Establish policies and procedures to facilitate effective service delivery

Promote greater regional authority and flexibility in service-dollar expenditures by maintaining central accountability while decentralizing decision making and fiscal management

Provide oversight with emphasis on interagency coordination, broad brush planning, and thorough-going client and management data systems

Financial incentives and support

Share with community in providing resources and incentives for the system

Establish state/local partnerships on state hospital admissions

Offer to hold harmless collaboratives that encounter financial ruin

Provide start-up funds to encourage the development of needed services and limit the risks to the provider

Establish incentive or performance contracts with local governments

Establish cost-sharing partnerships to control the use of the state mental health hospital system

Establish interagency policy and funding strategies designed to expand services and target populations

Seed money to local sites, pooled cross-agency funding of services

Other support

Provide consultation and technical assistance to help communities

Organize, serve on or consult with a wide variety of task forces and advisory committees

Conduct surveys and needs assessments related to both the target population and the service system

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Selected references for key elements at the state level

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SECTION SIX

OUTCOMES OF INTEGRATED SERVICES FOR CHILDREN AND FAMILIES

A results-oriented approach to evaluation focuses on the following questions: What changes have occurred in the service system as a whole? What changes have occurred in the behaviors, knowledge, skills or attitudes of participants? What difference has the initiative made in the lives of participants? What is the status or life situation of participants now as compared to what it was before the initiative?

In developing outcome evaluation plans, collaborative initiatives may want to think in terms of outcome *claims* and *indicators*. An outcome claim is defined as the observable effect of the collaborative initiative on children and youth, families, or on the service system as a whole. An indicator is the evidence or documentation that will be used to substantiate a claim about the observable effect of the initiative. In addition to thinking about the long-term impact, collaborative initiatives should consider the identification of intermediate indicators that reflect the observable effects during the next two years. The assumption is that changes in the intermediate indicators may predict long-term changes in key claim areas.

The outcome claims and indicators presented on the following pages have been compiled from a number of sources, including articles and books regarding community-based collaborative initiatives, prevention initiatives, and the reform of service systems for children, youth, and families. In many cases, the indicators represent hypothesized rather than substantiated results of these types of initiatives. Major categories of claims include:

Organizational and systemic change

Child and family health

Family functioning

Child development

School performance

Youth maturation and social integration

Child mental health

Economic self-sufficiency

In identifying outcome claims and indicators, collaborative initiatives should use the following guidelines:

Focus on outcome claims and indicators that relate directly to what the collaborative initiative is actually doing (i.e., the key program elements). Don't specify indicators related to promoting community strengths or reducing community problems that are beyond the scope of the initiative. At the same time, consider indicators that address the key issues in the community and then focus on implementing the program elements that would influence them.

Specify intermediate indicators, such as service patterns, that may be precursors to long-term indicators. For example, data regarding the rates of timely and complete immunizations is a short-term indicator of the incidence of communicable diseases (a longer-term indicator).

Be realistic. It takes time to affect community conditions that have developed over a long period of time. Select a mix of intermediate- and long-term indicators.

Prioritize. In selecting indicators, collaborative teams must strive to identify a number of variables that adequately represent the status of children, families, and the service system as a whole. At the same time, this set of indicators must not be so large that the required data cannot be easily collected and reported by local collaborative sites.

Organizational and systemic change

An "I" indicates an indicator that is intermediate rather than long-term.

Improved program/service effectiveness and efficiency

Increased number of available programs and services (need to specify types of programs and services) (I)

Increased rates of participation in prevention programs (need to specify which programs) (I)

Increased rates of participation in intervention programs (need to specify which programs) (I)

Decreased system response times to family needs for programs and services (I)

Increased parent perception of child improvement

Increased child perception of child improvement

Increased satisfaction with services and programs

Increased parent satisfaction with services (I)

Increased child satisfaction with services (I)

Improved family and child perception of how well services fit problem (I)

Increase in the proportion of services provided in appropriate and least restrictive setting

Reduction in utilization and length of stay in mental health residential/inpatient settings (I)

Reduction of out-of-home placements (Rule 5, hospital, foster care) (I)

Reduction in out-of-county placements (I)

Increased utilization of mental health day treatment/outpatient, intermediate placements (I)

Increased utilization of wraparound services (I)

Increased stability and duration of placements (I)

Increased financial stability/coordination and efficient use of resources

Increased access to resources from multiple sources (private, local, state, federal**-** Medicaid) (I)

Increased coordination of multiple resources (pooling or integration of funds, wraparound funds, noncategorical funds) (I)

Amount and percentage of available funds that have shifted to an integrated fund under the control of the collaborative initiative (I)

Increased number of children served for similar costs (I)

Improved cost-efficiency in provision of services (I)

Maintenance or improvement of the quality of care while stabilizing or reducing unit costs (I)

Improved integration of services

Increased number of state-mandated councils and advisory groups that have been merged or collapsed (I)

Increase in the number and percentage of families that enter the service system through a common intake process (single point of entry) (I)

Degree of coordination of services among organizations offering similar/complementary services (I)

Increased satisfaction with collaborative decision-making structures (I)

Increase in the number and percentage of collaborative partners (including parents) that agree on overall goals, objectives, and outcomes for the initiative (I)

Increased opportunities for cross-training and interagency staff development (I)

Reduction in number and percentage of children needing multiple services who have separate agency-based plans (I)

Child and family health

An "I" indicates an indicator that is intermediate rather than long-term.

Increased access to health care

Increase in mothers and children covered by health insurance (I)

Increase in incidence of children who have a regular source of routine medical care (I)

Increase in proportion of providers willing to serve Medicaid patients (I)

Increase in number of eligible women and children participating in Medicaid (I)

Increase in incidence of children who receive a regular well-child examination (I)

Increase in proportion of children who have regular vision and hearing screenings (I)

Increase in rates of completed immunizations (I)

Increase in proportion of children who have regular dental checkups (I)

Increased proportion of high-risk children participating in early intervention programs (I)

Decrease in incidence of children using emergency rooms for non emergency conditions (I)

Improved prenatal care

Increased rates of participation in prenatal care (I)

Increase in WIC enrollments of eligible pregnant women (I)

Increase in appropriate medical referrals to hospitals for high-risk pregnancies (I)

Decreased incidence of women smoking during pregnancy

Decreased incidence of women using alcohol during pregnancy

Improved maternal health

Increase in proportion of mothers who report improvements in six health concept areas: Physical functioning, role functioning, social functioning, mental health, health perceptions, and pain (I)

Increased use of regular source of gynecological care (I)

Increased use of family planning services (I)

Increased birth intervals

Decrease in second births to adolescents

Improved birth outcomes

Increase in gestational age at birth

Decrease in incidence of low-birthweight babies

Decrease in infant and neonatal mortality rates

Improved overall health

More positive parent perceptions of child's health status (I)

Increase in proportion of children who are within age-appropriate height and weight norms

Decreased number and proportion of children with functional limitations due to health conditions

Decreased number and proportion of children with morbidities or serious morbidities

Decreased incidence of preventable diseases and disabilities

Increased use of safety precautions to reduce accidents and unintentional injury (e.g. car seats, seat belts) (I)

Decrease in hospitalizations for upper respiratory tract infections, otitis media, croup, toxic ingestions, bronchitis and asthma, fractures and sprains, pneumonia, and gastroenteritis

Decrease in number of children with preventable complications of diabetes mellitus, sickle cell anemia, seizure disorder

Reduced number of cases of diseases for which immunization is available: pertussis, polio, measles, mumps, or rubella

Decrease in percent of children with elevated blood levels

Increase in percent of infants who are breast-fed

Increase in percent of children who are physically active for a total of at least 30 minutes most days of the week

Family functioning

An "I" indicates an indicator that is intermediate rather than long-term.

Increased intellectual stimulation

Increase in amount of time caregivers spend with child in intellectually challenging activities (reading, arts and crafts, trips to parks or museums) (I)

Increase in number of educational materials in the home (I)

Increase in caregiver regulation of children's television viewing (I)

Increased emotional supportiveness

More emotionally supportive styles of parental discipline and control

Increased warmth and responsiveness of parents

Improved family relationships

Reduced incidence of youth runaways

Decrease in child maltreatment

Increase in reports of child abuse and neglect (I)

Decrease in reports of substantiated abuse and neglect

Decreased incidence of adult depression

Reduced proportion of parents reporting/indicating high levels of depression

Decreased incidence of adult substance abuse

Reduced proportion of parents reporting/indicating high levels of substance abuse

Decreased rates of adult conflict and violence

Increased levels of spouse/partner abuse reports in the short-term (I)

Reductions in repeated use of battered women's shelters

Reductions in frequency and severity of verbal and physical violence between parent and spouse or partner

Reductions in substantiated reports of spouse/partner abuse

Decreased levels of adult daily stress

Decrease in identified hassles of daily living

Increases in adult sense of well-being

Decreased family isolation/increased rates of connectedness

Increased parental involvement in supportive community-level organizations and groups (schools and preschools, child care centers, libraries, religious organizations, family centers, community centers, parent support groups and activities)

Increase in use of family, friends, books, teachers, religious advisers, support groups for support in child rearing and child mental health

Improved family stability

Increased labor-force participation among mothers choosing employment

Improved maternal employment patterns, including: increased labor-force participation rates, increase in number of weeks worked in the past year, and increased earnings

Decrease in number of work days missed for child-related reasons

Decrease in divorce rates

Decrease in number and proportion of children in out-of-home placements

Child development

An "I" indicates an indicator that is intermediate rather than long-term.

Increased participation in early childhood programs before kindergarten

Increased supply of early childhood programs or slots; shorter waiting lists (I)

Increased enrollments in early education and care programs (I)

Improved child development

Decrease in percentage of children participating in early childhood screening for whom problems are identified

Increased levels of receptive, expressive, and productive language among preschoolers

Increased school-related knowledge and skills

Improved motor development and coordination

Increased levels of cooperation, assertion, and responsibility, and increased degree of self-control
Decreased levels of withdrawn, antisocial, anxious, depressed, and overly dependent behavior

School performance

An "I" indicates an indicator that is intermediate rather than long-term.

Decreased need for remediation

Decreased proportions of children identified as developmentally delayed at kindergarten entry
Reductions in number of children assigned to special education programs
Reduction in restrictiveness of educational placements
Reduction in need for restrictive educational placements

Improved attendance

Decreased incidence of unapproved absences
Decreased incidence of suspensions, dropouts
Improved overall rate of suspensions, expulsions
Improved overall attendance

Increased rates of steady grade progression and school achievement

Improved basic skills and academic achievement
Reductions in rates of children retained in grade (retention policy held constant)
Increased school adjustment
Decreased school dropout rates
Increased high school graduation rates

Youth maturation and social integration

An "I" indicates an indicator that is intermediate rather than long-term.

Increased rate of youth who are productively engaged

Decrease in percentage of youth who watch 42 or more hours of television per week (I)

Decrease in youth not in school and not in labor force (I)

Increase in percentage of youth who participate in school- or community-based youth service programs (I)

Increase in percentage of youth bonded to prosocial influences such as school, family, and friends

Decrease in anti-social or violent behavior

Increased rates of participation in problem-solving skills development training (I)

Increased rates of participation in social skills training opportunities (I)

Increased rates of participation in supervised extra-curricular activities (I)

Reductions in violations of the law (I)

Decreased incidents of runaways

Decrease in teenage arrests for violent crime (with policies held constant)

Reductions in recidivism or incarcerations for juvenile offenders (with policies held constant)

Decrease in teenage fatalities as a result of violent crimes

Decrease in teen suicides

Improved adolescent well-being

Increased percentage of teenagers with a specified number of protection factors

Increased percentage of teenagers who discuss personal problems with a trusted adult

Decrease in births to teenagers

Decrease in cases of sexually transmitted disease

Decrease in the proportion of teenagers using or abusing drugs and/or alcohol

Decrease in youth receiving traffic violation citations

Increase in use of safety precautions to reduce accidents and unintentional injury (e.g. seat belts, motorcycle helmets)

Decrease in the number of teenage accidental deaths

Child mental health

In a 1994 report to the Minnesota Legislature, the Children's Mental Health Integrated Fund Task Force recommended that indicators related child functioning serve as the primary outcome measures for local children's mental health collaborative initiatives. Indicators related to child functioning fall under the claim categories summarized in the previous sections and include such areas as school attendance, disciplinary referrals, academic performance, arrests, etc. Additionally the Task Force cited indicators related to placement of children, use of restrictive service options, and satisfaction with services. These more "system" outcomes are described under the claim category: Organizational and systemic change. Claim areas and indicators related to mental health treatment are summarized here.

Improved clinical functioning

Reduction in symptoms

Progress toward treatment goals

Increased level of functioning

Increased number of positive behaviors

Increased self-control

Decreased levels of withdrawn, antisocial, anxious, depressed, and problematic behaviors

Reduction in restrictiveness of living environment

Decreased incidents of hospitalization

Reduction in the number of clients re-entering the system at a higher level of care

Increased social competence

Improved level of adaptive functioning

Improved social skills

Improved peer relationships

Improved self-esteem/self-worth

Increased ability to accomplish activities of daily living

Economic self-sufficiency

An "I" indicates an indicator that is intermediate rather than long-term.

Increased economic stability for families

Increased participation in job training programs (I)

Increased number of parents who receive full payment of awarded child support (I)

Increase in percentage of families who have access to reliable transportation (I)

Increased number of families paying bills on time

Decrease in number of families that spend less than 20% of income on housing

Decreased number of families on income support programs

Decrease in number of families using homeless shelters

Increased community-wide economic stability

Increased number of permanent job positions with benefits

Increased percentage of employers who commit to hiring community members

Increased number of affordable housing units

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