Intensive Community-Based Treatment of Children, Adolescents, and Their Families: The Effectiveness of Integrative Family and Systems Treatment (I-FAST)

Final Report

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Executive Summary

This study examined the effectiveness of Integrative Family and Systems Treatment (I-FAST) in reducing out-of-home placement of at-risk children or adolescents and improving individual and family functioning. Integrative Family and Systems Treatment (I-FAST) is a home-based model that was developed and implemented from within the community mental health system. Building on evidence-based literature regarding effective treatment for this population, I-FAST identifies three core treatment components to intervene with for families with children who are at risk of out-of-home placement: (1) therapeutic alliance (2) second-order change strategies; and (3) systems collaboration. The study included quantitative and qualitative inquiry. The outcome evaluation used a one-group pre-test and post-test design with a six-month follow-up evaluation to test the effectiveness of I-FAST in treating families with children who were at risk of out-of-home placement that had received services from Intensive Community-Based Program ICBP at Scioto Paint Valley Mental Health Center or home-based services from Thompkins Child and Adolescent Services. A total of 125 families consented to participate in the study. Findings of the outcome evaluation were based on 77 families who completed the program as well as provided data at initial assessment and termination. Qualitative inquiry focused on exploring the detailed process involved in systems collaboration at the inter-agency and intra-agency levels. Regarding inter-agency collaboration, the study conducted a total of 8 focus groups with 26 agency collaborators who were nominated by ICBP case managers. For intra-agency collaboration, 2 focus groups were conducted with 7 informants from SPVMHC. Findings of the outcome study provided initial evidence that I-FAST was effective in improving the children's outcomes, reducing out-of-home placement, improving family functioning, enhancing parental competence in addressing problems in children, and facilitating family participation in treatment. The treatment components of I-FAST, including therapeutic alliance and systems collaboration, were predictive of child's outcomes. Findings based on qualitative inquiry of systems collaboration provided useful and detailed descriptions about the process of developing beneficial collaboration between home-based programs and other involved institutions as well as within the agency. Both participating case managers and their collaborators from diverse institutions or disciplines fundamentally defined systems collaboration as a relational activity. Recognizing the inherent difficulties of collaboration among different disciplines and institutions, informants described a particular set of skills and attitudes that were facilitative of successful collaboration in providing home-based treatment. The development of trust was essential in the collaborative process, which led to successful collaboration between diverse institutions and disciplines and brought diverse benefits to both the collaborating professionals and the families. Limitations of this study included issues with sample size, lack of comparison groups, attrition problems, and a lack of racially diverse samples. The significance of the study was discussed in reference to the development of I-FAST as a feasible and effective alternative home-based treatment model that was developed within the local mental health systems, addressed challenges of cost containment, facilitated continuity of expertise in home-based treatment at the agency level, and met realities of practice demands to serve families with children at risk of out-of-home placement.

Report

Home-based treatment[1] has been increasingly used for treating families with a child or adolescent who is at risk of out-of-home placement. Effective treatment of a severely disturbed child or adolescent frequently necessitates treatment of the family system as well as coordination of diverse services for the benefit of the child and the family. Different approaches to home-based treatment have been developed to address the multiple needs of these families and children. All of these treatment approaches operate from a systems theory perspective and, to varying degrees, are based on structural-strategic family therapy. These approaches include, but are not limited to: Solution-Focused Family Therapy (Berg & Kelly, 2000; Lee, Sebold, Uken, 2003); Brief Strategic Family Therapy (Fraser & Solovey, 2006; Greene, 2002; Grove & Haley, 1993; Szapocznik, Robbins, Mitrani, Santisteban, Hervis & Williams, 2002); Multidimensional Family Therapy (MDFT) (Hogue, Liddle, Becker & Johnson-Leckrone, 2002; Hogue, Liddle & Becker, 2002); Ecosystemic Structural Family Therapy (ESFT) (Jones & Lindblad-Goldber, 2002); and Multisystemic Therapy (MST) (Henggler, Schoenwold, Rowland & Cunningham, 2002).

Although home-based treatment is a widely adopted model for treating families with a child or adolescent who is at risk of out-of-home placement, provision of effective treatment fundamentally encounters the following challenges: (1) How to empower families and parents to develop competence to address problems in their children? (2) How to facilitate systems collaboration among multiple institutions serving the family when different institutions and/or disciplines have diverse professional mandates, philosophies, and practices? (3) How to facilitate development and continuity of expertise in home-based treatment at the agency level and at the same time effectively address the issue of burnout in case managers?

Empowering the families

One widely adopted approach that has been developed to provide coordinated services is “wraparound” (Burchard, Bruns & Burchard, 2002). Wraparound “is a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes…is child and family centered, focused on child and family strengths, community based, culturally relevant, flexible, and coordinated across agencies” (p. 69). This approach involves identifying the community services and supports a family needs and providing them to the family as long as they are needed (Burchard, et al., 2002, p. 69). While wraparound focuses on securing needed resources and services for the family to address the problems in children, the crucial question is whether families are empowered in the treatment process so that they believe that they can and have the tools to manage their children and their problems after community and professional

[1] The term Home-based Treatment and Intensive Community-Based Program (ICBP) are used interchangeably in the report. Two agencies participated in this study. The program at Scioto Paint Valley Mental Health Center is named " Intensive Community-Based Program" and the program at Thompkins Child & Adolescent Services is named "Home-based Program."

supports fade away. Oftentimes, professionals help parents to control the children or address their problems but do not empower the parents to do so themselves. Once these professionals leave, relapses may occur because parents have developed neither the competence nor the confidence to address problems in their child on their own.

Empowering home-based staff

Families served by home-based treatment are usually multi-problem families who are also struggling with other life adversities such as economic stress, unemployment, unsafe neighborhood, and crises in families such as parental divorce, domestic violence, physical and/or mental illnesses. Despite working with some of the most challenging cases, home-based services have been described as “step-child” in the agency. This unfortunate situation has happened via different pathways. First, some home-based services are contracted to programs such as Multi-systemic Therapy. While MST is one of the most researched effective home-based treatment models, MST is a licensed and trademarked approach in which the agency purchases services from MST. Because of the particular service arrangement, there is neither continuity nor development of expertise at the local agency level because outside providers provide all the training and supervision of home-based case managers. In a sense, the operation of home-based services is "separate" from other services at the agency because of the structural set-up of the services.

For agencies that do not purchase services from outside providers such as MST and provide home-based services under their regular service structure, home-based treatment can also become a “step-child” primarily because home-based services are usually provided in the homes of the clients rather than at the agency. As such, unlike conventional treatment in which agency staff are stationed at the agency and well connected to other professionals within agency, home-based case managers are oftentimes "on the road" and, unfortunately, receive little support, including clinical support, from the agency, despite providing treatment for some of the most difficult and volatile families. Some home-based case managers also receive meager pay and low status because of a lack of formal professional credentials. All these factors contribute to the high burnout phenomenon and high staff turnover rates for home-based case managers, which hinder the continuity and development of expertise of home-based treatment at the agency level.

Effective home-based services should entail a thoughtful design of service structure at the agency level. In addition to facilitating a treatment process that empowers families to address their problems, such a service design should also empower the home-based case managers with ongoing administrative and clinical support so that that home-based service constitutes a central and integral part of the agency. Excellent staff personnel would allow for the development and continuity of expertise of home-based treatment at the agency level.

Systems collaboration

Many if not most of the families with a severely emotionally disturbed child (SED) are involved with several different agencies and their representatives, i.e., mental health, social services, juvenile courts, schools, psychiatric hospitals and so on. While systems collaboration promises coordinated, effective, and efficient services for families, such a collaborative process between diverse disciplines, professionals, and/or systems are not without struggles and barriers. Bronstein (2003) suggested four dimensions that can influence interdisciplinary collaboration: (1) professional role, (2) structural characteristics, (3) personal characteristics, and (4) history of collaboration.

Challenges in collaboration can stem from a diverse knowledge base, mandate, goals for clients, intervention priorities, policy and procedures, and working practices of the collaborators (Cowling, 1997; Pietsch & Short, 1998; Wilmot, 1995). Personnel from the court and schools as well as psychiatrists are frequent collaborators in home-based treatment. On the other hand, the court is more concerned about safety and control while treatment agencies emphasize creating positive changes in clients. Similarly, psychiatrists usually rely more on medication for treating mental health problems because of their medical and biochemical perspectives. Based on statistics provided by Reuters Health (2006), approximately 2 million children take medication to control ADHD each month. Social workers, however, are more likely to understand client's problems from interpersonal, psychological, behavioral and/or environmental perspectives. Finally, school personnel are more concerned with the educational accomplishment of children while treatment professionals are more concerned about the mental health status of clients.

Despite the good intentions of the collaborating institutions or professionals from diverse disciplines, disconnection between diverse systems can send confusing messages to the parents and counteract the potential impact of treatment of each other as a result of lack of understanding, coordination, and cooperation among diverse professionals. For instance, the school suspends the child from school or the court sends the child to a residential treatment facility for his or her misbehavior while the home-based case manager or therapist attempts to work with the parents and the child to control the problem behaviors, which cannot be done in an out-of-home environment.

In sum, the challenges for most community mental health agencies are to develop and deliver realistic home-based family-centered treatment that meets local needs, can realistically fit within available budget and resource capabilities, and is effective in accomplishing the following goals: (1) Empowering the families to develop competence and confidence in addressing emotional and/or behavioral problems in children, (2) Preventing of out-of-home placement or residential placement of the symptomatic child; (3) Supporting the development and continuity of expertise in home-based treatment for case managers and therapists at the agency level; (4) Collaborating with institutions that determine placement, including, but are not limited to, Juvenile

Courts and Children Services; and (5) Cost-effective in attaining the goals of home-based treatment.

Integrative Family and Systems Treatment (I-FAST)

Integrative Family and Systems Treatment (I-FAST) is a home-based treatment model that is developed and implemented from within the community mental health system. I-FAST assumes that: (1) Families are resilient and have strengths and resources to build solutions, (2) Effective treatment of a severely disturbed child or adolescent necessitates treatment of the family system, (3) Effective treatment must include coordination and collaboration of diverse services serving the child and the family, and (4) Effective treatment is built upon excellent staff with continuity in expertise of home-based services. The model entails a parallel process of empowering at the client level, agency level, and inter-agency level (Figure 1).

Programmatic Structure

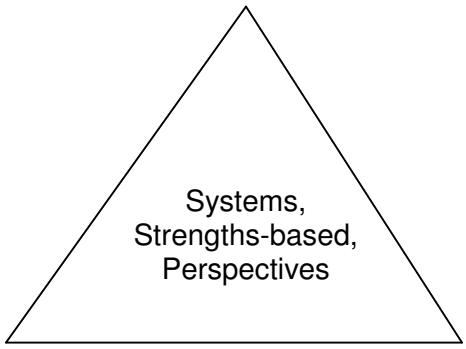
The programmatic structure of home-based treatment using I-FAST engenders administrative support and clinical support to the home-based staff. I-FAST provides ongoing clinical support to home-based staff on a regular basis. To this end, an outside clinical consultant was hired for training purpose and served the role of a teacher. Through the process of consulting with cases, the consultant taught supervisors and staff about how to use the core I-FAST treatment components (establishing the therapeutic alliance and second-order change) and how these treatment principles could be generalized to other cases. Through this process of consultation, home-based case staff and other professionals at the center, including center supervisors, learned how to apply the core concepts and techniques of I-FAST. Because clinical consultation was offered to the home-based staff as well as other treatment professionals at the agency, home-based service afforded a central position of service provision at the agency. Such a practice also facilitated the continuity of care at the agency level when families terminated from intense community-based services but continued to receive treatment from other professionals. In addition, it is expected that eventually, expertise of home-based treatment will be developed and the need for outside consultants would fade. The ultimate training goal was to influence the entire treatment culture within the agency as opposed to creating a special area of knowledge or expertise that is known only by a limited number of specialists.

With respect to administrative support, the home-based staff was assigned no more than 10 – 12 cases at one time. In addition, the agency involved Emergency Services and other agencies that were involved with providing emergency services in service delivery. Each family receiving ICBP services had a crisis plan. The staff who might have been involved in providing emergency services were informed of the plan. This approach allowed ICBP case managers to not have to be on call all the time. We believed that being on call all the time constituted a major drawback in other approaches that resulted in burnout and turnover of intensive community-based staff.

Figure 1. Integrative Family and Systems Treatment (I-FAST): A Parallel Process of Empowerment

Empowering parents and children

- Partnership with parents and children
- Therapeutic alliance



The Agency

- Empowering social workers
- Ongoing clinical and programmatic support
- Continuity in expertise

Systems Collaboration

- Shared goals
- Coordinated efforts
- Complementary roles

The Treatment Model

Building on evidence-based literature regarding effective treatment for this population, I-FAST identifies three core treatment components that can be integrated into a coherent treatment protocol in working with children, adolescents, and families at risk. These three core treatment components are described as follows:

Therapeutic alliance

Literature has repeatedly described the important role of therapeutic alliance in facilitating positive outcomes in clients and families (Asay & Lambert, 1999). A primary therapeutic focus of I-FAST is to establish and maintain a therapeutic alliance with families that will facilitate the collaborative development of a common understanding of the problem, behaviorally specific treatment goals, and activities to achieve these goals with the family. Based on Bordin's theory on therapeutic alliance (1979), I-FAST recognizes three constructs of therapeutic alliance: (1) "Development of Bond", which refers to the affective aspects of the therapeutic alliance, including, but not limited to trust, respect, and caring (Johnson, Wright & Ketring, 2002); (2) "Agreement on Goals", which refers to a mutual agreement between therapist and clients about their investment in achieving the treatment goals after a clear definition of the problem (Bordin, 1979; Johnson, et al., 2002; Pinsof, 1994); and (3) "Assignment of Tasks", which refers to the collaborative process and activities in which therapists and families engage during therapy, the agreement and collaboration around the tasks, and the timing and pacing of these activities (Johnson, et al., 2002).

Changing family interactional patterns that are maintaining the problem behaviors

The development of I-FAST was strongly influenced by a systems perspective (Hoffman, 1981; Keeney, 1983; Keeney & Ross, 1985; Watzlawick, Weakland, & Fisch, 1974). Because of the assumption that life is changing and evolving constantly, I-FAST believes that problems will come and go. The more important question, therefore, is how clients and families are stuck in problem situations. I-FAST believes that problem behaviors in children are maintained by ineffective attempted solutions (Fisch, Weakland, & Segal, 1982; Fraser & Solovey, 2006; Greene, 2003; Grove & Haley, 1993; Haley, 1990; Nardone & Watzlawick, 1993). Families, like other systems, are goal-oriented with the primary goal being their continued existence and survival. Consequently, families develop and seek to maintain a certain patterned regularity and stability (homeostasis). These repetitive patterns become the family rules (assumptions/ premises) that organize how the family functions. When families engage in repetitive but ineffective "solutions" to address emotional or behavioral problems in their children, these repetitive interactions among family members become the feedback loop that maintains the problem behaviors in children (Nardone & Watzlawick, 1993). Instead of aiming at changing the problematic behavior, I-FAST focuses on changing family interactional patterns that are maintaining the problem behaviors, that is, second-order change. By selecting second-order change as the guiding principle of treatment, I-FAST

opens the door for case managers and therapists to select from a wide range of therapy models and work collaboratively with the family members to change behavioral patterns that will result in solving presenting problems and achieving treatment goals.

Systems Collaboration

Systems collaboration is an integral part of I-FAST. Many, if not most, of the families with a severely emotionally disturbed child (SED) are involved with several different agencies and their representatives, i.e., mental health, social services, juvenile courts, schools, psychiatric hospitals and so on. Besides the coordination of community and natural resources/supports to meet the needs of children and families across multiple life domains as based on a wraparound approach (Burns & Goldman, 1999), systems collaboration also constitutes a crucial component for facilitating changes in interactional patterns in families, which are consistently supported by involving agencies such as child welfare agencies, juvenile courts or psychiatric hospitals. Traditionally, these institutions are usually involved with these families to "help" them when the SED child is out-of-control by restraining the child using different venues such as: removing the child and placing him or her in residential care, foster care, or hospitals. In those situations, the family's interactional pattern with the SED child is not changed for two reasons: (1) the goal of the intervention was safety and not changes in how parents deal with the problems the child has, and (2) the child was settled down by outsiders, not within the family. If parents are to be helped to regain control over their out-of-control child, or if they are to be empowered to help their child, the agencies that have power to remove their child or dis-empower parents must be included in the treatment process because how these agencies intervene can either facilitate the family making positive changes or reinforce the presenting problem(s). In other words, for mental health agencies to offer home-based services as an alternative to out-of-home placement and thus promise more cost effective interventions, a mental health agency must be in a position to influence institutions that are in charge of placing children such as child welfare agencies, juvenile courts or psychiatric hospitals in addition to assisting the child and his/her family to learn different ways to address the problem. Systems collaboration is fundamental to successful outcomes in families both via providing resources and supports as well as working together with different systems, especially the placement-determining agencies, to create a context for interactional and/or behavioral change for these families. In sum, I-FAST perceives systems collaboration as a crucial therapeutic component with a focus on developing and maintaining collaborative teamwork with community agencies to address the organic needs of the family and the child.

The simplicity of this treatment model engenders a parallel process between the social work professionals and the families in implementing the model: social work professionals are encouraged to utilize and integrate their expertise around using these core components in providing treatment, and facilitate families to utilize their strengths and resilience in finding solutions that successfully address their child's problems. The simplicity of the model should reduce cost of training, increase utilization of case

managers and therapists' prior expertise, and create a context for focused treatment efforts and therapeutic interventions.

Community mental health agencies are consistently challenged to develop and deliver realistic home-based family-centered treatment that meets local needs, can realistically fit within available budget and resource capabilities, and is effective in accomplishing the following goals: (1) Prevention of out-of-home placement or residential placement of the symptomatic child; (2) Inclusive of families of diverse nature and problems that occur in the real world of community mental health agencies; (3) Cost–effective in attaining the goals of the home-based treatment; and (4) Functional collaboration with institutions that determine placement including but are not limited to juvenile Courts and Children Services.

Goals of the Study

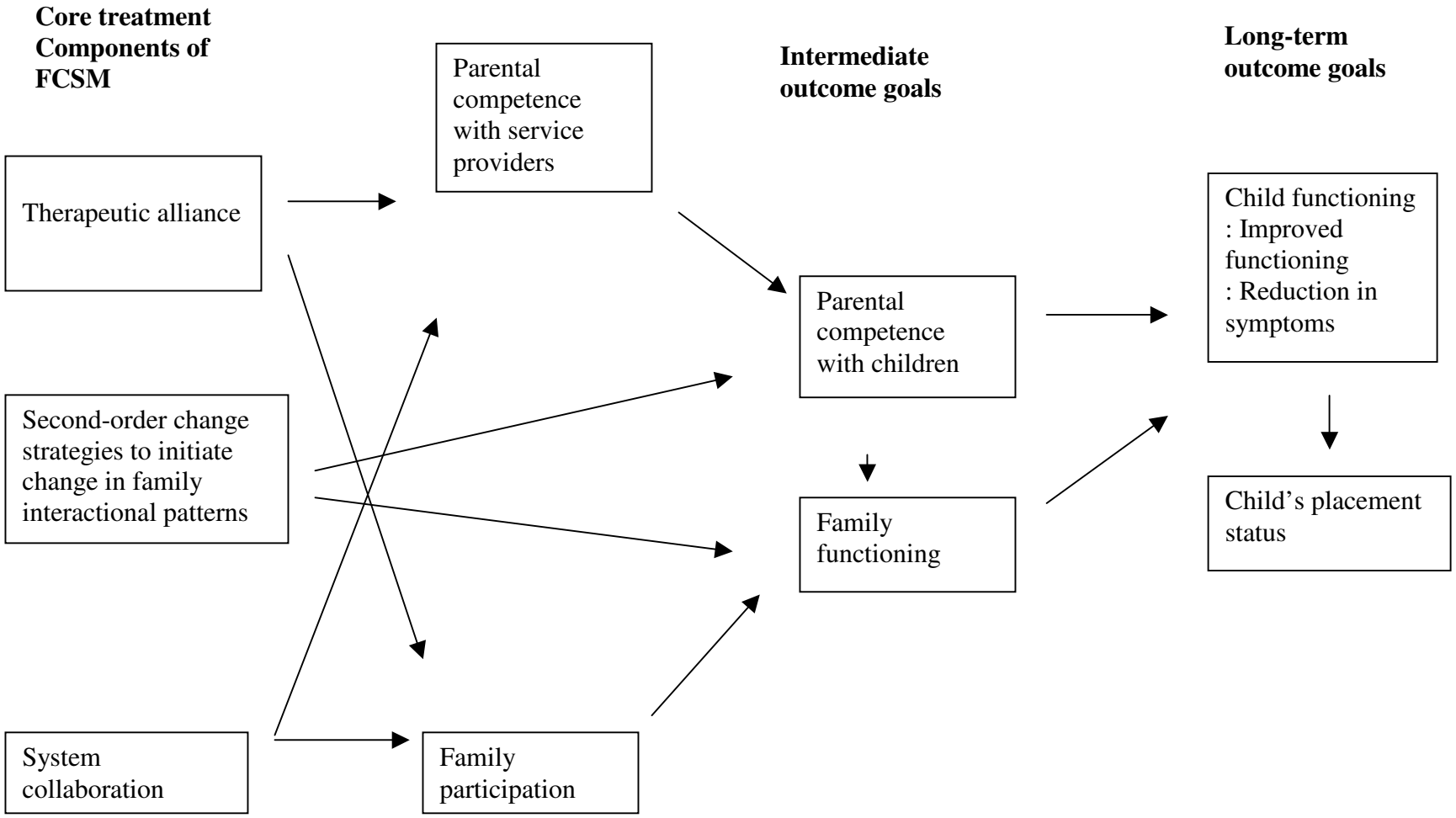
The project's goal was to test the effectiveness of Integrative Family and Systems Treatment (I-FAST). In addition, we examined specific treatment components of FSCT that predicted positive outcomes in children and families. The ultimate purpose of conducting this study was to examine the effectiveness of I-FAST for reducing out-of-home placement of at-risk children and adolescents and improving individual and family functioning. We hypothesized that FSCT treatment would be effective in achieving the long-term outcome goals of improved functioning and reduced behavioral and/or emotional problems in the symptomatic child, which would in turn lead to the avoidance of out-of-home placement of the child. Effective treatment should also result in achieving the intermediate treatment goals of increased parental efficacy in addressing their child's issues, increased sense of empowerment of parents in relation to treatment providers, increased family participation in the treatment process, and improved family functioning (Figure 2).

Another project goal was to explore the process of and the skill components involved in inter-agency and intra-agency collaboration when providing intensive community-based treatment for families with children who were at risk of out-of-home placement. The study used a qualitative method to explore the process involved in systems collaboration as based on narratives of informants. We were interested in exploring the following questions:

- How do service providers/professionals from different institutions understand and construct the meaning of collaboration in the context of intensive community-based treatment?
- What was helpful in the process of building a beneficial collaborative relationship with other agencies, especially when the collaborators have more power (e.g., placement-determining power) or status (e.g., psychiatrist Vs case managers)?
- How has the collaborative relationship been helpful or unhelpful to service provision?
- What were some obstacles that stood in the way of a collaborating process?
- What are the key ingredients in creating a beneficial collaborative relationship?

- What constitutes the core skill sets in facilitating a beneficial collaborative relationship?
- What is involved in the process of initiating as well as facilitating a beneficial collaborative relationship at an agency-to-agency level?
- How do informants perceive the climate/culture of intra-agency collaboration at their respective office? What agency policies, procedures, or practices facilitate or hinder intra-agency collaboration?

Figure 2: Framework of the study



Methodology
Outcome Evaluation

The outcome evaluation used a one-group pre-test and post-test design with a six-month follow-up evaluation to test the effectiveness of I-FAST in treating families with children at risk of out-of-home placement and who were receiving intensive community-based treatment. Participants of the research included families with children or adolescents at risk of out-of-home placement and that had received intensive community-based services (ICBP) from Scioto Paint Valley Mental Health Center or Thompkins Child and Adolescent Services. The Court, Children's Services, hospitals, or mental health professionals referred families to the programs. We invited parents and children who were at risk of placement and were 12-years-old or older to participate in the study. Participation in the study was voluntary and formal written consent was obtained from all participants.

In this study, independent variables included the core treatment components of I-FAST, namely, therapeutic alliance, second-order change strategies for changing family interactional patterns, and systems collaboration. Dependent variables included child's placement status, level of functioning of the child, level of problem severity, level of family functioning, family participation in the treatment process, parental competence in relation to the child, and parental competence in relation to service providers.

Instrumentation

Treatment Conditions and Treatment Fidelity Measures

Families participating in the study received intensive community-based services for up to a six-week period with additional 6-week increments negotiated based upon the family's needs and progress. We standardized treatment conditions by requiring the participating case managers to adhere to a standard protocol of treatment structure and techniques. Training and ongoing consultation in I-FAST were provided to participating case managers to ensure the standardization of treatment conditions. The study developed The FSCT Checklist to measure treatment fidelity (Appendix 1). The I-FAST Checklist was used to assess the presence of the identified core treatment components of I-FAST. The study also adopted The I-FAST Interview Schedule that consisted of 13 questions to conduct a follow-up phone interviews with case managers to examine their conceptualization of treatment interventions if information from the I-FAST Checklist was incomplete (Appendix 1).

I-FAST Checklist. The I-FAST Checklist is a 31-item checklist that assesses core treatment components of I-FAST: therapeutic alliance (item 1-20), second order change strategies (item 21-25), and systems collaboration (item 26-31). A list of items was first generated based on the identified core treatment components of I-FAST. The identification of these treatment components was informed by evidence-based factors of family and community treatment of at-risk families and guided by existing literature

regarding home-based treatment and evidence-based approaches to family therapy with at-risk families. The list was reviewed by a panel of seven experienced professionals who developed I-FAST and also by professionals who were currently working with home-based populations. The checklist was further refined based on their feedback and pilot-tested by 5 clinical supervisors for usability before actual implementation.

Case managers videotaped or audiotaped one family session at the beginning of treatment and another session at 6 weeks with formal consent obtained from participating families. Two clinical consultants of the program also videotaped their consultation sessions for fidelity purposes. Independent raters used The I-FAST Checklist to rate specific interventions of each core treatment components used by case managers and the clinical consultants in the treatment process or the consultation process. The focus of rating with the initial family session was on the development of therapeutic alliance. The focus of rating with the 6-week family session was on second-order change strategies and systems collaboration. The focus of rating with the consultation session was on three core treatment components as suggested by I-FAST. Two independent raters who had received training on I-FAST rated the skill level of the interventions of each core treatment component on a three-point Likert scale from (0) absence, (1) some, to (2) excellent. The I-FAST Checklist was scored by summing individual items and ranges from 0 to 40 for Therapeutic Alliance, 0 to10 for Second Order Change Strategies, and 0 to 12 for Systems Collaboration subscales. Higher scores are indicative of greater adherence to I-FAST in the treatment process by case managers or in the consultation process by clinical consultants.

Variables examined in the study

Independent variables

Integrative Family and Systems Treatment. Integrative Family and Systems Treatment was operationally defined as the implementation of the home-based treatment model as prescribed by the I-FAST Treatment Model.

Therapeutic Alliance. Therapeutic Alliance was operationally defined by the scores of the Family Alliance Scale (Pinsof, 2003) as completed by the parents at termination of the treatment (Appendix 2). The Family Therapy Alliance Scale, which is a 40-item scale developed by William M. Pinsof, was adapted and expanded from the original 29-item Family Therapy Alliance Scale developed by Pinsof and Catherall (1986) to assess the quality of therapeutic alliance between the therapist and the family. The Family Therapy Alliance Scale consists of three subscales of: Bonds, Tasks, and Goals. Examples of statements are “The therapist cares about my family” (Bonds); “The therapist has the skill and ability to help my family” (Tasks); “The therapist is in agreement with my family’s goals for this therapy” (Goals). Statements are rated on a 7-point Likert scale with responses ranging from (7) completely agree with the statement to (1) completely disagree with the statement. One-half of the items on each subscale

are reverse scored. The three subscale scores can be summed to a total score. Pinsof and Catherall (1986) reported a satisfactory reliability coefficient of .83 (Cronbach's alpha) of the original scale. Heatherington and Friedlander (1990) examined the internal consistency of the original scale and reported satisfactory Cronbach's alpha of .94 for the total scale, .81 for Bonds subscale, .90 for Tasks subscale, and .80 for Goals subscale.

Second-Order Change Strategies. Second order change strategies were defined as interventions used by case managers that disrupted the problem-maintaining patterns of the family and initiated alternative, beneficial, new behaviors in the family/child. Second order change strategies broadly included four types of interventions: (1) Case managers align with a family and suggest actions that were inconsistent with the premises of the system of interaction around a problem; (2) Case managers took a position that was unexpected or inconsistent with expectations for how people were supposed to behave in a system of interaction; (3) Case managers offered different or alternative meanings to problem situations; (4) Families/children reframed problematic situations through the interaction that they had with the case managers. Second order change strategies were defined by the section “Second Order Change Strategies” in I-FAST Checklist.

Systems Collaboration. Systems collaboration was operationally defined as the scores of the Systems Collaboration Scale (SCS) as completed by case managers at termination of the treatment (Appendix 3). Systems Collaboration Scale is a self-constructed scale developed by Lee and Greene (2002) to assess the extent to which service systems collaborate with each other in the treatment process. The SCS consists of three subscales of: Cooperation, Goal Accomplishment, and Helpfulness. The extent of collaboration with other service systems is rated on a 3-point Likert scale with 1 indicating positive collaboration and 3 indicating negative collaboration. A total score for each subscale, which ranges between one and three, is obtained by adding the score for each individual system contacted and then dividing by the number of systems contacted.

Dependent variables

Parental Competence with Service Providers. Parental competence with service providers was operationally defined by the scores of Service Systems Subscale of the Parents’ Competence Questionnaire (item 1-12) as completed by the parents (Appendix 4). The Parents’ Competence Questionnaire (PCQ) is a 21-item questionnaire compiled by M. Y. Lee (2001) to measure parents’ sense of competence in relation to the service system and to the child. The Service System Subscale of PCQ is an 11-item scale adapted from the Service System Subscale of Family Empowerment Scales (Koren, DeChillo, & Friesen, 1992). Permission of using the items was obtained from the respective authors. Examples of the items are “I know the steps to take when I am concerned about the services that I and my child(ren) receive,” “I am able to work with agencies and professionals that I and my child(ren) are involved in.” Parents were

asked to rate their responses on a five-point Likert-type scale from “strongly disagree”(1), “disagree” (2), “neither agree or disagree” (3), “agree” (4), to “strongly agree”(5). The Service System Subscale is scored by summing individual items and ranges from 5 to 55, with a higher score indicating a greater sense of parental competence in relation to service providers. Norms for the original Service System subscale are not established although means for parents who were involved in empowerment activities (53.56) were distinguished from parents who did not involve in advisory empowerment activities (48.6) (Koren et al., 1992). The internal consistency alpha for the original subscale was .87, test-retest reliability coefficients of stability over a several-week period was .77 (Koren et al., 1992).

Parental Competence with Children. Parental competence with children was operationally defined by the scores of the Parental Efficacy Subscale of the Parents’ Competence Questionnaire (item 12-21), which was completed by the parents (Appendix 4). The Parental Efficacy Subscale is a 10-items subscale adapted and modified from the Parental Locus of Control Scale (Campis, Lyman, & Prentice-Dunn, 1986). Permission for using the items was obtained from the authors. Examples of items are “When my child gets angry I can usually deal with him/her if I stay calm,” “My child usually ends up getting his/her way, so why try” (reverse scored item). Parents were asked to rate their responses on a five-point Likert-type scale from “strongly disagree”(1), “disagree” (2), “neither agree or disagree” (3), “agree” (4), to “strongly agree”(5). The Parental Efficacy subscale is scored by summing individual items with item 15, 16, 17, 18, 20, and 21 reverse-scored. The scores range from 5 to 50 with higher scores indicating greater parental competence in relation to children. Norms for the original Parental Efficacy subscale are not reported although means for parents who did not report difficulties in the parenting role (17.62) were distinguished from means of parents who had requested counseling services for parental problems (19.27) (Campis et al., 1986). Campis, Lyman, and Prentice-Dunn (1986) reported good internal consistency of the Parental Efficacy subscale.

Family Participation. Family participation was operationally defined by the scores of the Family Participation Scale, which was completed by the parents. The Family Participation Scale is a 7-item scale developed by Barbara Friesen and her associates at the Regional Research Institute for Human Services, Research and Training Center on Family Support and Children’s Mental Health, Portland State University (2001) (Appendix 5). The Scale was designed to measure a caregiver’s impression of his or her level of participation in planning for a child’s service and treatment. Examples of the questions are “Were your ideas valued in planning services for your child?” and “How much did staff listen to your ideas about ways to change or improve treatment or service planning?” Respondents were asked to answer the questions on a four-point Likert-type scale from “Not at all”(1), “A little” (2), “Some” (3), to “A lot”(4). A total score, which ranges between one and four, is obtained by adding the score of individual items and dividing by seven. Psychometric properties have not been reported by the authors because this is a relatively new scale. On the other hand, the scale was developed in a

large-scale national study that investigates experiences of families whose children received services for severe emotional and behavioral disorders.

Family Functioning. In this study, family functioning referred to the cohesion and adaptability of the family. Family cohesion was defined as the emotional bonding that family members had toward one another and was operationally defined as the scores on Family Cohesion of FACESII, which was completed by parents and children-at-risk who were 12 years of age or older (Appendix 6). Family adaptability was defined as the ability of the family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress. Family adaptability was operationally defined by the scores on Family Adaptability of FACESII, which was completed by parents and children 12 years of age or older. FACESII is 30-item scale developed by Olson, Portner, and Bell (1982) based on the Circumplex Model of family as formulated by David H. Olson, Candyce Russell, and Douglas Sprenkle. FACESII contains 16 cohesion items and 14 adaptability items. Respondents are requested to rate how frequently the described behavior occurs in his/her family on a 5-point Likert scale that ranges from 1 (almost never) to 5 (almost always). Examples of cohesion item are “Family members are supportive of each other during difficult times”, and “Our family does things together.” Examples of adaptability items are “Children have a say in their discipline”, “Our family tries new ways of dealing with problems.” Scoring procedures are described in the Family Inventories Manual (Olson, 1992). FACESII gives rise to two scores: a Cohesion score and an Adaptability score, and their correspondence to Family Types in terms of Balanced, Moderately Balanced, Mid-Range, and Extreme. Olson (1992) reported satisfactory Cronbach's alpha of .90 for the total scale, .87 for Cohesion, and .78 for Adaptability. Test-retest reliability over a period of 4-5 weeks was .83 for Cohesion and .80 for Adaptability. Good concurrent validity was also established for FACESII. Hampson, Hulgus and Beavers (1991) compared the Dallas Self-Report Family Inventory (SFI) with FACESII and reported strong and significant correlations between SFI global measure of family health and FACESII (.93 for cohesion and .79 for adaptability).

Child’s Functioning. In this study, child’s functioning referred to the level of emotional and behavioral functioning of the child. Child’s functioning was operationally defined as the scores the child had on the Problem Severity and Functioning subscales of The Ohio Scale-Short Form as completed by his/her parents, case managers, and the child if s/he was 12 years of age or older. The Ohio Scale-Short-Form was developed by Benjamin M. Ogles (Ogles, Lambert, & Masters, 1996) to provide multi-source, multi-content measures of clinical outcomes of youth ages 5-18 (Appendix 7). The Ohio Scale-Short Form consists of four content areas of assessment: Problem severity, Functioning, Hopefulness, and Satisfaction with mental health services. Multiple reporting sources are included in the process of data collection: the youth (if age 12 and older), parents or primary caretakers, and the agency workers. The Problem Severity Scale-Short Form is comprised of 20 items covering common problems associated with youth who receive mental health services. Examples of items are “Arguing with others”, “Using drugs or alcohol.” Raters are asked to rate the degree to which the youth has experienced the problem in the past 30 days on a six-point scale (0 “Not at all” to 5 “All the time”). The

scores range from 0 to 100 with higher scores indicating more severe problems. The Functioning Scale is comprised of 20 items designed to rate the youth's level of functioning in a variety of areas of daily activity. Examples of items are "Getting along with friends," "Thinking clearly and making good decisions." Raters are asked to rate the current level of functioning of the youth using a five-point scale (0 "Extreme troubles" to 4 "Doing very well"). The scores range from 0 to 80 with higher scores indicating higher level of functioning in the youth. The Problem Severity Scale and the Functioning Scale are completed by the youth, the parents or primary caretakers, and the agency worker.

Two four-item scales that assess satisfaction and hopefulness are completed by the youth and the parent/primary caretaker. Four items assess satisfaction with and inclusion in mental health services on a six-point scale (1 "Extremely satisfied" to 6 "Extremely dissatisfied"). An example is "How satisfied are you with the mental health services your child has received so far?" Four items assess levels of hopefulness and well-being about either parenting or self/future respectively. An example of items is "How optimistic are you about your child's future (or your future) right now?" The scores of each scale range from 6 to 24 with higher scores indicating a more negative evaluation.

Ogles and his associates (2001) reported satisfactory reliability coefficients of the four subscales across multiple reporting sources that range from .65 to .97 (Cronbach's alpha). The test-retest reliabilities are adequate and range from .43 to .88. In addition, the Ohio Scale ratings were significantly correlated with other established measures including, but not limited to, the Progress Evaluation Scales (Ihilevich & Gleser, 1982), the Child and Adolescent Functional Assessment Scales (Hodges & Wong, 1996), Children's Global Assessment Scale (Shaffer et al., 1983), CBCL (Achenbach, 1991), and Vanderbilt Functioning Index.

Child's Placement Status. Child's placement status was operationally defined by the location and times of out-of-home placement during the period of the study (Appendix 8).

Variables to be Controlled

The variables to be controlled in this study included: (1) age of the child-at-risk, (2) gender of the child-at-risk, (3) the level of emotional and behavioral functioning of the child-at-risk as measured by The Ohio Scale at initial assessment, and (4) race or ethnicity of the child. These variables have been shown to influence treatment outcomes or potentially might influence treatment outcomes.

Data Analysis

Data collected from various instruments was checked and coded for data processing and statistical analyses. The Statistical Package for Social Sciences was used for this purpose.

Regarding treatment fidelity, the study used intraclass correlation to assess inter-rater reliability of I-FAST.

To examine within-subjects changes between different assessment points, the study used paired-sample t-tests to compare findings at initial assessment and termination for assessment instruments regarding child's functioning, parental competence with service providers and the child, and family participation. In addition, repeated measures analysis of variance was employed to assess the within-subjects changes during the three assessments of initial assessment, termination, and 6-month follow-up. The study used Wilcoxon signed-rank tests to assess the within-subjects changes during the three assessments of initial assessment, termination, and 6-month follow-up for categorical variables including Family Functioning and Child's Placement Status.

Structural equation modeling was used in the final phase of data analysis to develop a causal model that accounted for outcomes in children; the model included treatment variables, families' profiles, demographic variables, and child's outcomes. The software AMOS4 was used to conduct the analysis.

Qualitative Inquiry

Qualitative data was collected to explore the process of and the skill components involved in inter-agency and intra-agency collaboration when providing I-FAST treatment for families with children who were at risk of out-of-home placement. A series of focus groups and interviews were conducted with ICBP case managers and their collaborators. We explored the following questions in relation to the process of systems collaboration:

- How do service providers/professionals from different institutions understand and construct the meaning of collaboration in the context of intensive community-based treatment?
- What has been helpful in the process of building a beneficial collaborative relationship with other agencies especially when the collaborators has more power (e.g., placement-determining power) or status (e.g., psychiatrist Vs case managers)?
- How has the collaborative relationship been helpful or unhelpful to service provision?
- What had been some obstacles that stood in the way of a collaborating process?
- What are the key ingredients in creating a beneficial collaborative relationship?
- What constitutes the core skill sets in facilitating a beneficial collaborative relationship?
- What is involved in the process of initiating as well as facilitating a beneficial collaborative relationship at an agency-to-agency level?
- How do informants perceive the climate/culture of intra-agency collaboration at their respective office? What are agency policies, procedures, or practices that facilitate or hinder intra-agency collaboration?

Data Collection Procedures

There were two major components of the data collection process in exploring the process of systems collaboration of I-FAST.

Inter-Agency Collaboration

The study explored the process of inter-agency collaboration primarily through conducting focus group discussions with agency collaborators nominated by ICBP case managers. The ICBP case managers were asked to nominate professionals from various agencies that they frequently collaborated with in the treatment process. Our research team sent invitation letters to potential informants inviting them to participate in the focus group discussions. Formal written consent was obtained from focus group informants. Because systems collaboration was likely to be circumscribed by locality, we conducted one focus group for each county office. All focus groups were conducted at a participating county office. The focus groups were conducted by two facilitators from the research team and guided by a semi-structured, 11-item, *Inter-agency*

Systems Collaboration Discussion Guide (Appendix 9). The design of the Guide was based on research questions proposed by the study.

Intra-Agency Collaboration

The study explored the process of intra-agency collaboration primarily through conducting focus group discussions with intra-agency collaborators nominated by ICBP case managers. These informants consisted of agency personnel that ICBP case managers frequently collaborated with during the treatment process. The focus groups were conducted by two facilitators from the research team and guided by a semi-structured, 11-item, *Intra-Agency Systems Collaboration Discussion Guide* (Appendix 10). The design of the Guide was based on research questions proposed by the study.

Methods of Data Analysis

The study used content analysis to understand informants' perception of systems collaboration of I-FAST. An emergent design based on the constant comparison method was used to explore the qualitative data (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Charmaz, 2000). Constant interaction and reciprocal consideration of data and method was conducted at each stage of inquiry. The qualitative inquiry adopted the following data analyses procedures: Informants' responses and narratives during the focus group discussions or interviews were transcribed and computed. The software for qualitative inquiry, Atlas.ti 5.0 (2005) and QSR NUD*IST Vivo (Qualitative Solutions and Research, 1999) were used in the data analysis process. All data was coded using an open coding process during the initial stage. Each "unit" with a single idea was identified, and a code was assigned to each of them. Rules of inclusion were made for each code to standardize the content. Codes that addressed similar themes were later organized under "tree nodes." This process continued until the highest-level of conceptualization was attained that best described the characteristics of and connections among individual codes. In other words, the process of coding, recoding, and making connections stopped at the point of "theoretical saturation," when additional data did not increase our understanding of the studied phenomena. Sometimes, the rules of inclusion were changed to make it more accurate to describe the properties of the included units. After the first round of data analysis on all data, a revised list of codes was prepared and all data was coded again according to this new scheme.

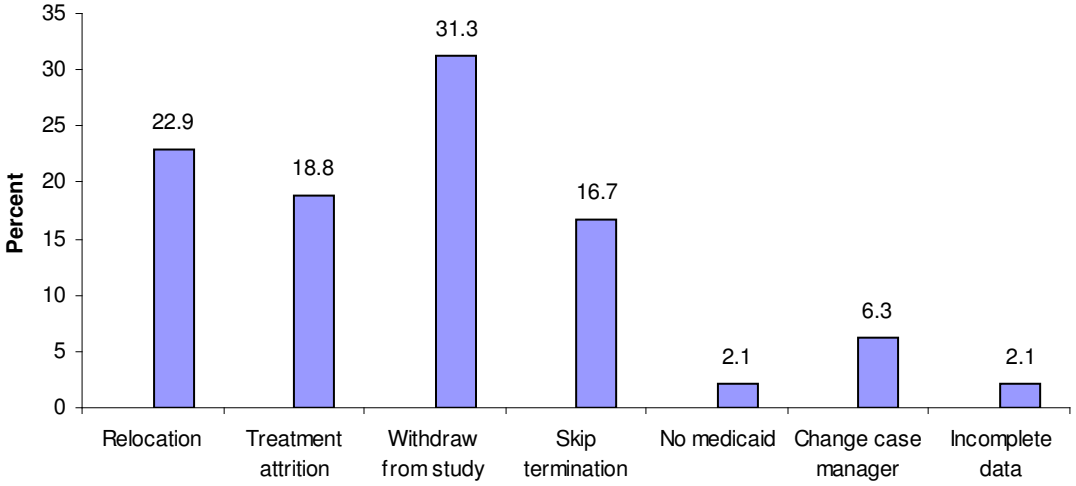
Research sites

Research sites of the study consisted of The Scioto Paint Valley Mental Health Center, which services five counties of the Paint Valley Alcohol, Drug Addiction and Mental Health Services Board (PVADAMH) service area. The second research site was Thompkins Child and Adolescent Services, which serves six counties of the Muskingham Alcohol, Drug Addiction and Mental Health Services Board (MADAMH) service area.

Findings of Outcome Evaluation

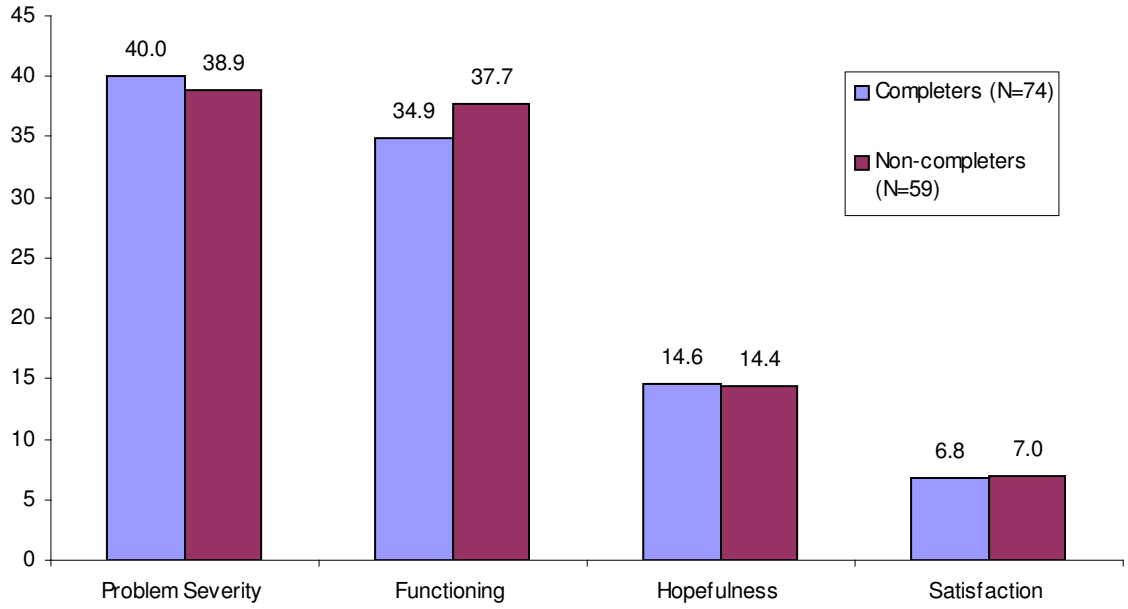
A total of 125 families consented to participate in the study. We had data on 125 families at initial assessment, 77 families at termination, and 72 families at six-month follow-up. Findings of the outcome evaluation were based on the 77 families who completed the program as well as provided data at initial assessment and termination. Out of the 125 families who consented to participate in the study at pre-treatment, 48 families did not complete data at termination. Figure 3 describes reasons for non-completion that primarily included relocation of families (22.9%), treatment attrition (18.8%), and discontinuation from the research (31.3%). In addition, 16.7% of families continued with the program and the study but did not provide data on termination.

Figure 3. Attribution reasons (N=48).



We conducted analyses to first determine whether there were significant differences between the completers and non-completers in children's behavior and functioning as assessed by The Ohio Scales. Parents who did not complete the study at termination on average reported their children at a lower level of problem severity and higher level of functioning. Using paired-sample t-tests, we determined that between those that completed the study and those that did not, there were no significant differences in the severity of problem behaviors in the child, the child's level of functioning, parents' hopefulness about their role, or the satisfaction of services. There were also no significant differences between those two groups' demographic characteristics, which include age, gender, educational status, and race.

Figure 4. Completers and non-completers: Parents' Evaluation of The Ohio Scales at Initial assessment



Research participants

Among the 77 children, 64.9% were males (50) and 35.1% females (27). The majority of child participants were students in middle school (41.9%) and elementary schools (32.3). 14.5% were high school students and 11.3% were in kindergarten or preschool. Child participants were predominantly Caucasian (93.2%), with 2.6% African Americans, and 5.2% multiracial. The age of the children ranged from 4 to 17 (mean: 11.8, S.D. 3.3) with slightly over 60% between the ages of 9 to 14. Regarding children's mental status, almost half of the child participants had a diagnosis of Hyperactive Attention Deficit Disorder (48.4%), 12.9% Adjustment Disorder, 11.3% Mood Disorder, 8.1% Depression Disorder NOS, 4.8% Oppositional Defiant Disorder, 3.2% Bipolar, 3.2% Disruptive Disorder, 1.6% Impulse-Control Disorder, 1.6% Dysthymic Disorder, 1.6% Anxiety Disorder, 1.6% Post-traumatic Stress Disorder, and 1.6% Trichotillomania.

Figure 5. Gender of research participants (N=77)

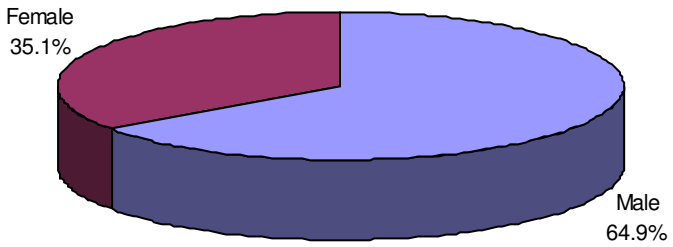


Figure 6. Educational status of research participants (N=77)

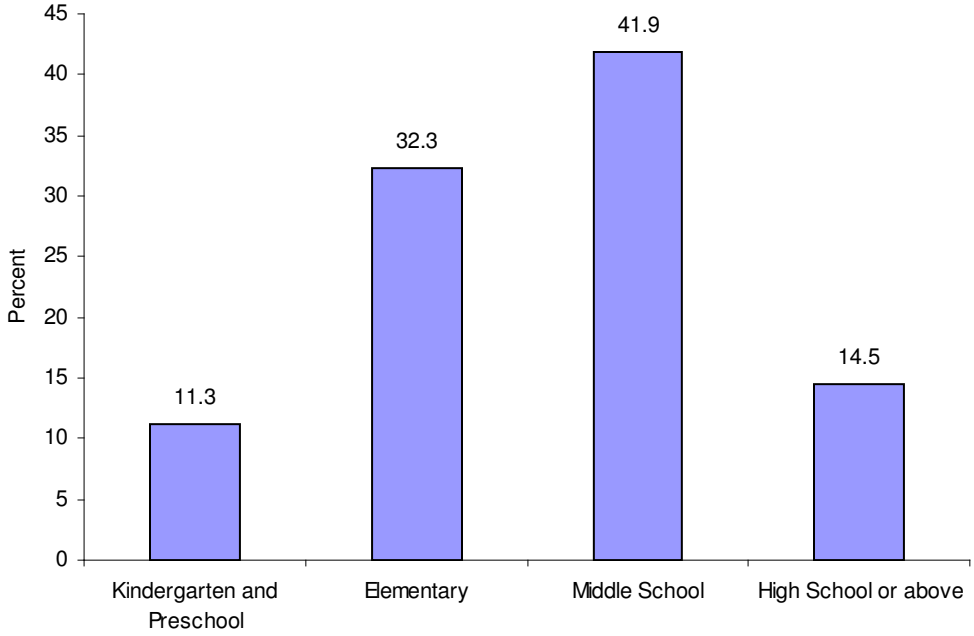


Figure 7. Race of research participants (N=77)

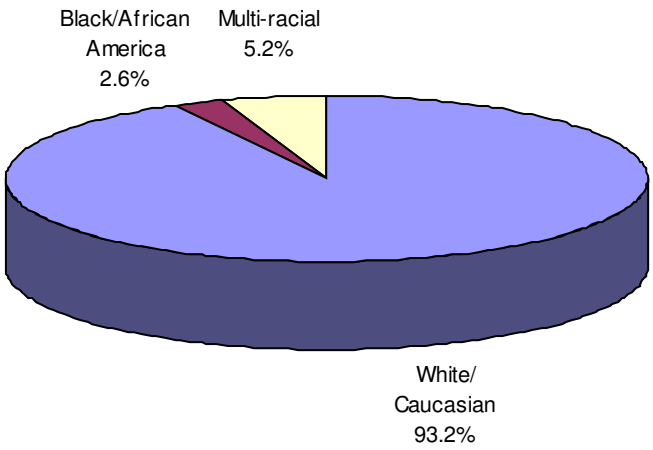
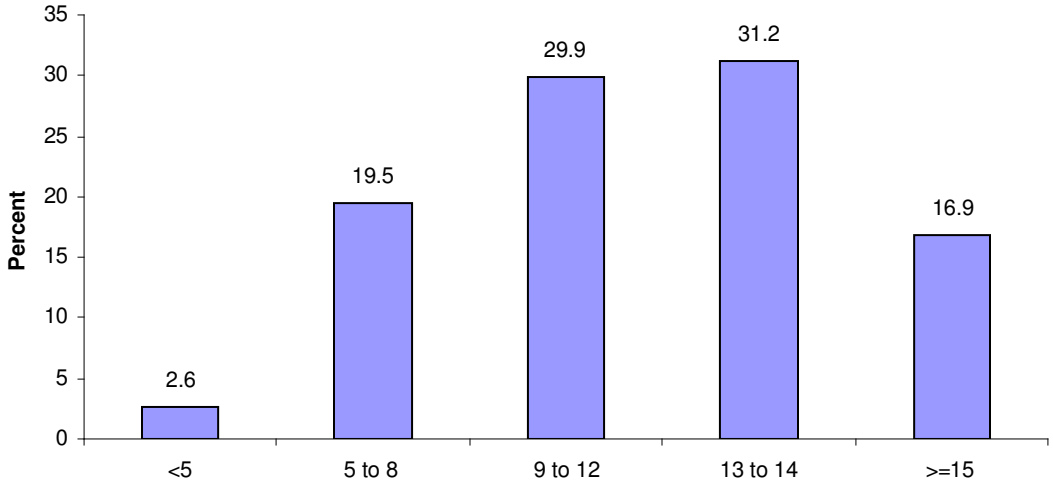


Figure 8. Age of research participants at initial assessment (N=77)

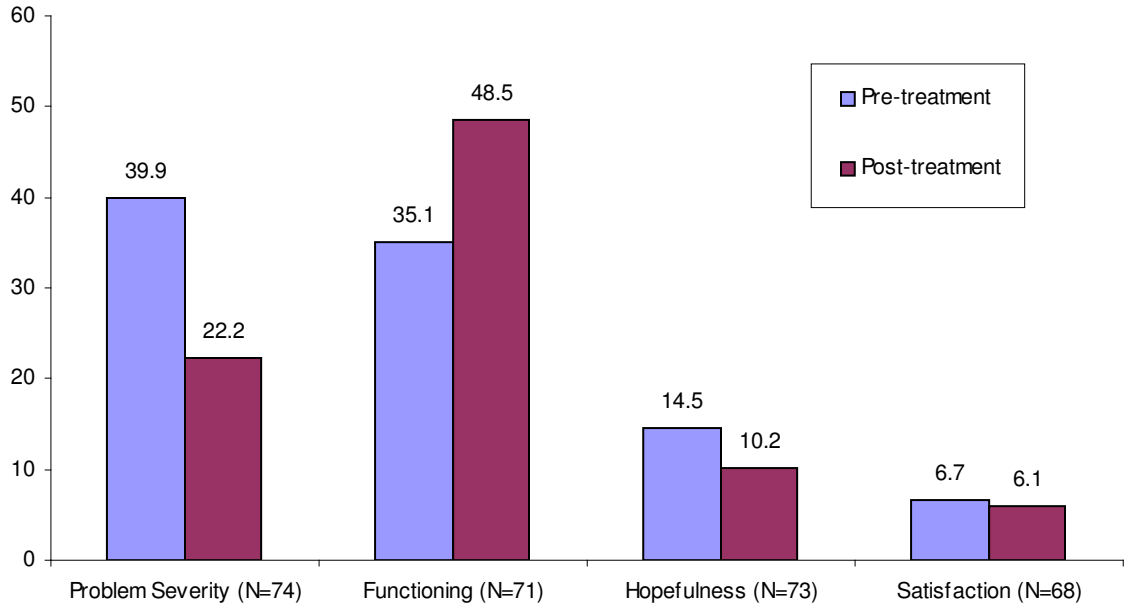


Child's outcomes: The Ohio Scales

Parents' Assessments

The parents' rating of The Ohio Scale indicated a significant improvement in the three areas of assessment including Problem severity, Functioning, and Hopefulness from initial assessment to termination. The mean score of problem severity at initial assessment, based on parents' evaluation, was 39.9, meaning that the child, on average, engaged several times of each listed problem behaviors in the past 30 days (Figure 9). The mean score of the Functioning scale was 35.1 (SD=17.5) at initial assessment indicating a relatively low level of functioning in children. The mean score of the Hopefulness scale at pre-program was 14.5 (SD=4.7) indicating that average parents were split between "somewhat" hopeful and unhopeful about their role as parents. The mean score of the Satisfaction scale was 6.7 (SD=3.7) at initial assessment indicating that an average respondent was "extremely" to "moderately" satisfied with the program at the beginning of participating in the home-based services.

Figure 8. Parents' Evaluation of The Ohio Scales: Initial assessment and Termination



[1] Lower scores indicate less severe behavioral problems.
[2] Lower scores indicate more hopefulness and well-being about parenting.
[3] Lower scores indicate greater satisfaction with the mental health services.
[4] Higher scores indicate higher level of functioning in a child in the past 30 days.

Based on findings from paired-sample t-tests of the parents' evaluations, there was a significant decrease in the severity of problem behaviors in the child [t=8.3, df=73, p <.001], significant improvement in child's level of functioning [t=-6.6, df=70, p <.001], and significantly greater hopefulness in parents about their role as parents [t=6.7, df=72, p <.001] from initial assessment to termination. Findings indicated non-significant changes in parents' satisfaction of services from initial assessment to termination. Parents were already extremely satisfied with the services at initial assessment and such a high level of satisfaction was maintained at termination.

Table 1. Paired-sample *t*-tests of The Ohio Scales – Parent Form at Initial assessment and Termination

	Pre-program Assessment	Post-program Assessment	*t*	*df*	*p*
Problem Severity (n=74)	40.0 (SD=20.4)	22.2 (SD=16.4)	8.3	73	.000
Functioning (n=71)	35.1 (SD=17.5)	48.5 (SD=15.6)	-6.6	70	.000
Hopefulness (n=72)	14.5 (SD=4.7)	10.2 (SD=3.7)	6.7	71	.000
Satisfaction (n=68)	6.7 (SD=3.7)	6.1 (SD=3.3)	1.5	67	.150

Figure 10 shows the mean scores of problem severity, level of functioning, parent's hopefulness, and satisfaction of services at initial assessment, termination, and 6-month follow-up based on parents' reports. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination and non-significant changes from termination to six-month follow-up for problem severity, level of functioning, parent's hopefulness and parent's satisfaction of services. In other words, significant positive changes in children's behavioral outcomes from initial assessment to termination were maintained six months after the families terminated from the program. Findings also indicated significant changes in parents' hopefulness and satisfaction of services from initial assessment to termination; those positive changes were maintained at six-month follow-up (Table 2-5).

Figure 9. Parents' Evaluation of The Ohio Scales: Initial assessment and Termination, and Six-month follow-up

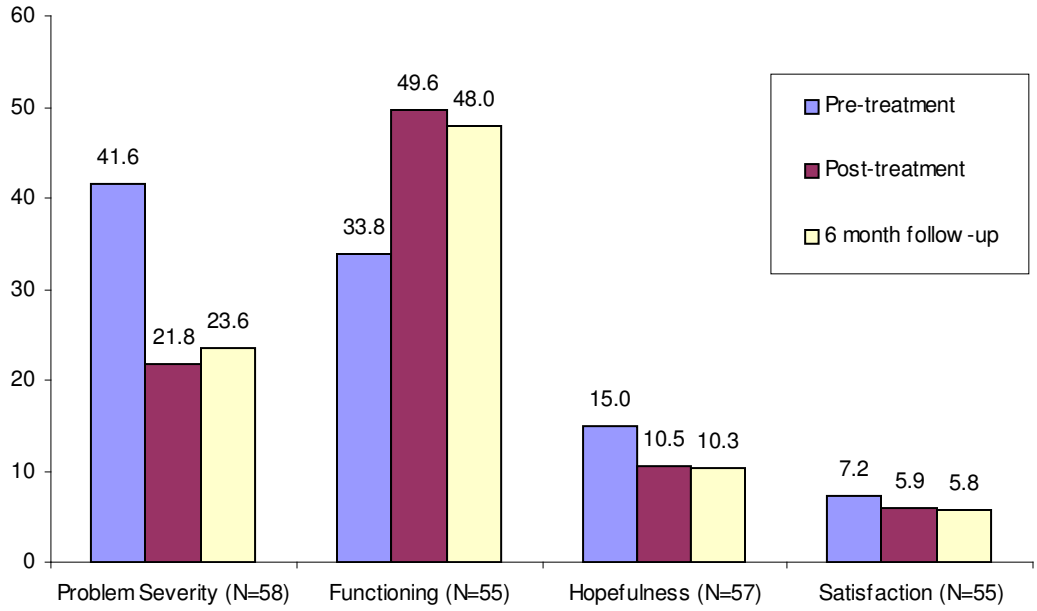


Table 2: Pairwise Comparisons for Problem Severity on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Parents' assessment (N=58).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		19.9	2.5	.000	14.9	24.8
Initial Assessment		6-month Follow-up	18.0	2.4	.000	13.2	22.8
	Termination	6-month Follow-up	-1.8	2.3	.429	-6.5	2.8

Table 3: Pairwise Comparisons for Levels of Functioning on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Parents' assessment (N=55).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-15.8	2.4	.000	-20.5	-11.0
Initial Assessment		6-month Follow-up	-14.2	2.4	.000	-19.0	-9.3
	Termination	6-month Follow-up	1.6	2.1	.436	-2.5	5.7

Table 4: Pairwise Comparisons for Hopefulness on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Parents' assessment (N=57).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		4.6	0.7	.000	3.1	6.1
Initial Assessment		6-month Follow-up	4.7	0.7	.000	3.4	6.0
	Termination	6-month Follow-up	0.1	.05	.808	-0.9	1.1

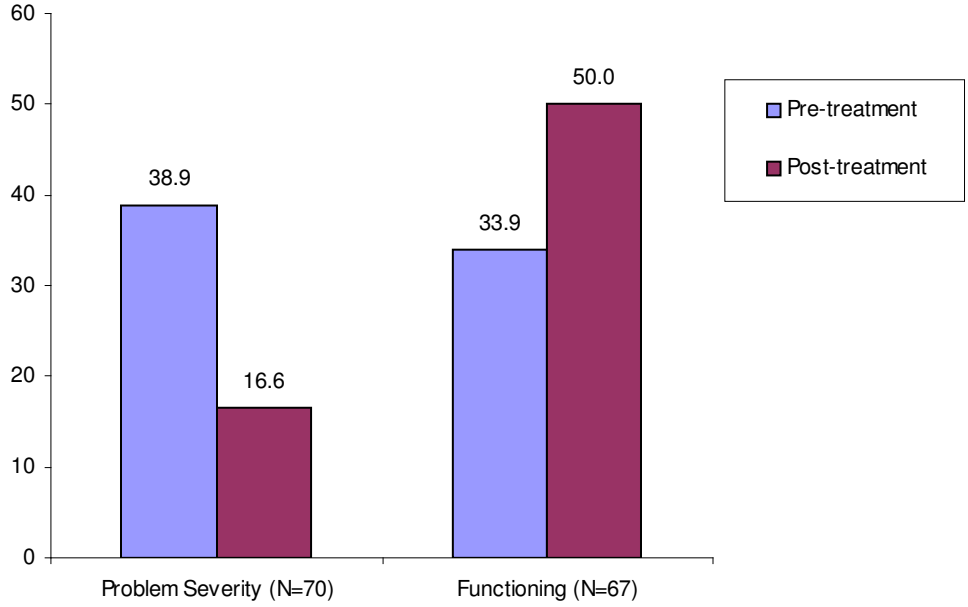
Table 5. Pairwise Comparisons for Satisfaction on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Parents' assessment (N=55).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		1.3	0.5	.008	0.3	2.3
Initial Assessment		6-month Follow-up	1.4	0.5	.009	0.4	2.4
	Termination	6-month Follow-up	0.1	0.4	.826	-0.7	0.9

Case Managers' Assessments

Case managers shared a similar pattern of evaluation to the parents for problem severity and level of functioning in children at initial assessment. Mean scores of problem severity at initial assessment, based on case managers' evaluation, was 38.9, meaning that the child, on average, engaged several times of each listed problem behaviors in the past 30 days (Figure 11). Such an evaluation was strikingly similar to parents' assessment of 39.9 for problem severity at initial assessment. Similarly, parents on average rated their children at 35.1 for their level of functioning and case managers on average rated the child 33.9. Case managers in general reported a lower level of problem severity than parents at termination (16.6 Vs 22.2)

Figure 11. Case managers' Evaluation of The Ohio Scales: Initial assessment and Termination



The case managers' rating of The Ohio Scale indicated a significant improvement in the areas of assessment of Problem severity and Functioning from initial assessment to termination. Based on findings from paired-sample t-tests on the case managers' evaluations, there was a significant decrease in the severity of problem behaviors in the child [t=12.5, df=69, p <.001] and significant improvement in child's level of functioning [t=-9.4, df=66, p <.001] from initial assessment to termination (Table 6).

Table 6. Paired-sample *t*-tests of The Ohio Scales – Worker Form at Initial assessment and Termination

	Pre-program Assessment	Post-program Assessment	*t*	*df*	*p*
Problem Severity (n=70)	38.9 (SD=15.8)	16.6 (SD=10.1)	12.5	69	.000
Functioning (n=67)	34.0 (SD=12.6)	50.0 (SD=12.1)	-9.4	66	.000

Figure 12 shows the mean scores of problem severity and level of functioning at initial assessment, termination, and 6-month follow-up based on case managers' assessment. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination and non-significant changes from termination to six-month follow-up for problem severity and level of functioning in children. In other words, based on the assessment of case managers, significant positive changes in children's behavioral outcomes from initial assessment to termination were maintained six months after the families terminated from the program (Table 7 & 8).

Figure 12. Case managers' Evaluation of The Ohio Scales: Initial assessment and Termination, and Six-Month Follow-up.

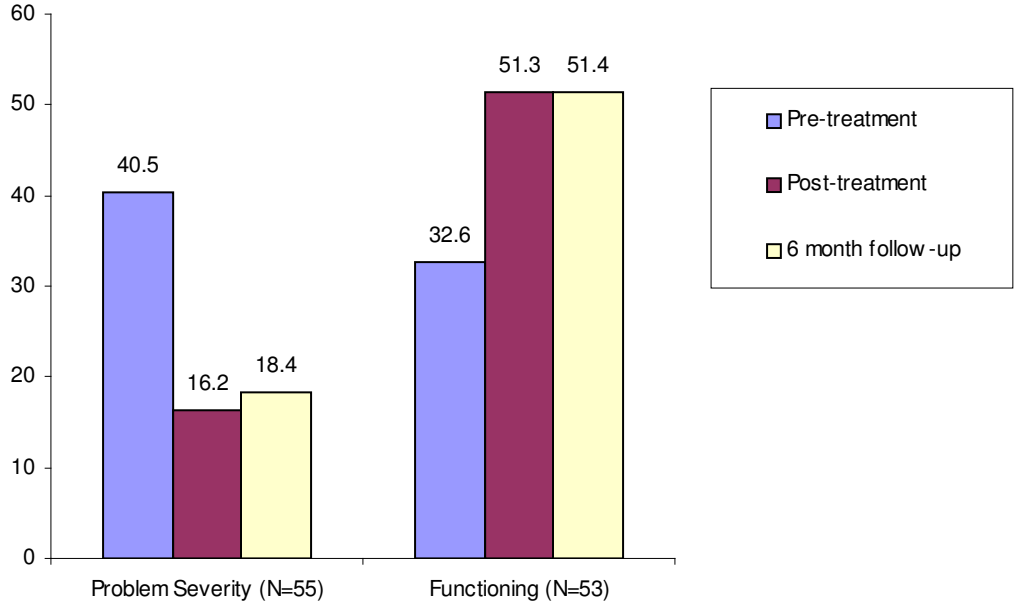


Table 7: Pairwise Comparisons for Problem Severity on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Case managers' assessment (N=55).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		24.2	2.0	.000	20.2	28.3
Initial Assessment		6-month Follow-up	22.1	1.9	.000	18.2	25.9
	Termination	6-month Follow-up	-2.2	1.6	.191	-5.4	1.1

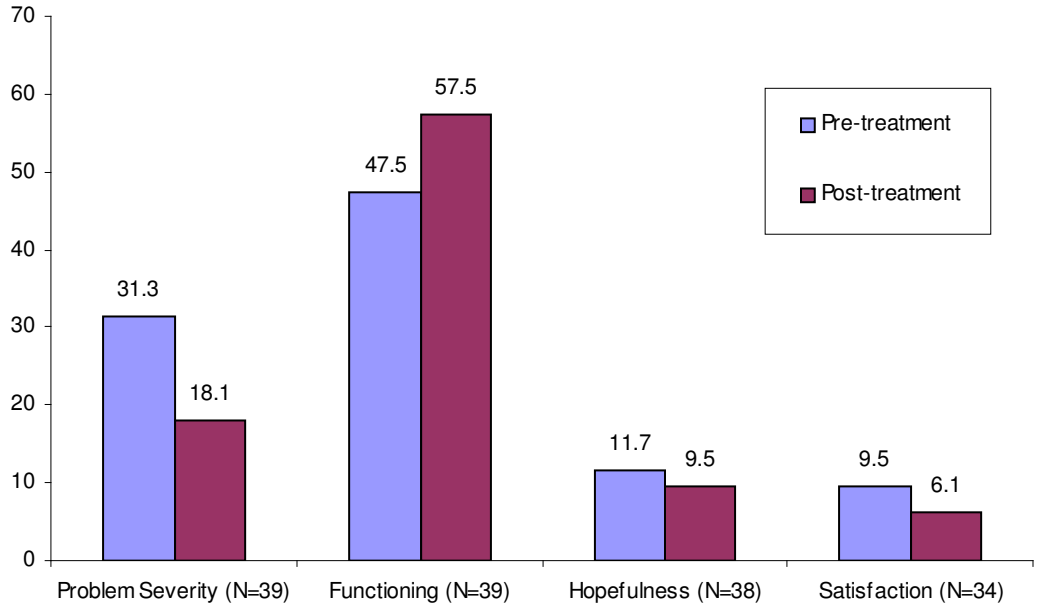
Table 8: Pairwise Comparisons for Levels of Functioning on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Case managers' assessment (N=55).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-18.7	1.7	.000	-22.1	-15.3
Initial Assessment		6-month Follow-up	-18.8	2.1	.000	-23.0	-14.6
	Termination	6-month Follow-up	-0.1	1.5	.946	-3.0	2.8

Youth Assessment

Youth reported a different pattern of evaluation of their problem severity and level of functioning at initial assessment. On average, youth assessed themselves at a lower level of problem severity (31.3 Vs 39.9 and 38.9) and at higher level of functioning (47.5 Vs 35.1 and 33.9) as compared to parents and case managers (Figure 13). Interestingly, the differences in pattern of evaluation at termination between youth and their parents and case managers were greatly reduced. In fact, the mean scores of problem severity as rated by youth, parents, and case managers were 18.1, 22.2, and 16.6 respectively. Youth, however, still rated themselves at a higher level of functioning at termination than their parents or case managers (57.5 Vs 50 and 48.5).

Figure 13.Youth's Evaluation of The Ohio Scales: Initial assessment and Termination



The youth's rating of The Ohio Scale indicated a significant improvement in all four areas of assessment including Problem severity, Functioning, Hopefulness, and Satisfaction from initial assessment to termination. Based on findings from paired-sample t-tests on the youth's evaluations, there was a significant decrease in the severity of problem behaviors in the youth [t=4.2, df=38, p <.000], significant improvement in their level of functioning [t=-3.4, df=38, p <.05], significantly greater hopefulness in youth about their future [t=2.9, df=37, p <.05], and significantly greater satisfaction in youth with service [t=3.7, df=33, p=.001] from initial assessment to termination (Table 9).

Table 9. Paired-sample *t*-tests of The Ohio Scales – Parent Form at Initial assessment and Termination

	Pre-program Assessment	Post-program Assessment	*t*	*df*	*p*
Problem Severity (n=39)	31.3 (SD=20.4)	18.1 (SD=12.5)	4.2	38	.000
Functioning (n=39)	47.5 (SD=19.2)	57.5 (SD=10.6)	-3.4	38	.002
Hopefulness (n=38)	11.7 (SD=4.6)	9.5 (SD=2.7)	2.9	37	.006
Satisfaction (n=34)	9.5 (SD=4.9)	6.1 (SD=2.5)	3.7	33	.001

Figure 14 shows the mean scores of problem severity, level of functioning, youth's hopefulness, and satisfaction of services at initial assessment, termination, and 6-month follow-up based on parents' report. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination and non-significant changes from termination to six-month follow-up in problem severity, level of functioning, youth's hopefulness, and satisfaction of services (Table 10-13). In other words, significant positive changes in children's behavioral outcomes from initial assessment to termination were maintained six months after the families terminated from the program.

Figure 14. Youth's Evaluation of The Ohio Scales: Initial assessment, Termination, and Six-Month Follow-up

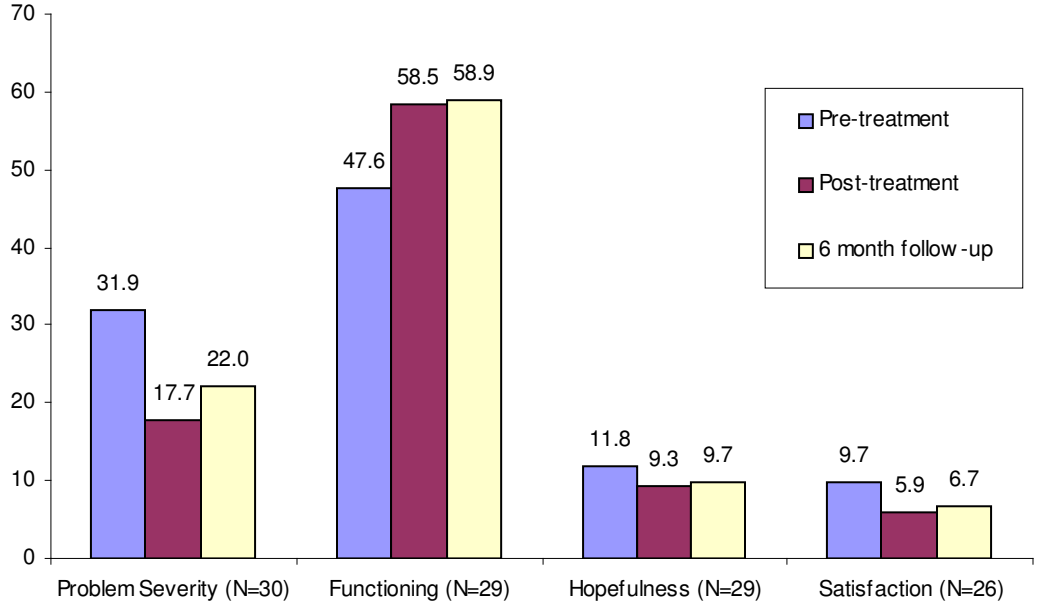


Table 10: Pairwise Comparisons for Problem Severity on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Youth's assessment (N=30).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		14.2	3.5	.000	7.0	21.3
Initial Assessment		6-month Follow-up	9.9	3.8	.015	2.1	17.7
	Termination	6-month Follow-up	-4.3	3.8	.275	-12.2	3.6

Table 11: Pairwise Comparisons for Levels of Functioning on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Youth's assessment (N=29).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-11.0	3.2	.002	-17.6	-4.4
Initial Assessment		6-month Follow-up	-11.3	3.9	.007	-19.3	-3.4
	Termination	6-month Follow-up	-0.3	2.4	.889	-5.3	4.6

Table 12: Pairwise Comparisons for Hopefulness on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Youth's assessment (N=29).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		2.5	0.9	.008	0.7	4.3
Initial Assessment		6-month Follow-up	2.2	1.0	.033	0.2	4.2
	Termination	6-month Follow-up	-0.3	0.9	.693	-2.1	1.4

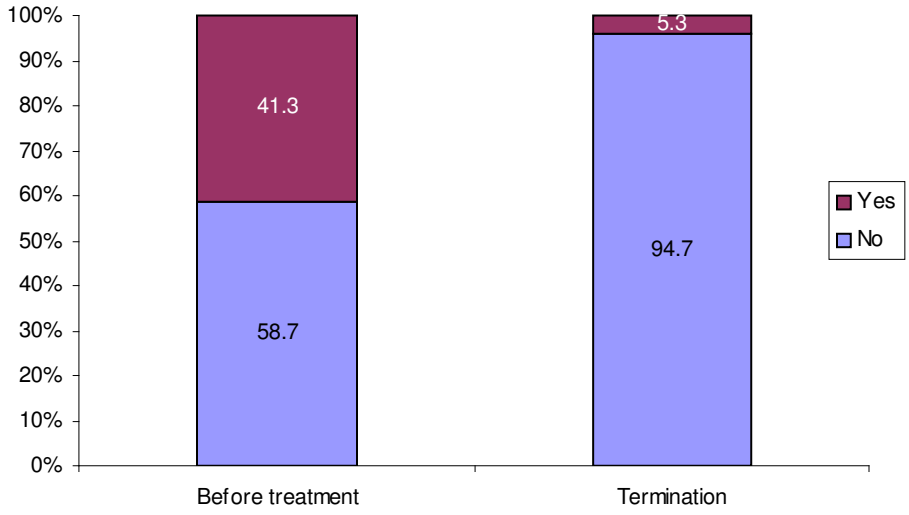
Table 13. Pairwise Comparisons for Satisfaction on Initial Assessment, Termination, and 6-month Follow-up: The Ohio Scales - Youth's assessment (N=26).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		3.7	1.0	.001	1.6	5.9
Initial Assessment		6-month Follow-up	2.9	0.9	.004	1.0	4.8
	Termination	6-month Follow-up	-0.8	0.8	.3	-2.5	0.9

Placement Status

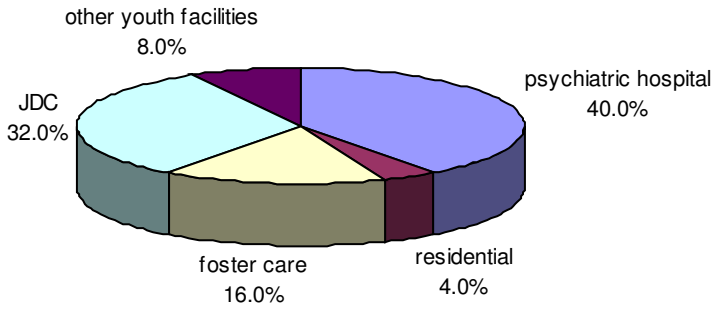
Another examined child's outcome was the placement status of the children. We had data on the placement status of 75 children prior to their receiving treatment and at termination. Among the 75 children, 41.3% (31) had been in out-of-home placement before receiving intensive community-based services (Figure 15). Figure 16 shows the placement settings where the children had been placed before they participated in the ICBP program. Children were most frequently placed in psychiatric hospitals (40%) and juvenile detention centers (32%), which was followed by foster care (16%), other youth facilities (8%) and residential treatment facilities (4%). At termination, only 5.3% (4) of child participants were in out-of-home placement. Three of them were placed in psychiatric hospitals and 1 in residential treatment facility. Findings based on Wilcoxon signed-rank tests indicated significant differences in the pattern of distribution of placement status of children from initial assessment to termination with significantly higher percentage of children in out-of-home placement before treatment than at termination (Figure 15).

Figure 15. Placement Status of Children: Before Treatment and at Termination (N=75).



Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test = .000

Figure 16. Placement Setting Before Treatment (N=25).

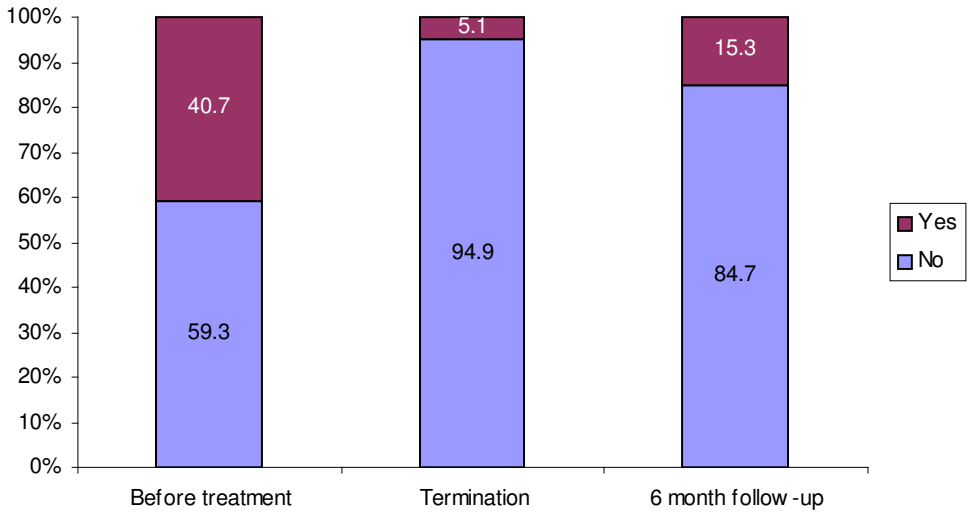


Of the 75 children, 59 provided complete data regarding placement status before treatment, at termination, and 6-month follow-up. Among these 59 children, 40.7% were placed at out-of-home placement before treatment. Only 5.1% (3) were in out-of-home placement at termination, and 15.3% (9) were in out-of-home placement at 6-month follow-up (Figure 16). Specifically, 3 children were placed in psychiatric hospitals at termination. At 6-month follow-up, 5 children were placed in psychiatric hospitals, 1 in a residential treatment facility, and 3 in juvenile detention centers.

Findings based on Wilcoxon signed-rank tests indicated significant differences in the pattern of distribution of placement status of children from before treatment to termination, termination to 6-month follow-up, and before treatment to 6-month follow-up. A significantly higher percentage of children were in out-of-home placement before treatment than at termination. In addition, there were a higher percentage of children in placement at 6-month follow-up than at termination. Despite so, there was still a significantly lower percentage of children in placement at 6-month follow-up than before treatment (Figure 17).

In sum, there was a significant decrease in the number of children in out-of-home placement at termination than at pre-treatment. In addition, despite significantly more children placed at out-of-home placement at 6-month follow-up than at termination, the number was still significantly less than the number of children in out-of-home placement before they participated in the program.

Figure 17. Placement Status of Children: Before Treatment, Termination, 6-Month Follow-up (N=59).



Before treatment and Termination: Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test =.000
Termination and 6-Month Follow-up: Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test =.026
Before treatment and 6-Month Follow-up: Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test =.224

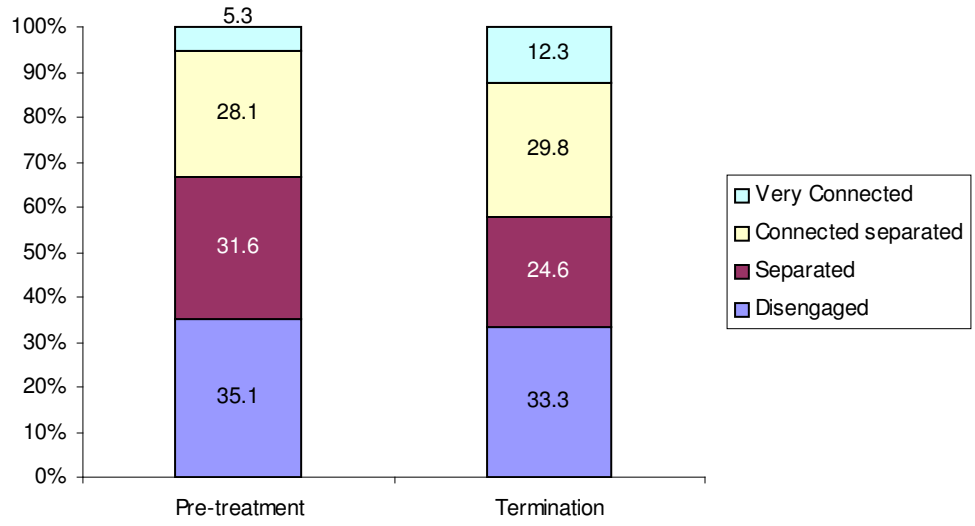
Family Functioning

Family functioning was defined by the scores of FACESII, which was completed by parents (Oslon, Portner, & Bell, 1982). FACESII evaluates cohesiveness and adaptability of families. FACESII gives rise to two scores: Cohesion scores and Adaptability scores, and their correspondence to Family Types in terms of Balanced (scores 7-8), Moderately Balanced (5-6), Mid-Range (4-3), and Extreme (1-2). Families can be categorized into four types under each evaluated dimension. Family cohesion types include: Disengaged (12-50), Separated (51-59), Connected separated (60-70), and Very Connected (71-80). Family adaptability types include: Rigid (15-39), Structured (40-45), Flexible (46-54), and Very Flexible (55-70).

Family Cohesion

With respect to family cohesion, 57 families provided data at initial assessment and termination (Figure 18). Approximately one-third of these families belonged to the “Disengaged” type at initial assessment as well as at termination. There were slightly fewer families in the categories of "Separated" and "Disengaged" at termination than at initial assessment and slightly more families in the category of 'Connected separated" at termination than at initial assessment. In addition, percentage of families in the category of "very connected" doubled from initial assessment to termination (5.3% Vs 12.3%). Overall, families showed a trend of becoming more connected with treatment. Findings based on Wilcoxon signed-rank tests, however, did not indicate significant differences in the pattern of distribution of family types from initial assessment to termination in the dimension of family cohesion.

Figure 18. FACESII: Family Cohesion at Initial assessment and Termination (N=57).



Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test = .184

Of these 57 families, 45 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 18 showed the distribution of families for each family type at initial assessment, termination, and 6-month follow-up. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to and 6-month follow-up in family cohesion (Table 14). The pattern of distribution showed an increase of families in the category of "Very connected " (2.2% Vs 6.7%) and "Connected separated" (28.9% Vs 42.2%) from initial assessment to the 6-month follow-up (Figure 19). There were also slightly fewer families in the categories of "Separated" and "Disengaged" at 6-month follow-up than at initial assessment.

With respect to changes from initial assessment to termination, fewer families were in the categories of "Separated" and "Connected separated" and slightly more families were in the category of "Disengaged" at termination than at initial assessment. There was also a large percentage increase of families in the category of "Very connected" from initial assessment to termination (2.2% V 13.3%) (Figure 19). Regarding changes between termination and 6-month follow-up, there were more families in the categories of "Connected separated" and "Separated" and fewer families in the categories of "Very connected" and "Disengaged" at 6-month follow-up than at termination. Findings of pairwise comparisons indicated non-significant changes from initial assessment to termination, and termination to six-month follow-up in terms of family cohesion (Table 14).

Overall, there was a trend of families becoming more connected and less separated and/or disengaged from initial assessment to termination, and to 6-month follow-up.

Figure 19. FACESII: Family Cohesion at Initial assessment, Termination, and 6-month Follow-up (N=45).

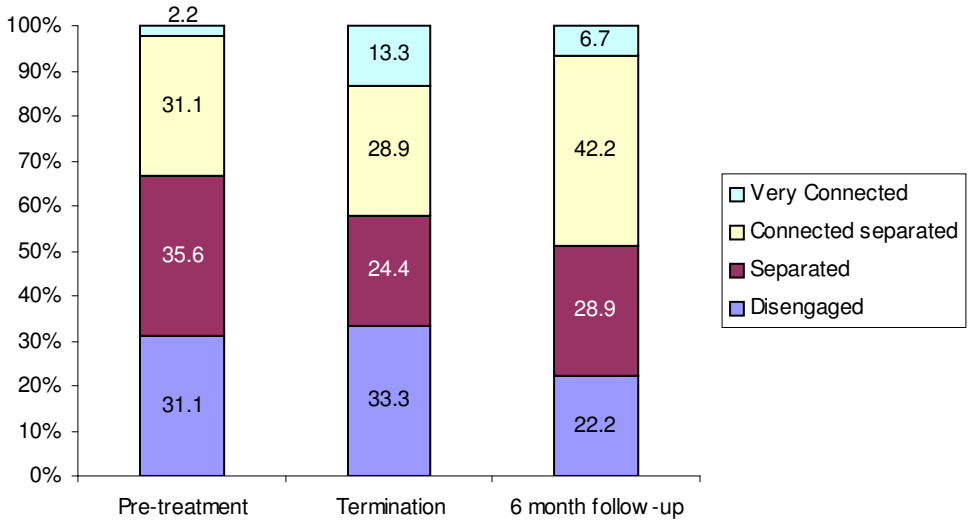


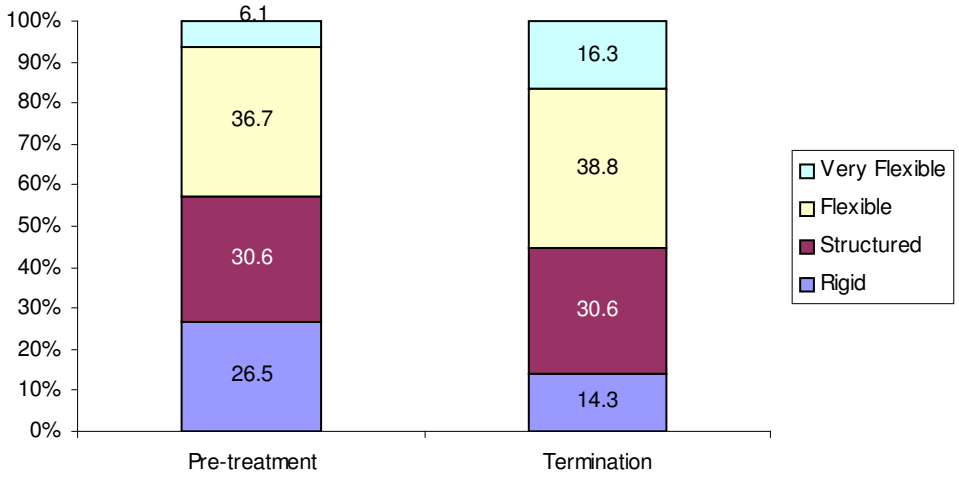
Table .14 Pairwise Comparisons for Family Cohesion on Initial Assessment, Termination, and 6-month Follow-up: FACESII (N=45).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-3.8	2.0	.057	-7.8	0.1
Initial Assessment		6-month Follow-up	-5.0	2.1	.022	-9.2	-0.7
	Termination	6-month Follow-up	-1.1	1.4	.416	-3.9	1.7

Family Adaptability

With respect to the dimension of family adaptability, 49 families provided data at initial assessment and termination (Figure 0). Approximately one-third of these families belonged to the “Structured” type at initial assessment as well as at termination (30.6%). There were fewer families in the category of "Rigid" at termination than at initial assessment and more families in the categories of "Very flexible" and "Flexible" at termination than at initial assessment. In other words, families showed a trend of becoming more flexible throughout treatment. Findings based on Wilcoxon signed-rank tests indicated significant differences in the pattern of distribution of family types from initial assessment to termination in the dimension of family adaptability (Figure 20).

Figure 20. FACESII: Family Adaptability at Initial assessment and Termination (N=49).



Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test = .038

Out of these 49 families, 39 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 19 shows the distribution of families for each family type at initial assessment, termination, and 6-month follow-up. With respect to changes from initial assessment to termination, fewer families were in the categories of "Structured" and "Rigid" and more families in the category of "Flexible" at termination than at initial assessment. There was also a large percentage increase of families in the category of "Very flexible" from initial assessment to termination (5.1% V 17.9%) (Figure 21). In other words, families showed a trend from "Structured" and "Rigid" to more flexible in their ability to adapt to changes. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination in family adaptability (Table 15).

Regarding changes between termination and 6-month follow-up, there were increasingly more families in the categories of "Flexible" but also a slight decrease for families in the categories of "Very Flexible" at 6-month follow-up than at termination. In addition, there were slightly more families in the category of "Rigid" at 6-month follow-up than at termination (17.9% Vs 15.4%) while the percentage of families in the category of "Structure" remained unchanged (Figure 21). Findings of pairwise comparisons indicated non-significant changes from termination to six-month follow-up in terms of family adaptability (Table 15).

In sum, families showed a trend of becoming more flexible and less rigid with treatment with these changes being maintained at 6-month follow-up.

Figure 21. FACESII: Family Adaptability at Initial assessment, Termination, and 6-month Follow-up (N=39).

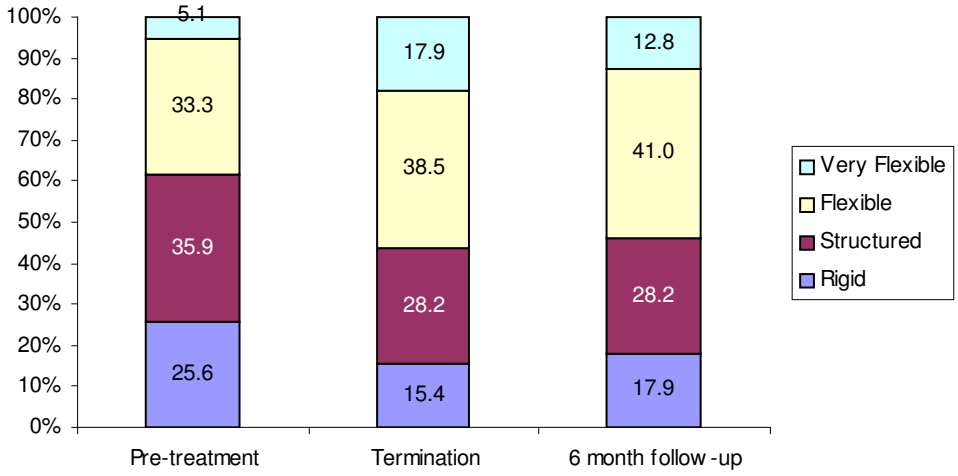


Table 15. Pairwise Comparisons for Family Adaptability on Initial Assessment, Termination, and 6-month Follow-up: FACE II (N=39).

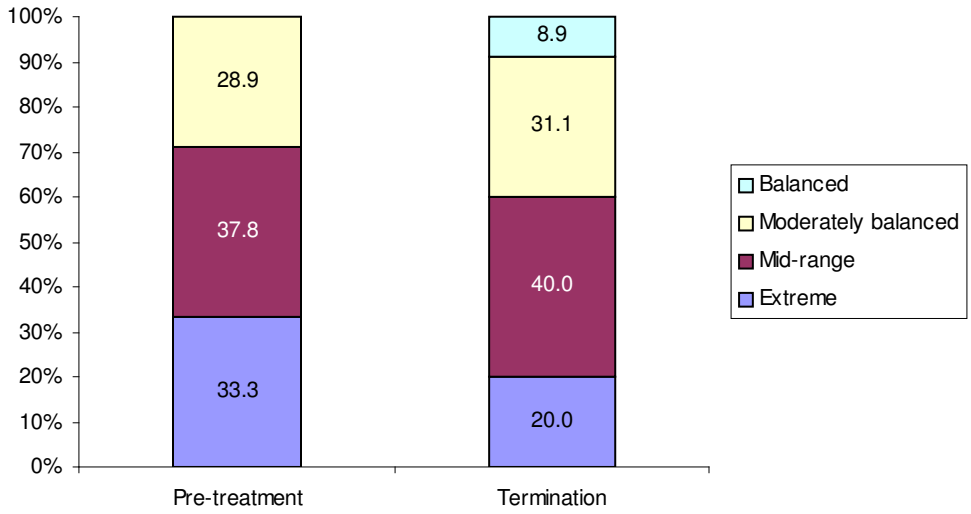
			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-3.7	1.6	.032	-7.0	-0.3
Initial Assessment		6-month Follow-up	-3.1	1.6	.057	-6.2	0.1
	Termination	6-month Follow-up	0.6	1.1	.590	-1.7	2.9

Family Type

With respect to the family type, 45 families provided data at initial assessment and termination (Figure 22). No families were in the category of "Balanced" at initial assessment. At termination, there were 8.9% of families in the category of "Balanced," more families were “Moderately balanced" and "Mid-range," and fewer families were "Extreme." In other words, families showed a trend of becoming more balanced and less extreme throughout treatment in terms of family type. Findings based on Wilcoxon

signed-rank tests indicated significant differences in the pattern of distribution of family types from initial assessment to termination.

Figure 22. FACESII: Family Type at Initial assessment and Termination (N=45).



Aysmp. Sig. (2-tailed) from Wilcoxon signed-rank test = .027

Out of these 45 families, 36 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 23 showed the distribution of families for each family type at initial assessment, termination, and 6-month follow-up. There was a continuous trend of families becoming more balanced and less extreme from initial assessment, to termination, and to 6-month follow-up. With respect to changes from initial assessment to termination, no families were in the category of "Balanced" at initial assessment. At termination, 11.1% of families were in the category of "Balanced" (Figure 23). In addition, fewer families were in the categories of "Mid-range" and "Extreme" at termination than at initial assessment. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination in Family Type (Table 16).

Regarding changes between termination and 6-month follow-up, there were increasingly more families in the categories of "Moderately balanced" but also a slight decrease in the number of families in the category of "balanced" at 6-month follow-up than at termination. In addition, there were increasingly fewer families in the category of "Mid-range" and "Extreme" at 6-month follow-up than at termination. Findings of pairwise comparisons indicated non-significant changes from termination to six-month follow-up in terms of Family Type (Table 16).

In sum, families showed a trend of becoming more balanced and less extreme with treatment, and these changes were maintained at 6-month follow-up.

Figure 23. FACESII: Family Type at Initial assessment, Termination, and 6-month Follow-up (N=36).

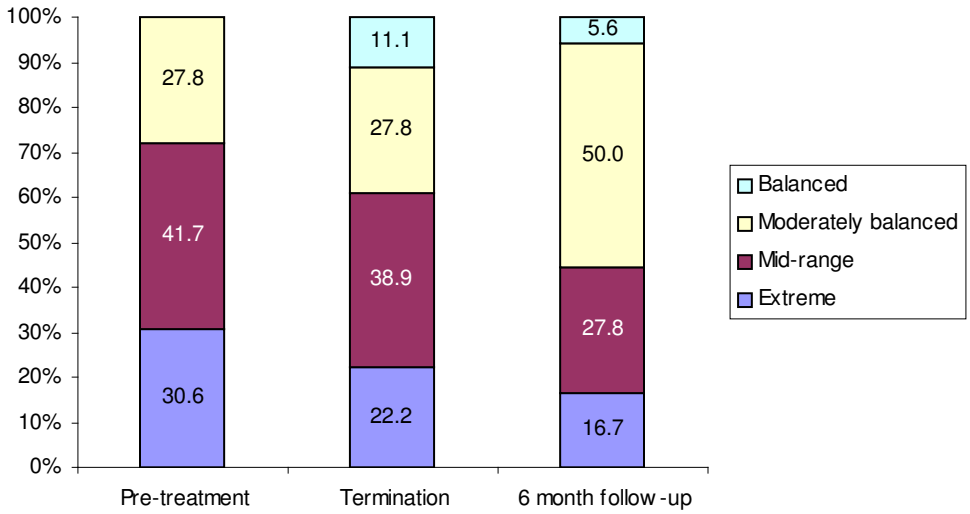


Table 16. Pairwise Comparisons for Family Type on Initial Assessment, Termination, and 6-month Follow-up: FACE II (N=36).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-0.7	0.3	.040	-1.4	-0.03
Initial Assessment		6-month Follow-up	-0.9	0.3	.004	-1.5	0.3
	Termination	6-month Follow-up	-0.2	0.2	.321	-0.6	0.2

Parental Competence with Service Providers

Fifty-nine families provided data for Parental Competence with Service Providers (Figure 24). Participating families reported very high competence with service providers at initial assessment (54.3, S.D.=7.1). Parents also reported high competence with service providers at termination (53.0, S.D.=7.7), despite a slight decrease of the mean scores from initial assessment to termination (54.3 Vs 53.0). Findings from the paired-sample t-tests did not indicate significant differences in parental competence with service providers from initial assessment to termination [*t*=1.1, *df*=68, *p=.270*) (Table 17).

Figure 24. Parents' Evaluation of Parental Competence and Family Participation: Initial assessment and Termination

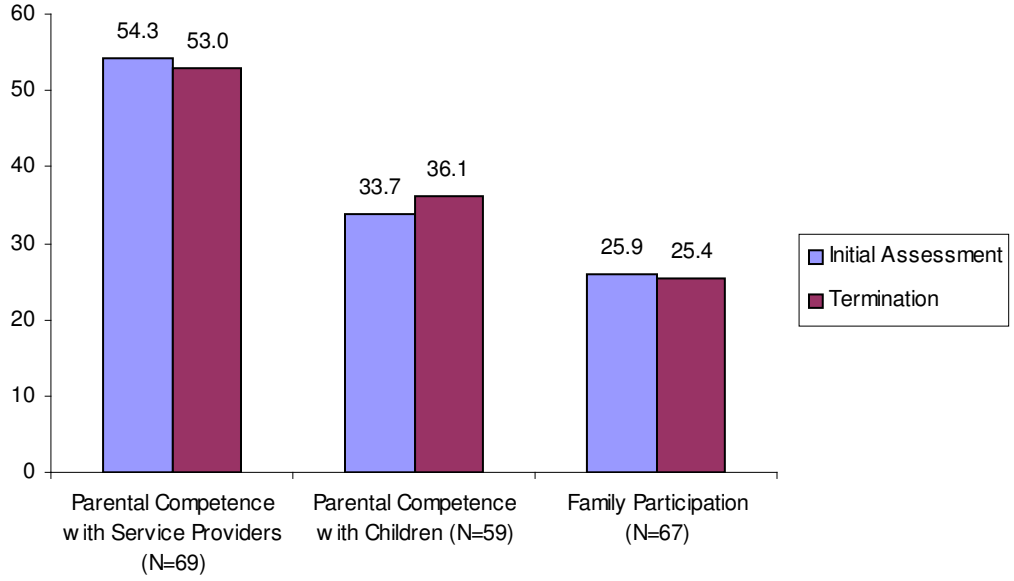


Table 17. Paired-sample *t*-tests of Parental Competence and Family Participation at Initial assessment and Termination

	Pre-program Assessment	Post-program Assessment	*t*	*df*	*p*
Parental competence with service providers (n=69)	54.3 (SD=7.1)	53.0 (SD=7.7)	1.1	68	.270
Parental competence with children (n=59)	33.7 (SD=6.6)	36.1 (SD=5.7)	-2.8	58	.007
Family participation (n=67)	25.9 (SD=3.0)	25.4 (SD=3.7)	0.9	66	.369

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Out of these 69 families, 53 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 25 showed the mean scores of Parental Competence with Service Providers at initial assessment, termination, and 6-month follow-up. There was a slight decease in mean scores from initial assessment to termination (54.5 Vs 53.3) and an increase in mean scores from termination to 6-month follow-up (53.3 Vs 55.2). Findings based on pairwise comparisons indicated there were no significant changes from initial assessment to termination and to 6-month follow-up in Parental Competence with Service Providers (Table 18). In sum, parents already reported high competence with service providers at initial assessment and such a positive evaluation was maintained at termination as well as at 6-month follow-up.

Figure 25. Parents' Evaluation of Parental Competence and Family Participation: Initial assessment, Termination, and Six-Month Follow-up

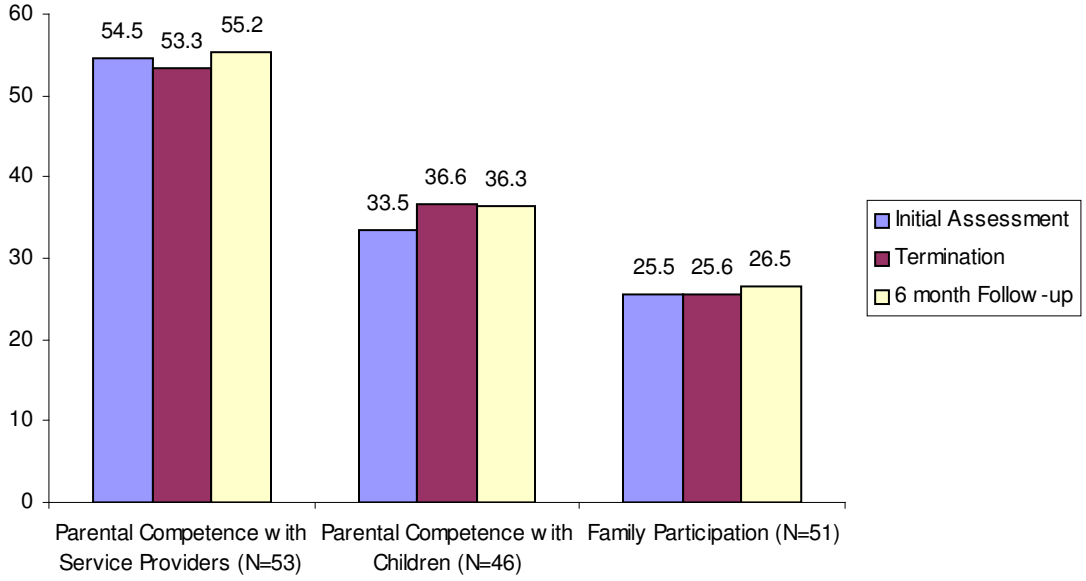


Table 18: Pairwise Comparisons for Parental Competence with Service Providers on Initial Assessment, Termination, and 6-month Follow-up (N=53).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		1.3	1.2	.278	-1.0	3.6
Initial Assessment		6-month Follow-up	-0.7	0.8	.363	-2.2	0.8
	Termination	6-month Follow-up	-2.0	11	.086	-4.2	0.3

Parental Competence with Children

Fifty-nine families provided data for Parental Competence with Children (Figure 24). The mean score of 36.1 (S.D.=5.7) at termination compared favorably with the mean score of 33.7 (S.D.=6.6) at initial assessment. Based on findings from the paired-sample t-test of the parents' evaluations, there was a significant improvement in parental competence with children from initial assessment to termination [t=-2.8, df=58, p <.01) (Table 17).

Out of these 59 families, 46 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 25 showed the mean scores of Parental Competence with Children at initial assessment, termination, and 6-month follow-up. There was a slight decrease of mean score from termination to 6-month follow-up (36.6 Vs 36.3), although the mean score at 6-month follow-up still compared favorably to the mean score at initial assessment (36.3 Vs 33.5). Findings based on pairwise comparisons indicated there were significant changes from initial assessment to termination, as well as from initial assessment to 6-month follow-up, with non-significant changes from termination to six-month follow-up in Parental Competence with Children (Table 19). In sum, parents became significantly more competent in addressing problems with their children with treatment and they were able to maintain these positive changes at 6-month follow-up.

Table 19: Pairwise Comparisons for Parental Competence with Children on Initial Assessment, Termination, and 6-month Follow-up (N=46).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-3.1	0.8	.001	-4.8	-1.4
Initial Assessment		6-month Follow-up	-2.8	1.0	.007	-4.8	-0.8
	Termination	6-month Follow-up	0.3	0.9	.767	-1.5	2.0

Family Participation

Sixty-seven families provided data for Family Participation at initial assessment and termination (Figure 24). Participating families reported very high family participation in the treatment process at initial assessment (25.9, S.D.=3.0). Parents continuously reported high family participation at termination (25.4, S.D.=3.7), despite a slight decrease of the mean scores from initial assessment to termination (25.9 Vs 25.4). Findings from the paired-sample t-test of the parents' evaluations did not indicate significant differences in parental competence with service providers from initial assessment to termination [t=0.9, df=66, p=.396) (Table 17).

Among these 67 families, 51 families provided complete data at initial assessment, termination, and 6-month follow-up. Figure 25 showed the mean scores of Family Participation at initial assessment, termination, and 6-month follow-up. There was a continuous increase in mean scores from initial assessment to termination to 6-month follow-up (25.5 Vs 25.6 Vs 26.5) indicating families' increasingly higher level of participation in the treatment process. Findings based on pairwise comparisons indicated there were significant changes from initial assessment to 6-month follow-up in Family Participation, with non-significant changes from initial assessment to termination and from termination to 6-month follow-up in (Table 20). In sum, families reported a significantly higher level of participation in the treatment process from initial assessment to 6-month follow-up.

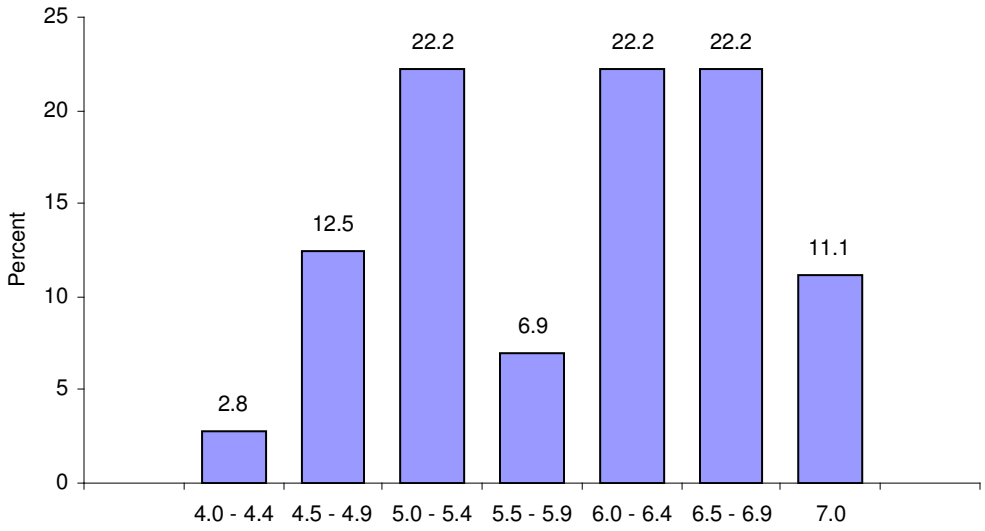
Table 20: Pairwise Comparisons for Family Participation on Initial Assessment, Termination, and 6-month Follow-up (N=51).

			Mean Difference	Std. Error	Sig.	95% Confidence Interval for Difference	
Initial Assessment	Termination		-0.1	0.6	.928	-1.4	1.2
Initial Assessment		6-month Follow-up	-0.9	0.5	.047	-1.9	-.01
	Termination	6-month Follow-up	-0.9	0.	.073	-1.8	.08

Family Therapy Alliance

Seventy-one parents completed the Family Therapy Alliance Scale at termination. Findings indicated an average score of 5.9 on a scale from 1 to 7 (S.D. .8; range: 4.1-7). Specifically, over 50% of families rated their therapeutic alliance with their case managers at 6 or above (55.5%) while 11.1% families rated their alliance with their case managers at a 7 (Figure 26). Only 2.8% families provided a rating below 4.5. Overall, families reported a positive therapeutic alliance with their intensive community-based program case managers.

Figure 26. Family Therapy Alliance (N=71).

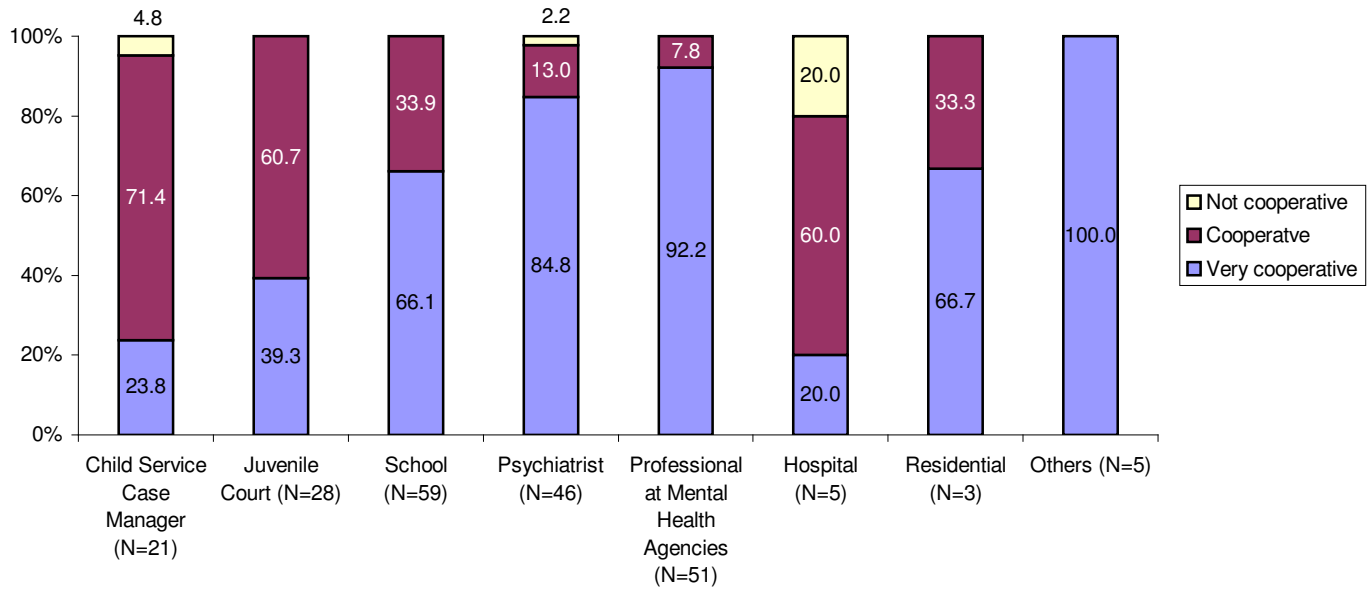


Systems collaboration

Case managers completed the System Collaboration Scale at termination. There were variations in terms of how frequent the case managers collaborated with professionals from diverse institutions as well as how they evaluated the level of cooperation, helpfulness, and goal attainment of the collaborative process. Overall, case managers most often collaborated with other mental health professionals, psychiatrists, school teachers and personnel, court personnel, and Children Services case managers. They had less collaborative activities with professionals at the hospitals and residential treatment facilities (Figure 27-29). They also collaborated with staff at domestic violence shelters and parent visitation centers.

In terms of the level of cooperation, case managers perceived mental health professionals (92.2%), psychiatrists (84.8%), staff at residential treatment facilities (66.7%) and school teachers and personnel (66.1%) as the four most cooperative collaborators. They only reported professionals from three institutions as non-cooperative: 20% hospital personnel, 4.8% Children Services case managers, and 2.2% psychiatrists (Figure 25).

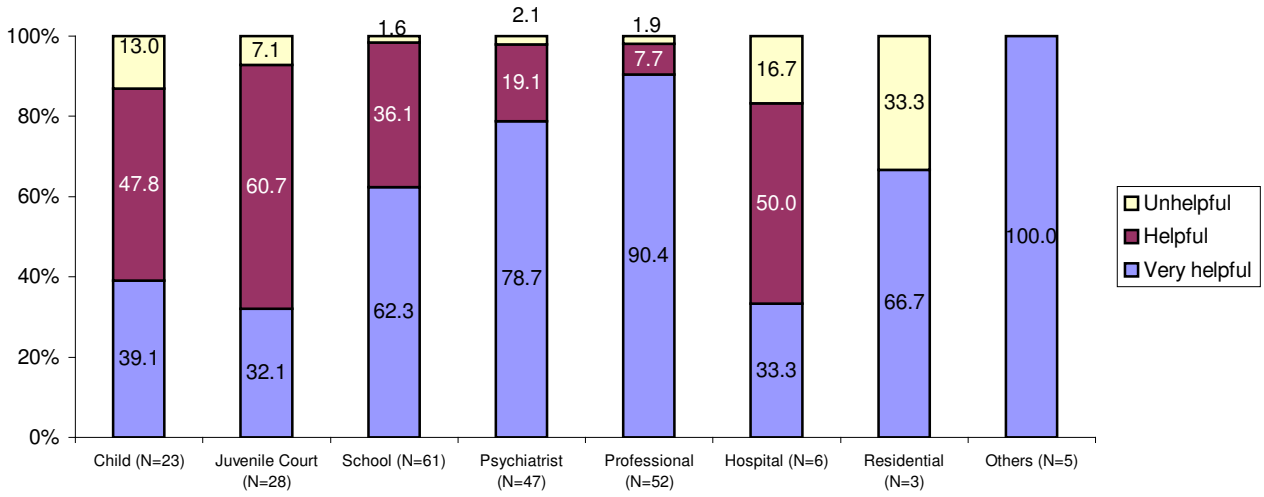
Figure 27. Systems Collaboration: Cooperation



In terms of the level of helpfulness, case managers perceived mental health professionals (90.4%), psychiatrists (78.7%), school teachers and personnel (62.3%) as the three most helpful collaborators. Case managers also perceived approximately one-third of collaborators from Children services, Court, and Hospitals as very helpful.

In addition, case managers reported varying numbers of professionals from all collaborating institutions as unhelpful, with professionals from Residential treatment facilities (33.3%), Hospitals (16.7%), Children Services (13%), and Court (7.1%) as more unhelpful than others.

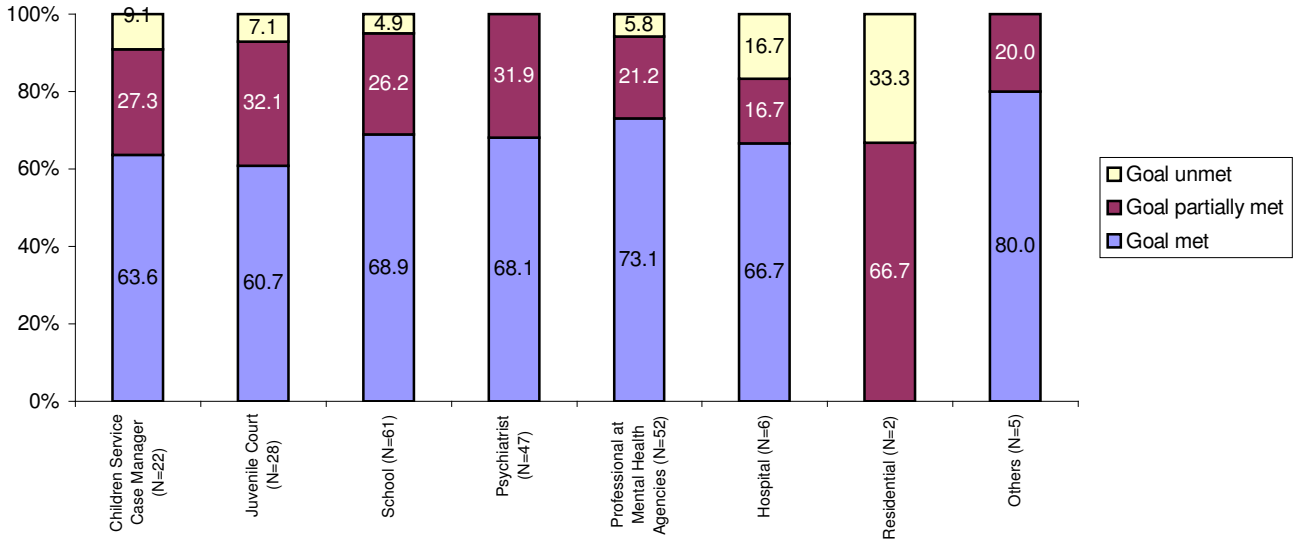
Figure 28. Systems Collaboration: Level of Helpfulness



Goal Attainment

In terms of goal attainment, case managers perceived approximately two-thirds of collaboration with all institutions, with the exception of residential treatment facilities, as successful in accomplishing the goal of collaboration. On the other hand, there were also situations where the goal of collaboration was unmet: 33.3% of goals were unmet with residential treatment facilities, 16.7% with hospitals, 9.1% with Children Services, 7.1% with the court, 5.8% with other mental health professionals, and 4.9% with the schools.

Figure 29. Systems Collaboration: Goal Attainment



Overall, case managers collaborated most often with other mental health professionals, psychiatrists, schools, Children Services, and the Court. Based on case managers' reports, they found other mental health professionals, psychiatrists, and schools especially cooperative and helpful in the collaborative process. Regardless of different perceptions of the degree of cooperation and helpfulness of professionals from diverse institutions and disciplines, approximately two-thirds of all collaborative activities attained or partly met the goal of the collaboration.

The Model

Structural Equation Modeling was used to examine the extent to which the implementation of I-FAST influenced child and family's outcomes as depicted in Figure 2. We used child and family outcome data obtained at termination to test the model. We did not include Second-order change strategies in the model because of a lack of a standardized measurement of this variable in the study. Although the study developed the I-FAST Checklist to examine fidelity and second-order change strategies constituted one of the rated treatment components, we did not have sufficient numbers of tapes on family treatment sessions that would allow us to include the data in the analyses. In addition, we used data on Systems Collaboration with Schools in testing the model because school professionals constituted the largest group of collaborators in our home-based programs.

The study used AMOS 4 to test the hypothetical model. We used multiple criteria to compare the models: The χ^2 Goodness-of-fit Index (GFI), Adjusted Goodness-of-fit Index (AGFI), and Root Mean Square Error of Approximation (RMSEA). The mean-adjusted χ^2 is a robust measure of differences in fit between models. A value of 1.0 for

the Goodness-of-Fit Index (GFI) indicates perfect fit. Values of less than.05 for the Root Mean Square Error of Approximation (RMSEA) also indicate good fit between the model and the data.

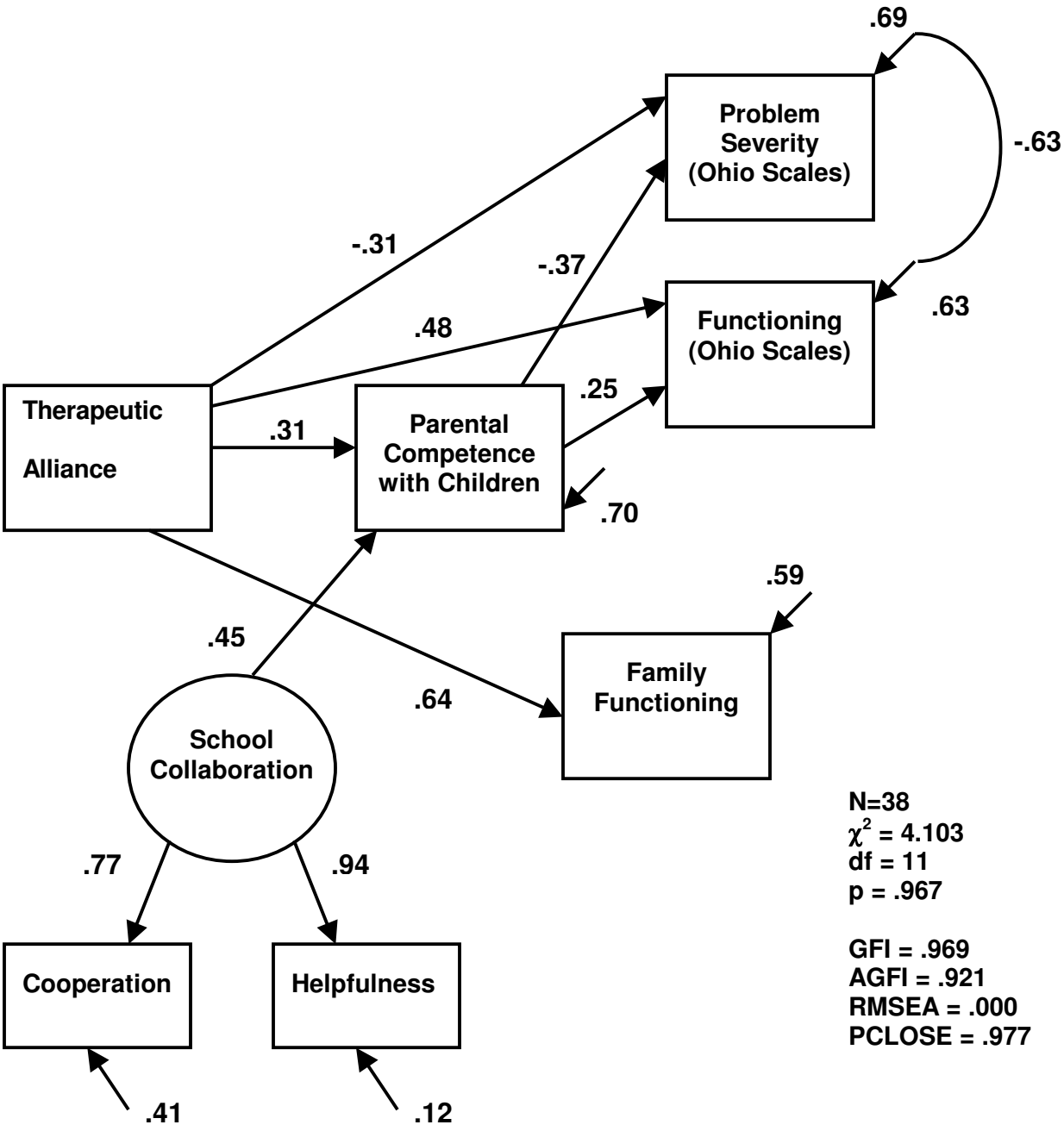
The initial result of the hypothetical model lacked a good fit to the data. Parameters in the hypothetical model were non-significant for the paths between Therapeutic Alliance and Systems Collaboration to Parental Competence with Service Providers, Family Participation, and Placement status. One plausible reason was the lack of variations in these three outcome variables at termination. Parents consistently provided high ratings on Parental Competence with Service Providers (53.0, S.D. 7.7) and Family Participation (25.4, S.D. 3.7). In addition, only 4 children were in out-of-home placement at termination.

We adjusted our model parameters accordingly and arrived at a final model that showed a good fit to the data [(χ^2 =4.103, *df*=11, *p*=.967, *n*=38); GFI=.969, AGFI=.921, RMSEA=.000, PCLOSE=.977]. Figure 30 showed findings of the final model in which we modified the parameters and excluded Parental Competence with Service Providers, Family Participation, and Placement status in the model. Data on 38 children were included in the final model. Among the 38 children, 71.1% were males (27) and 28.9% females (11). Majority of child participants were students at middle school (36.8%) and elementary schools (34.2%). 5.3% were high school students and 5.3% were in kindergarten or preschool. Child participants were predominantly Caucasian (92.1%), with 2.6% African Americans, and 5.2% biracial. The age of the children ranged from 4.7 to 16.6 (mean: 11.9, S.D. 3.0). Demographics of children included in the model were consistent with the demographics of the total sample (p. 21)

The final model accounted for 31% of the variance in Problem Severity in Children, 37% of the variance in Level of Functioning in Children, 30% of the variance in Parental Competence with Children, and 41% of the variance in Family Functioning as indicated by Family Type. Consistent with the hypothetical model (see Figure 2), the final model indicated that Therapeutic Alliance positively predicted Parental Competence with Children, Family Functioning, Level of Functioning in Children, and negatively predicted Problem Severity in Children. Therapeutic Alliance also positively predicted Level of Functioning in Children and negatively predicted Problem Severity in Children as mediated by Parental Competence with Children. Systems Collaboration with School positively predicted Parental Competence with Children, which positively predicted Level of Functioning in Children and negatively predicted Problem Severity in Children. In sum, Therapeutic Alliance had both direct effects and indirect effects on child's outcome while Systems Collaboration primarily predicted child's outcomes through its impact on Parental Competence with Children.

Several relationships that had been hypothesized in the hypothetical model did not find support in the final (1) Family functioning did not mediate relationships between I-FAST treatment components and child's outcomes, (2) Family functioning did not predict child's outcomes.

Figure 30. Final Model of I-FAST and Outcomes (N=38).



Fidelity

The I-FAST Checklist was used to assess the presence of the identified core treatment components of I-FAST. In addition, a I-FAST Interview Schedule that consisted of 13 questions was used to conduct a follow-up phone interview with case managers and therapists to examine their conceptualization of treatment interventions if information from the I-FAST Checklist was incomplete.

We had tapes on 35 initial family sessions and 17 6-week family sessions. The study used intraclass correlation to assess inter-rater reliability of I-FAST. Findings of ICC showed a satisfactory level of inter-rater reliability. The intraclass coefficient for therapeutic alliance was .84, for second-order change was .86, and for systems collaboration was .88 (Table 21).

Table 21. Inter-rater Reliability of I-FAST Checklist: Treatment Sessions

I-FAST Checklist	ICC	Confidence Interval	F-value	*df*	*sig*
Therapeutic Alliance (n=35)	.84.	.68-.92	6.25	34	.000
Second-order change (n=17)	.86	.61-.95	7.11	16	.000
Systems Collaboration (n=17)	.88	.66-.96	8.15	16	.000

We had tapes on 9 consultation sessions. Findings of ICC showed a satisfactory level of inter-rater reliability. The intraclass coefficient for therapeutic alliance was .82, for second-order change was .88, and for systems collaboration was .80. The intraclass coefficient for the overall I-FAST was .88 (Table 22).

Table 22. Inter-rater Reliability of I-FAST Checklist: Consultation Sessions (N=9).

I-FAST Checklist	ICC	Confidence Interval	F-value	*df*	*sig*
Therapeutic Alliance	.82.	.19-.96	5.48	8	.013
Second-order change	.88	.47-.97	8.42	8	.003
Systems Collaboration	.80	.10-.95	4.92	8	.018
Overall I-FAST	.88	.47-.97	8.31	8	.004

Cost of the Program

The study also assessed the program cost of using I-FAST in providing intensive community-based treatment. Table 23 showed the cost analysis of the home-based program by fiscal year of the two participating agencies. SPVMHC and TCAS showed differential patterns of program cost for their intensive community-based services. The program cost for ICBP at SPVMHC in the past three years showed a stable trend with the average cost per family around 1100.00 to 1200.00. The program cost for the home-based program at TCAS was in generally higher with the average cost per family decreasing each year from approximately 7000.00 in FY 2003-04 to 3000.00 in FY2005-06.

In addition to different administrative structure and the size of the home-based programs at these two agencies, one plausible reason for differential program cost was the qualification and salary of the case managers at each agency. While no ICBP case manager at SPVMHC had a master degree, some case managers or professionals at TCAS providing home-based treatment for families attained education at a master level.

Among the 77 families included in the outcome study, 70 were families were served by SPVMHC. As such, the program costs of ICBP at SPVMHC should be more reflective of the program cost of I-FAST in the present study.

Table 23. Program Costs of I-FAST from FY2003-FY2005

Agency	Fiscal year	Number of case managers	Number of families served	Total cost	Average cost per family
SPVMHC	FY2003-04	13	317	366,002	1155
	FY2004-05	12	293	343,762	1173
	FY2005-06	14.5	354	397,114	1122
TCAS	FY2003-04	4	22	161,037	7320
	FY2004-05	4	27	121,637	4505
	FY2005-06	4	45	136,915	3042

Findings of Qualitative Inquiry
Interagency Collaboration

The study conducted a total of 8 focus groups with 26 agency collaborators whom were nominated by ICBP case managers. Letters of invitation were sent to these nominees and formal consent was obtained prior to each focus group discussion. Informants consisted of 14 personnel from schools, including 3 school principals, 1 special education director, 5 teachers, 2 school counselors, 2 attendance officers, and 1 parent mentor; 6 from the court, including 1 judge, 2 probation officers, 3 diversion officers, and 1 diversion coordinator; 4 from child welfare agencies, including 1 director and 3 case managers; and 3 informants from other collaborating agencies, including 1 director of domestic violence shelter; 1 director of parent visitation center and 1 MRDD staff (Table 24).

Table 24. Informants of Inter-Agency Collaboration Focus Groups (N=26).

Location of Focus Groups	Total Number of Participants	Collaborating agencies
Washington Court House, SPVMHC	8	1 Middle School Assistant Principal 3 Elementary School Teachers 1 Alternative School Teacher 1 Special Education Teacher 1 Fayette County MRDD 1 School Counselor
Washington Court House, SPVMHC	3	1 Chief Probation Officer 1 Diversion Coordinator 1 Diversion Officer
Waverly, SPVMHC	3	2 School Attendance Officers 1 Probation Officer
Chillicothe, SPVMHC	4	1 Guidance Counselor 1 Special Education Teacher 1 Elementary School Principal 1 School Parent Mentor
Circleville, SPVMHC	3	1 Children Services Worker 1 Director of Domestic Violence Shelter 1 Director of Parent Visitation Center
Hillsboro, SPVMHC	1	1 Alternative School Principal
Thompkins Child & Adolescent Services	2	1 Judge 1 Director of Children's Services
Thompkins Child & Adolescent Services	2	2 Diversion Officers

Process of developing collaboration

Informants described the development of collaboration between ICBP and their institution as a process. Informants unanimously shared the change in the quality of inter-agency collaboration since the instigation of the Intensive Community-Based Program. Prior to ICBP, the collaboration between agencies was more of an administrative collaboration in which agencies knew the existence of each other but collaborated in a superficial and distant manner in the absence of ongoing contact.

- Prior to that, I didn't have the ongoing contact. Occasionally, they would request information from me regarding grades and disciplinary notices, but, um, I didn't feel that there was a return collaboration, it was, "okay, here's the information." (School)

- You get a check list to fill out and you send it back, um, we didn't really talk to counselors like we do, we didn't see mental health personnel on our grounds (School).

- So, uh, this is my third year doing it…the first year I was introduced to somewhere here and then I never saw them again, uh, made a couple phone calls and that was it....(Court)

<u>Making initial contact</u>

The process of developing beneficial collaboration usually started with ICBP case managers actively contacting the collaborating agencies and introducing themselves.

- They first came here, they introduced themselves and told us what they would be doing, and then, then we talked about the child they were going to be working with, and so forth. So, I would say they came to us. (Court)

- I only one addition to what [ICBP case manager] was saying as far as the introduction and that was [ICBP case manager] coming in really coming across as an advocate, "hey, I'm here for this student. This is what I do, um, do you mind if I come into your classroom." And, basically just asking for an invitation to come into the classroom, "we just want to help you make him successful in the classroom." Well, then it wasn't just about it, it was like, "well, what can I do to help you. I want to help you too, obviously if you're dealing with this, you're frustrated, what can I do to help you. Can I sit in your classroom?" (School)

However, other professionals or the court could also introduce ICBP to the collaborating agencies.

- Imagine my surprise when my cell phone rang in about two minutes, it was [name of psychiatrist], and she said, "what's going on?" She said, "well, we can't have this,

tell me what you need." And then I said, "well, what we need is somebody that can help us walk through what we need to do with him," and she said, "well, I have this intensive case manager," and that was [ICBP case manager] (School)
- It was…yeah…court referrals (School)

The trial period

The introduction constituted a necessary but insufficient condition to develop trust and collaboration. Interestingly, informants described a trial period in which collaborators carried an attitude of mistrust toward the collaboration and the ICBP case managers had yet to proved themselves.

- When [ICBP case manager] came and introduced her program, I thought, "yeah, this is a fly by night too, I'm sure." I shouldn't, but it sounded too good to be true. Yeah, it did. And, and, like he said, there she was the next day, and then the next day, and then the next day." (school)

Developing trust

The process of developing trust is best elucidated by the following narration:

- "They do that process where they come in, they introduce themselves, they sell you on believing them, and you do that, and then you're like, "okay, we'll see." And then a day or two later there they are, and then you're thinking, "huh…maybe?" And then a day or two later here they come again, and they also, they're seeing the kids or they're stopping in to see you, and now you're really starting to really buy into it, and believe it, and then that first time you've got to make that phone call, "hey, we need to, when can we schedule an appointment?" (acting as case manager) "I'm in the parking lot." "Great…come on in." So, now you start to trust that they're gonna be there, and they're dependable, and now you've bought into completely what they said at the beginning, which is "I'm here to help out any way that I can." (school)

Besides being visible, available, accessible, and responsive, informants mentioned a number of qualities and characteristics that were related to a successful process of developing trust. Some of these qualities were relational or communication skills while others pertained to effective treatment with clients.

Relational and/or communication aspects
Follow through:
- "And, um, that was the initial, that's what I remember about the initial introduction, but what really sold us was what [ICBP case manager] said, being there every day or every two days, that's, I mean, the follow through." (School)
- "But, I knew from having worked with [ICBP case manager] for several months, what [another ICBP case manager] was promising was real, but it's the follow through that

really sold us. That's exactly what it was, we had to be, they had to show us." (School)

Responsive:

- "We had a situation with a young man who was having problems and the first thing, you know, we'd done everything we can, we're to the point to where it's almost to the courts. "Wait, before we do that, let me give [ICBP case manager] a call." And next thing you know, [ICBP case manager] [ICBP case manager] is talking to the mom, they're down here, they're getting [name of client] on their case load and next thing you know, things are going well again, and, um, you just need that piece every once in a while to put it together. It's the involvement and the follow through. (Alternative school)

Professional:

- "And, then I remember just being so impressed that this brand new counselor or case manager was able to talk so professionally and comforting, uh, you know, giving this family, um, and I knew by that time, that what she was saying was real.." (School)

Explicit about role and expectation

- "And, I think that's it, you know, you go in clear at the beginning, and I think that works out much better, if you can each state what you, you know, what you expect to do and what you want to do, and, you know, I've never been afraid to call [center director] if there's a problem, and consequently I don't think [center director] is ever afraid to call the Judge if he feels there's a problem there. So, you know, there is that communication. (Chief probation officer)
- "Explained what her role was, and she was really good about if you referred a client to intense case management, she was really good about getting right on it, and, and letting them know what her role was." (Diversion officer)

Treatment-related

Effective:

- "and I think that was real important that she [ICBP case manager] developed a real bond with, um, with the people that she worked with. And she was one that would include you in a lot of things, um, I know that, you know, when she'd take a client to lunch or something she'd call and say, "we're going to so-and-so, do you want to come out and meet us?" So, that worked out pretty well." (Probation officer)
- "A significant change in services came with the intensive case management, probably the most positive thing that I've seen because they work with us and they work across areas…home, school, and this office, um, I was a principal in this district for 16 years prior to being in this position and never have had anything as productive as intensive case managers as far as problem solving with me, as liaison between home and school. Um, supporting teachers and parents, as well as working with kids." (School principal)

Involved and knowledgeable

- They start having some court referrals, kids that end up in Juvenile Court. And, by the time, my initial meeting with them is they know everything I know, as far as the family history, where they've been, what they're doing, and now they want to know what I can give them to put those pieces of the puzzle together, and that's what makes me a believer is you're already involved to the point that you know out there what I know in here, let's put it together. (Diversion officer)

Being advocate for kids

- "Advocate for kids. I mean they do that in a balanced way…I mean they don't always, they see the child doing something, I mean they don't, it's not like they don't believe that child can do wrong, but they always find positive ways to work with it. So, they are really strong advocates for the kids they work with." (School principle)

Realistic treatment recommendations

- And they're realistic about what they expect us to do. You know, sometimes you get recommendations from somebody, or whatever and you just literally laugh and say, "yeah, right. You think that, you come do it." (School)
- It's a let's bring it to a realistic perspective for everyone, let's see if we can't come to a commonality to help everyone achieve what they need to, so, they are definitely the advocates for the kids first and foremost, but they don't neglect the other pieces of the puzzle. (School)

Focus on real and not superficial change

- "Not a band-aide. It's a real too for real change. Maybe that's something that hasn't been said. It's not a band-aide. It's not just get you through this everything's gonna be okay, but it really, they provide us tools for change with that child." (School)
- And, it seems real. It's not a, cause I've seen them both in action with the parents, and it's not a, you know, "we need to sit down and kumbyah this." "Listen, you need to get your act together and get this done, and you're not following through with what they're asking." And, I've seen them both in action do that. And, as soon as they kind of get on them about that it kind of, it's a wake up call for the parents, I mean parents need parenting skills also, and they need somebody on them once and a while, the schools are sometimes the enemy, not the ally, and I think they kind turn that into, "we're gonna get on your case because we care," and they make the parents believe that. Um, so, it's not a soft, you know, approach, it's in your face, let's get it done, and, uh, I like that. I like the way they handle that. (School)

Performance exceeds expectation

- Um, they even, I have, um, for our state grants we have to go to alternative education summit in February, um, [supervisors of ICBP]were both there, it's like, it's just support, they don't even have to be there, and they're sitting right there with me and my staff, so, there are very supportive so. (Alternate school)

The process of developing inter-agency collaboration resulted in professionals at other institutions willing to make referral to ICBP.

- So, all it took was wanting to refer other people. And, at first I'd make it real formal, after that I'd just fax them and say, "help! This parent agreed that if intensive case manager contacted them, you know, or they agreed to come in for an intake, please consider intensive case management." I've never had one kid I've asked to be considered for intensive case management ever turned down, 100%, if we ask, they must figure we know what they're asking for. (Principal)

ICBP case managers and professionals from different agencies also developed relationship that enabled them to work together. The following description is a vivid illustration of such a collaborative relationship.

- I'll call home and have the mom or the dad in certain situations talk to the kid about a problem, they'll actually call [ICBP case manager] and then [ICBP case manager] will call my room, or call on the cell phone and say, "well, let me have so and so," and I'll just hand them the phone. And, he talks to him and sometimes it works and sometimes he takes them home or takes them wherever. I'm like, "are you in town?" That's my first question, "are you in town, are you close?" (School)
- With this little boy that I had, they had an issue early on in the school year with the medication issues, and I called our Special Ed. office, and then I called our case worker, she was talking to somebody else from the court, they were talking to Dr. X (psychiatrist), we ended up talking to the drug store, [ICBP case manager] ended up talking in there, and we had like, I think we were on the phone till 5:30 that to help this parent get through this medicine crisis, and it was like everybody, and it wasn't just, I mean, like we're in Highland County, but then because they live in Fayette, we were dealing with the Fayette people, and it was just like there wasn't anything we couldn't do that like, it was gold. It was really good. And the mother got what she needed and then the kid, it trickled down, the kid got what he needed and everything was okay. (School)

Key ingredients of inter-agency collaboration

Informants perceived key ingredients of inter-agency collaboration as consisting of diverse skills, behaviors, attitudes, and factors that could be categorized into three major domains: (1) interpersonal skills, (2) attitudes, (3) professional qualities, and (3) contextual factors.

Interpersonal skills

Informants described a range of interpersonal skills that constitute key ingredients of inter-agency collaboration

Being visible

- The omnipresence of the, of the caseworkers, they just there all the time (Court)
- I see them on almost a daily basis. (School)

Being available and accessible

- We get the case manager in here understanding the intensity of the situation and when I would call, they would come. (School)
- The availability is, you know, we got good people, available people, and once they get in the door, I mean, I have no problem. (School)

Being responsive

- Sometimes calling and getting a kid added very quickly because of a crisis…very fast response (School)

Ability to communicate

- Open communication (court)

Ability to work together

- I'll call home and have the mom or the dad in certain situations talk to the kid about a problem, they'll actually call [ICBP case manager] and then [ICBP case manager] will call my room, or call on the cell phone and say, "well, let me have so and so," and I'll just hand them the phone. And, he talks to him and sometimes it works and sometimes he takes them home or takes them wherever. I'm like, "are you in town?" That's my first question, "are you in town, are you close?" (School)

Ability to share

- Sharing feelings: (Sharing) our feelings when we're frustrated (School)
- Sharing information: "but I know that I'm, I probably give them more information than I have in the past, because I know they're gonna give me the information too, and they will us that information only in a positive way." (School)

Compliment

- Caseworkers from Scioto Paint have said wonderful things about our, um, probation and diversion staff at our Juvenile Court. (Court)

Rapport

- And, I mean, and that doesn't go there, but part of that is, I can think of one time when [ICBP case manager] and I and the kindergarten principal laughed until we almost cried after we'd been through a two hour crisis together trying to write down everything a kid did and said, and we were all using language that was part of our vocabulary. (Laughter) And, so, I mean, just, and so, I think, that's rapport. (School)

Patience

- Patience (DV)

Sense of humor

- I don't mean this to come off wrong, but to be able to laugh too. (School)

Support each other

- "I mean sometimes there's families that, you know, I'll call [ICBP case managers] and say, "I'm gonna frickin' kill them," you know, but we know that I just got to vent and then I'll be okay." (Child welfare)
- They [ICBP case manager] listen to you express your frustrations a lot, but there are times you reciprocate that as well. (Court)

Being understanding

- Understanding that she's limited as well. Her hands are tied to certain aspects as well. Um, calling in the right parties. (Parent Visitation Center)

Positive relationship

- "And it helps to like each other. I mean you really have to be a likeable group to make it work." (Child Welfare)

One informant from the court succinctly summarized her perception about key ingredients of inter-agency collaboration that pertains to the relational domain:

- "that's rapport, but the sense of humor that just, a positive relationship among the collaborators, you know, and in everyway that you can say all those things…respect, rapport, trust, honesty, communication, I mean, pretty much all of that. And, the follow through just cannot be, it just doesn't do any good to collaborate if no body does what they say." (Court)

<u>Attitudes</u>

The other set of descriptions pertained more to attitudes that facilitated positive inter-agency collaboration in the context of ICBP.

Trust

- "I think the other thing is that really right now we have people that we really trust. And, I know you think that when you're working with professionals you always are gonna trust them, but I know that I'm, I probably give them more information than I have in the past, because I know they're gonna give me the information too, and they will us that information only in a positive way.... So trust is huge. (School)
- "Well, I think that the other thing you spoke about that I didn't put on this list specifically was the trust. That there, there's, um, as you work together there's a trust, and that's part of what I was asking when you share information or you get the information about the school from the case managers, do you trust that they're accurately reflecting what the situation is." (Diversion officer)

Working together toward common goal

- Different individuals working together to achieve a common goal (school)
- I think they've got to be, and working toward a common goal, and, again, in our situation it's working for whatever is best for the student. What we can do to help the student be successful. If everyone focuses on what you can do to help that child, it's going to work. (school)

Mutual respect

- The respect, the mutual respect. And, I think that's important because we respect them therefore we are going to share with them. And, it's because they show that they are truly interested in our input too. (Court)
- I try to respect everybody's job and know what they do and I know they come across problems, and hopefully they, you know, see my point of view, and that I can have disagreements here, but know we're all in it for the same reason. (School)

Willing to accommodate

- And, that's the other thing, we don't have a lot of flexibility sometimes, and they are more than willing to be flexible. That's an important part of the collaborative process. (Court)

Honesty

- Being honest (Court)

<u>Professional qualities</u>

Clear understanding of individual roles and responsibilities

- "...you go in clear at the beginning, and I think that works out much better, if you can each state what you, you know, what you expect to do and what you want to do." (Probation officer)
- "…what the individual responsibilities are sometimes, cause sometimes among different agencies it's assumed that's somebody else's responsibility, not ours." (School)

- I think a big role in the collaboration is knowing your role and what you can do (School)

Confidentiality
- ..and the last thing is confidentiality. And we know if there are things we tell them that we say are off the record, we know it's off the record. (Court)

Complementarity
- "..you refer them here. And, I'm not good at Social Security, so I would not be the one to get them their social security, so I would refer them to Jobs and Family Services, because they're the experts in that field, and everyone is an expert in their own field, or thinks they are, and so we all have to deal with that aspect. It's like, a butcher takes that person and cuts them up and gives the part to the person, to the agency that's gonna work the best to fix that part." (Child welfare)

Knowing who to collaborate with
- Calling in the right parties for individual treatment for the families. Finding the right resources. (Parent Visitation Center)

Involved and knowledgeable
- They [ICBP case managers] sit down, they introduce themselves, they say, "I'm here, I'm working with so and so." Okay, "I've been with so and so, let's talk about so and so." And they sit down and they start talking about, "okay, I've met with mom and I've met with boyfriend, I've met with grandpa Ed, and then we did this and we did that, and I know this is going on, and I know they've been in the rehab center in Dayton." And I'm starting, the more they tell me the more I'm thinking, "they're involved. I like this. They know where we're coming from, they know what we're dealing with." (Diversion officer)
- "They [ICBP case managers] start having some court referrals, kids that end up in Juvenile Court. And, by the time, my initial meeting with them is they know everything I know, as far as the family history, where they've been, what they're doing, and now they want to know what I can give them to put those pieces of the puzzle together, and that's what makes me a believer is you're already involved to the point that you know out there what I know in here, let's put it together. And, it sounds like we both have something that we can meet in the middle and fix something. Um, so that's what kind of hooked me. (Probation officer)

Follow-through
- The follow through on all parties involved between the caseworker and us and the parents. (Court)

Total/systemic perspective
- What parents often reported wasn't what school reported, and many time, um, we saw things differently and that was never addressed. Um, we also weren't in the

homes, so we didn't see it from the parents' perspective.... So, I think to have everybody look at it from all viewpoints, but more looking at the total kid, not looking at them coming in and doing counseling as an isolated thing, which is more of how I saw it before as to dealing with the whole kid on all grounds, understanding that they had to generalize what they learned here to somewhere else, both at home and at school (School)

- It's a let's bring it to a realistic perspective for everyone, let's see if we can't come to a commonality to help everyone achieve what they need to, so, they are definitely the advocates for the kids first and foremost, but they don't neglect the other pieces of the puzzle. (School)

Real change

- Not a band-aide. It's a real too for real change. Maybe that's something that hasn't been said. It's not a band-aide. It's not just get you through this everything's gonna be okay, but it really, they provide us tools for change with that child. (School)

Effective

- And, it seems real. It's not a, cause I've seen them both in action with the parents, and it's not a, you know, "we need to sit down and kumbyah this." "Listen, you need to get your act together and get this done, and you're not following through with what they're asking." And, I've seen them both in action do that. And, as soon as they kind of get on them about that it kind of, it's a wake up call for the parents, I mean parents need parenting skills also, and they need somebody on them once and a while, the schools are sometimes the enemy, not the ally, and I think they kind turn that into, "we're gonna get on your case because we care," and they make the parents believe that. Um, so, it's not a soft, you know, approach, it's in your face, let's get it done, and, uh, I like that. I like the way they handle that. (Probation officer)

Focusing on family strengths

- All the parties have to play a part in pulling out the strengths in families. Cause, most of the time the families don't even know that they have strengths. So, and sometime we wonder if they do have strengths (DV)

<u>Contextual factors</u>

Informants noted that being in a small community constituted a facilitative contextual factor for collaboration, partly because of the existence of the network, but also because agencies were "forced" to collaborate because of restricted choices and mutual dependence.

Existing network

- "And, I think it's a small community. And, you know, everybody, not everybody knows everybody, but, you know, a large majority of the people you know, so, it even helps the collaboration working together because you know them, you know

each other. You work with them on something else, you know, and then “oh, hey,” you know. So, I think that makes a big difference." (School)

Lack of choices

- We have such limited resources in this county because of the lack of the mental health levy. That, the work that we do with our families, and (judge) just alluded to it, our social workers do some social work counseling and do some social work, um, interventions with our families, but they’re limited on what they can do because of the time and the number of cases, so they have to, we have to depend on mental health, or our drug and alcohol or whatever, and because the services are very limited....Not because they’re our last resort, they aren’t, many times they’re our first resort, but they are the best and the most intense it will ever get, you know what I mean? (Child welfare)
- We’re a very small community here and you tend to know the people who have, share the similar values who also share the same similar work ethics and who want to be successful (Child welfare)

Mutual dependence

- And, so, um, we depend on them very much to tell us whether or not a child is safe in the home or can stay safely in that home. So, um, and they testify in court (Child welfare)

Benefits of Inter-agency collaboration

Successful inter-agency collaboration between ICBP case managers and other involved institutions brought various benefits to collaborating professionals in their work, which resulted in better abilities to serve families and successful treatment outcomes.

Benefits to the collaborating professionals

Provide useful information

- In terms of how they help us and what benefit we get from them, we depend on them because of their clinical background, because of their ability to be in the home as intensively as they are, to tell us, can this family be, can we keep this child safely in the home, or do we have to remove them. Or can these children be reunified safely, and we take to the bank what they say, very much so. (Children Services)
- There’s usually some pretty good contact involved as far as, you know, what’s going on here, you know, what have you seen, what have you heard, um, and it’s a good way to like, I guess, assess, assess maybe a situation. I guess maybe come to a conclusion on what you should do. (Court)

Serve a bridging function

- She [ICBP case manager] became involved and was kind of a go-between, between the school and the parents, and came in on a very regular basis. She's also been to the doctor's when they've met with the psychiatrist out here. (School)
- ..she's kind of the "go between" between the doctor the mom and I. (School)

Broader perspective/Total picture

- And looking at the whole child, I mean, that's a saying we used to say a lot, is looking at the whole child, not just one piece of them. I think that's something that they do that, you know, we might look at one part, and parents might look at one part, but I think they serve as somebody that looks at the big picture with every kid. (School)
- Helping you understand where they kids coming from and helping you deal with those circumstances before you, um, make it appear…more trying to help the kid in all aspects of life. (School)

Continuity of care

- It's a relief to have them involved. Because you feel like something is being done. And that they'll pick up where maybe you don't. (Court)

Complementary role: A balance between being supportive and adversarial

- I think their idea is to try to stay on, be an advocate for the family and stay on their side, and so, they kind of maybe, I don't know how to say it the right way, but they kind of water things down, or let the client think that they're supportive of something when maybe they're just trying to build a relationship with them because they don't feel like they're get anywhere if they're adversarial too. (Court)

Coordinating services

- Keeps me up-to-date about with things that she found out and talked about with different places. And, it's really nice to be able to have that input, cause like I said when she was first put on his caseload maybe a month ago, and at first it was we got one story, and then we get another story, it was kind of hard. It's nice to have that person there bringing all the pieces together. (School)

Different perspectives

- They'll give suggestions to me on how to deal with some of the emotions and behaviors and different things, and so I come at it from a different perspective. (School)
- You might handle a kid a certain way for a while, and when you see that it's not working, to be able to call and contact somebody and say, "hey, we've got this situation. I need you in here, or I would like to get some input from you before I move on this,"…they're right there. Um, helping you understand where they kids coming from and helping you deal with those circumstances before you, um, make it appear…more trying to help the kid in all aspects of life. (School)

- Well, just looking at something different. You know, we always, sometimes we just go with what we know, it's nice to have a fresh look sometimes. (School)

Engage all involved systems
- She [ICBP case manager] added, the extra piece that made the connection, which [ICBP case manager] was there between the parent and the school, but now we have the home, and so, she kind of tied it all together.

Additional resources
- I know I've got a resource that I can work with, an extra person (School)

Problem solving
- I was a principal in this district for 16 years prior to being in this position and never have had anything as productive as intensive case managers as far as problem solving with me. (School)
- Well, I think if we think we hit the wall, then somebody else, collaborator comes up with the idea. (School)
- And whether it was a five or ten minute conversation, they would get what they needed to, calm her down, and then work with me, "okay, these are things maybe we could try, we could do throughout the day," (School)

Provide useful modeling
- I mean, they're modeling no matter, you know, I've been doing it in education for 33 years or something like that now, and it's still nice to have somebody come in and model something for me, and for me to say, "gosh, isn't that great, I'm gonna try that." (School)
- And, in fact, there's been several times where I as a court employee, you know, um, because they do such a great job modeling, we've come to them and say, "hey, you know, you do such a great job with kids, what can we do?" And, they've invited me to several collaborations that they've had in the past. So, they're great. (Court)

<u>Benefits to families and children</u>

Coordinate needed services
- He [ICBP case manager] works with him and the family real, uh, intensively, and also has gotten through Dr. X (psychiatrist), his medication and things so that he had those ticks all the time…(Court)

Supporting families
- I think, um, with the families, one of the things that the home-based program has been able to do very, very well is to kind of join with the family, and become, they definitely start with where they are, you know, the old social work value "begin where they are," and they definitely do that and they begin to build a relationship and they

begin to build a sense or trust at the same time being confronted when they need to, that things need to change, and this dynamic needs to be worked on and that sort of stuff, so, I think they're very helpful to the families. (Court)
- so I think they're very helpful because they join in with the families, and they begin to help them very gradually make the changes that needs to be made and they stay with them until those changes are made. (Child welfare)

Successful outcomes

Informants mentioned different successes as a result of collaboration with ICBP. The following is one success story:
- "Then, um, we had a kindergartner this year, that (name of the kindergartener), the day we got out for Christmas vacation, the principal, and [ICBP case manager] and I took turns containing a 5-year-old. And, we all got kicked and stomped on and a few other things along the way. His behaviors improved immensely. But, she [ICBP case manager] was on-call for us almost daily at the kindergarten, while we tried to do an expedited Multi-Factor Evaluation, but we needed medical, and psychiatric and everything done first. And, and, uh, so [ICBP case manager] done an amazing job. (School)

Improved self-esteem in children
- I can see a big difference in her self-esteem since she's been working with [ICBP case manager], and I think that's a real positive for her. (Court)
- that's helped him a lot too for his self-esteem, but there's been a big improvement, probably the biggest one I've seen out of any of the kids that I've worked with has been him. (Court)

Behavioral changes in children
- I mean, we don't have temper tantrums and outbursts, and I don't have a parent calling all the time, so, yeah, that's kind of worked out. (Court)
- he actually went six weeks without having to go to the office, you know, that was just a big, a big thing and he's actually able to do things that normal kids do in the classroom. (Court)
- I think both of their [two boys] behaviors have improved significantly as a result of the work that we've all been able to do together. (School)

Improved functioning in families
- When you see things in the family working better, you know that it's working, and you're not, and the school isn't calling every day, and the parent isn't calling everyday. (Court)

Obstacles to inter-agency collaboration

Informants were also aware of obstacles to inter-agency collaboration. Some obstacles concern resources available for collaboration. Others pertained to the inherent difficulties of inter-agency and/or inter-disciplinary collaboration that stemmed from different perspectives and professional boundary or turf issues which exist between diverse institutions. Another group of obstacles belonged to normal challenges to the collaborative process, which involved issues such as lack of communication or staff turnover.

Resources

Inadequate time

- Probably having enough time for everybody to get together on a particular problem other than, you know, the little bit of time that we spend in court together. (Court)

High caseload

- High case loads, high number of cases, um, you know, sometimes I just don't, I just go with, you know, I come to work and it's like I have to take care of this and this and that, and I get phone calls sometimes that I should address, but then I might have a problem that I may be taking care of.. (Court)

Expansion of program without adequate support

- But I worry as our caseload increases with those kinds of kids, that we're gonna hit the point where they're gonna be saturated and I think that that is one of the things that we really need to be cautious about. I think that, you know, I don't want them to say no to me, but I think that at some point somebody's gonna have to say no to adding new cases because they need to be able to do the ones that they have well. And, that is an obstacle I'm concerned about occurring down the road. (School)
- Administrators, Teachers, Counselors, um, are quick to refer, but parents are saying, "wow, I see a difference in that person's child." And that is scary unless they are, you know, limit it somehow, or unless there are some more successful closures, you know, to open up spaces, I don't know. (School)
- I worry that down the road we're not going to have the same access. (School)

Lack of financial support

- You know another obstacle, and of course here we go, is probably money. Because I would like to see [ICBP case manager] in all of our school buildings. (School)

Differences between institutions/disciplines

Different perspectives

- I think sometimes, value judgments. (School)
- I think one is the difference of opinion (Child welfare)

- I think my last one would probably…involved a girl that I worked with and what she was and wasn't allowed to do according to case management, and what she was and wasn't allowed to do according to me. So, that, that, you know, causes a little bit of a disagreement there. (Court)

Boundary/turf issues

- It's kind of a system you grow up…that you work in as you're working up and up and up, and most of the people are there for ever and ever and ever and…A lot of people are not welcome to change, you know, "this is our model…this is how we do things," and it's kind of like in some instances if you interfere, it's you're told to mind your own business. But, I think, you know, I think a lot of times it's very territorial between the agencies. It's very difficult sometimes (Court)

Problem with information sharing and communication

Problem with information sharing could have been a result of lacking follow through.

- I'll be honest, there're times when I need information from them and it's not made available. (School)
- There's been a couple incidences where we've needed psychological evaluations done on, on like a person, and it's been requested that information come from here and it was not provided. (School)

However, there are times when the communication breakdown was related to diverse expectations between different institutions, particularly, between ICBP and the court.

- They expect us to be, they expect the court to share ALL that information, simply because maybe the client has been ordered into services, so then we should give them all the information we have, yet when it's kind of like we make the call, or the contact, you know, and ask this or that, "well, you know, we just really can't give you that information." (Court)
- I too would like more information, because by the time we take these people to court, we've got so many leg hours involved in this, and it's just, um, and especially when they are court ordered to receive, um, this mental health thing, we've got an awful amount of time involved in it, and I certainly would like to be, you know, know they're getting better. (Court)

Continuity of collaborative process

Staff turnover at both ends can creates challenges for inter-agency collaboration as professionals will need to get to know each other and build the collaborative relationship.

- And, there was times when I know I wasn't cooperating very well cause I was new at the job, but, you know, finally with this one case that I've worked on, it sort of all came together. (Court)

- But, I know in this line of work, there's a lot of turnover, and maybe there is here, I don't know, so sometimes, you know, look me at I just started and they had one, so these people had to get to know me. (Court)

Personality issues

- Everybody's got their own opinion of the family, you know, personalities come into it. You know, everybody can say, "my personality doesn't become involved in it," but I don't care, everybody's does. And, so, there are some personalities I don't work well with. (School)

Observed patterns and characteristics of inter-agency collaboration as revealed by informants' narrative descriptions

Several themes consistently emerged from the narratives that were not directly in response to the semi-structured interview questions of the focus groups. These themes, however, underscore successful collaboration between ICBP case managers and their collaborator from diverse institutions and disciplines.

Collaboration as a relational or interpersonal act

Regardless of the questions that were raised by the facilitators of the focus group discussions, narratives of informants invariably framed collaboration as interpersonal or relational activities. Responses to the process of developing collaboration, key ingredients, and core skills of collaboration all revolved around relational qualities or characteristics that facilitated successful collaboration. Even when the topic of "benefits of collaboration to professionals" was discussed, the participants emphasized the interpersonal benefits for collaborating parties. The stories shared by informants reflected a frame of collaboration as a relational act.

Active outreaching efforts of ICBP case managers

One primary theme that underscored the development of trust and successful collaboration between ICBP case managers and their collaborators was the active outreaching efforts of case managers who were visible, available, responsive, professional, and able to follow-through. Instead of trusting ICBP case managers from the beginning, what agency collaborators described was in fact a skeptical attitude about the collaborative process when the case managers had yet to prove themselves to be trustworthy. Narratives of informants from diverse disciplines, in one way or another, described a process of how they had been "convinced" by the ICBP case managers, primarily through personal encounters, of their professionalism in building the collaborative relationship

The importance of treatment-related competence

Besides the relational factors, another theme related to successful collaboration pertained to the pragmatic aspect of being effective, realistic, and helpful in the treatment process. Successful collaboration depended on effective, involved, and knowledgeable ICBP case managers.

ICBP case managers as playing a central linking role in successful treatment

Narrative descriptions of inter-agency collaborators showed the central role of ICBP case managers in coordinating treatment for the families. They became the "go-between," or the "link" in service provision. One collaborator from the school poetically described the central role of case manager as a spider web:

> "I see it as kind of a spider web, you said to visualize, so I guess, and, and the case managers being the center and pulling all of it together, because we don't often sit down with Children Services and the Court and all of us in the same room. But, the case manager can be that person that pulls us together, uh, you know, into a net that, that becomes a safety net for the child." (School)

Intra-agency Collaboration

The informants

Informants of the intra-agency collaboration consisted of 6 professionals and 1 student intern from 2 county offices at Scioto Paint Valley Mental Health agency (see Table 25)

Table 24. Informants of the Intra-Agency Collaboration Focus Group Discussions

Informant	Position	Gender	Years at agency
A	ICBP case managers	F	3
B	ICBP case managers	M	2
C	ICBP case managers	F	2
D	ICBP case managers	F	1
E	Child case manager	F	2
F	Adult counselor	F	1
G	Student Intern	F	Less than 1 year

Characteristics and activities of collaboration

Within the context of agency, collaborators can be conceptualized into three levels/groups of agency personnel. The first group is composed of the ICBP case managers and the other agency staff, including the child case managers, adult counselors, substance abuse counselors, family therapists, etc. The second level of personnel consisted of the agency supervisor and the clinical consultants. The third group is composed primarily of psychiatrists and psychologists who presumably have more placement-determining power over the child client than the ICBP case managers. The differential nature of the relationship between ICBP case managers and these constituencies had pragmatic influences on the process of intra-agency collaboration.

Overall, ICBP case managers collaborated on an equal basis with the other agency professionals, and their relationships were peer-to-peer. The supervisor and the clinical consultant served primarily as a resource and support to the case managers in their work. The collaboration with psychiatrists or psychologists who had more placement-determining power was more hierarchical and professional.

ICBP case managers and collaborative agency staff professionals: Peer to peer collaboration

While ICBP received referrals from diverse sources, child case managers, substance abuse counselor, adult counselors, and therapists at the agency represented the most significant referral sources. *F*, an adult counselor, described a typical scenario as follow:

> "Well, when a case first comes, it depends on whether like they're seen in crisis or they just come in and go through intake and become a client, then when they first see their first worker, who's a case manager, then that case manager has a little bit of time to think about, "okay, is this person appropriate for the intensive?" The case manager will enroll them in the program and then set them up with (ICBP case managers) and let them kind of meet them and see if that would be appropriate."

The collaboration, as described by both ICBP case managers and other agency staff professionals, was characterized by regular contact, constant communication, and working together. " We do a lot of talking amongst each other." (A) "The counselors and everybody talks to us." (C) In response to a question that was asked about how often the ICBP case managers "sit down with the therapist or the psychiatrist and make sure that you guys are on the same page or all have the same information about a case," D responded,

> "Weekly, if not daily, I would say. There's sometimes, I mean, there's some cases that we catch up with the therapist EVERYDAY on those cases. Um, just to let them know, you know, if it's a case that, there's a lot of activity in the home, um, just to let them know what's going on in the home, or in the schools, or whatever, um, but I have a couple of cases that I would say I touch base with their therapist daily. Just because they're asking me, or something's going on in the home and I need to make them aware of that, so." (D)

The regular contact between ICBP case managers and other agency staff professionals also represented a more peer-to-peer type of relationship. The following was a vivid description of the relationship between A, who is an ICBP case manager, and E, the child case manager who had referred a client to A.

> And your talking about studying the Mormon religion together, you're talking like getting together and sharing information up to 6 or 7 o'clock in our offices. And we flock to each other. I've noticed that. Have you ever noticed that? At lunchtime and after staff meetings. We just flock to one another, and then that will be, and we'll spend an hour or 45 minutes sitting there talking about all the cases that we all need to know about. And, that's, it's not really any formal way of meeting. After every Friday, we meet as a team, that's not usually when..." (E)

> And it's weird because if we see one another too, I mean, it's just like, "how's that going, have you talked to this one yet," that's just what we do when we see each other. (A)

ICBP case managers and center director and consultant: Supportive function

The center director and consultant constituted another group of collaborators that the ICBP case managers worked with. The nature of collaboration between ICBP case managers with the center director and the consultant was distinctively different from the nature of collaboration between ICBP case managers and other agency professionals in that it consisted of primarily a supportive function from the center director and the consultant to ICBP case managers. In addition, while both the center directors and the consultant provided important support for ICBP case managers in their work, they appeared to also function in diverse ways.

The consultant primarily provided clinical training for ICBP case managers and other agency staff pertaining to their work with families in the ICBP program. The consultant met with the team for 2 hours every week, shared the model with them, and encouraged them to collaborate with other systems.

> "[Consultant] has us talk to him [psychiatrist] a lot." (A)

Agency professionals obviously appreciated the training and, more importantly, benefited from it.

> "But, without him…I think I've learned more from him than I could ever learn in college or that I could ever learn from anybody else." (E)

The positive collaboration described by ICBP case managers with their center directors, who were also their supervisors, was a relationship underscored by a caring and supportive relationship in addition to professional support and resources for working with families and clients. The clinical support provided by center directors was broader in scope. The center director could offer support with clinical skills.

- I'm not trying to talk (clinical consultant) down or nothing like that, but I really think she's (center director) just as good as (clinical consultant)." (B)
- "And (center director) knows every single thing about every single one of our cases." (E)

The center director sometimes offered a helpful "third-person perspective."

- "Just because we didn't have somebody that not's out there working with the family that's got feelings, if that makes sense." (A)

In addition to being well versed in clinical skills, however, center directors also provided practical assistances such as the following:

- Provide helpful connections: "[Center director] is just so in tune to the higher ups. Like she's got connection" (E)
- Provide a push for collaborative activities: "She knows the people at that health department and children services and all these people who, and she's really good at identifying that if we don't get along with an agency, um, then she will force us to eat lunch with them, you know what I mean, "you must do that." (A)

Another aspect of the positive collaboration between center directors and ICBP case managers or other agency professionals was a caring personal relationship that served as a buffer to burnout and stress. Such a caring relationship also fostered a collegial atmosphere at the agency.

> "And we have a lot of stress in our own lives, and I think that that's something too that she [center supervisor] helped us cause she'll say, "you got to back off, you got to take time for yourself." (A)

> "... that's what she says…this hallway, there's a black cloud above this hallway. There's like this black cloud, and if it's not work, it's our personal life, and then she'll be like, "I think that you need to take tomorrow off, go ahead and take the rest of the day off." And, I mean, where can you find somebody who's going to…and she's like…but if we didn't have that personal relationship with her, you know what I mean, we wouldn't be able to function." (E)

> Center directors also fostered intra-agency collaboration in non-clinical ways. "Um, like I said, he nurtures it (intra-agency collaboration), with, uh, we have tail-gate party, you know, wearing his OSU and all of that stuff, so I mean he does a lot of things that I think nurture the environment." (C)

The described personal caring relationship served as a buffer to burnout and stress in work. "I don't even think I'd work (laughter). Because this is a hard job, and if I didn't have that type of supervisor, I couldn't do it." (A)

Despite diverse supportive activities center directors and the consultant engaged in to foster intra-agency collaboration, narratives of informants described similarities in terms of a non-hierarchical, respectful, and affirmative relationship that characterized positive collaboration. The followings are informants' descriptions of the relational aspect of the collaboration with their consultant:

- "And [consultant] let's us feel good too, you know what I mean, like…" (E)
- " He doesn't make you feel like a little peon.... But, I can tell him I disagree with him" (A)

- "He does not make us feel like we are underneath him. And, I think that a lot of upper people have the tendency to do that without knowing they do it." (E)
- "He just blends in with the collaboration, it doesn't alienate people. " (C)
- "And that's me noticing, [clinical consultant] is easy to talk to. I mean, just seems to be, not up here, he's not way up here, he's on our level." (A)

The following described an interaction between ICBP case managers and center supervisor, which was a vivid description of a spontaneous and collegial interaction that clearly elucidated that the center director did "take time for us." (B)

E: And we gather a lot with [center director]. And it will be, especially when we get really excited about something that just happened, like when me and A went out together…we're like, "[Center director], boom, boom, boom, boom, boom!" And then other team members will walk by and see us and be like, "what're you guys doing?" then we'll all start talking about…and that happens all the time, like on a daily basis."
B: [Center director]'s only got two chairs in there, and a lot of times there's more like four people.
E: And she'll go, "guys this isn't supervision, this isn't team meeting time." You know, because we'll all gather in the same place.

ICBP case managers and professionals with more place-determining power: Formal and professional

Psychiatrists and psychologists constituted yet another group of professionals within the agency with whom the ICBP case managers collaborated. These professionals also referred clients to ICBP. The described characteristics and activities of collaboration with these professionals who have more place-determining power appeared to be more formal and professional. There were efforts to "build" the collaborative relationship by making formal contact with psychiatrists and introducing the program to them.

- "[Center director] just wanted her (psychiatrist) to see all of our faces and realize how many people we do have on our kid team and how hard we do work together. So, I think, you know…
- "We all went down there and talked to her as a team, um…just voiced our opinion about residential treatment centers, and that we were doing a home based level, and that we didn't want to have children out of their home." (E)

Process of developing collaboration

Informants described a process of building trust and the collaborative relationship. Such a process was facilitated by case managers who were consistent, able to follow-through, and were effective in treatment.

- Not “drop the ball”:

"I just think simply, you know, they would refer cases, we would get referrals, um, they were kind of slow coming in the beginning because they didn’t quite understand the program, they didn’t understand what our presence would mean in their case. Um, wasn’t sure how to use us. So, as we did get cases, they started to see the benefit and the community started to see the benefit. I think that’s when, um, and when they handed us some, we didn’t drop the ball, so, um, I think that’s when the trust began and when they saw that it was working, and, that there was good outcomes then you get more cases. And, I think that’s where the trust started, and you have to earn the trust." (C)

- Effective:

A: But I think he sees what we’re doing too. I think he sees what we’re doing where before…
B: Yeah, I think he sees a difference because I know there’s a ton of kids without medication now.
E: Yeah, a lot of our intensive people have been completely off, are completely off of all their medicine. That’s a big deal when they’re on seven different ones. A huge lithium and resperdal. I mean that’s a huge deal.

- Comprehensive knowledge about the families and the system

"I’ve actually had Dr., our child psychiatrist, pull me into one of her sessions and say, “what is your opinion?” I think they value our opinions, they respect our opinion because we’re in the home so much, and we see, we see, we’re in, we see everything that goes on in the home, in the school, everywhere with this child, and they trust that and they trust our opinion, and, um, you know, from day one when I came here, you know, I’ve been here like I said, a little over a year, it’s always been, I never, I never knew anything of them not trusting our opinions, or not wanting, or not having that collaboration. From day one I felt that way. Um…" (D)

Collaborative activities

The collaborative activities primarily focused on psychiatrists making referrals, ICBP case managers sitting in sessions with the doctors, sharing information and discussing treatment for the families.

- "The doctor, you know, we used to sit in at the doctor’s request at, um, when they come in for their evaluations or consultations, uh, that wasn’t productivity effective, so it was kind of declined, but, we still if we’re asked and it’s necessary, we will go in and sit on that. Because the doctor wants the whole picture, and she doesn’t get it simply from the parent, and she doesn’t usually collaborate with the therapist too much that I know of." (C)
- "Our families when they come in usually the doctor’s already informed of what’s going on, and the therapist is already informed of what’s going on, so they don’t spend

the first twenty minutes rehashing the past month or the past week, or whichever, we've already taken care of that portion for them." (D)

Strategies to foster collaboration with professionals who have more placement-determining power

Fostering collaboration with professionals with more power can be a challenge: "They [psychiatrists] don't have to ask us or me (for my opinion)"

The process of building trust and collaboration was, of course, a significant piece. Informants also mentioned other strategies to foster collaboration when there was an inherent power differential between professionals.

- Playing one-down position: "You've got to be able to do the whole one-down thing, you know what I mean, um, when you collaborate with authority figures like principals, schools, the judge, you have to make them be part of the improvement." (E)

- Give collaborators credit for success: "And a lot of times that's what we're really great at as far as collaboration goes, we give them all the credit and take none of it, and then they'll work hard for the improvement. And that's, I think that people in bigger clinics and people who have big degrees they, they want that achievement, they want that recognition, and you can not get that when you collaborate with someone, it can not be all you, it has to be everybody." (A)

- Compliment: "We just tell her [psychiatrist] how great she is, and she's like, 'I am, and I'll do whatever you want.'" (C)

Helpful outcomes of collaboration

Positive collaboration between ICBP case managers and other agency personnel brought beneficial outcomes for the treatment process, successes in families and clients, and personal benefits for collaborating professionals in terms of enhanced morale and positive agency culture.

Treatment-related benefits

Complementary roles and characteristics: The art of utilizing differences in treatment

Collaboration among ICBP case managers and agency professionals allowed them to join efforts in treatment in ways that they could better utilize their personal strengths in a complementary manner when assigning cases or working with outside systems.

- "I was just gonna say that my noticing is that C seems to be the calm one, D is the one in your face, but they kind of compliment each other...I've noticed there might be

one client that I don't think C would be the best, they need D, and they need visa versa, they need a C." (G)

- "I know something else, like F with schools, and you [A] are like with vocational schools, and you [E] are like with Pike county schools, I'm good with the trade schools, so now each one of us have our own group of people, okay, just like, uh, well if we are having a problem with Pike County Schools, I'm not going to talk to them, she [E] will cause she's gonna get like twenty times more stuff done with them then I could. " (B)

The utilization of complementary strengths and skills also manifested in the treatment process. B, an ICBP case manager, shared with us a session in which he worked with E, a child case manager, in addressing a very difficult case situation:

- "Even if they was against us, I mean, I don't let things bother me, but I know some things bother her where it just don't bother me, and if I see that something is bothering her, that's when I step in and take, you know. Where I don't let things bother me that much, but they should bother me, she [E] steps in." (B)

Shared understanding between professionals with diverse training and orientation

Shared understanding constituted an important part of collaboration, especially between professions with diverse treatment philosophies, for instance, a medical model held by psychiatrists and systems thinking underlying the I-FAST model. One positive outcome was the narrowing of the gap between psychiatrists and case managers in their understanding of clients and change process

B: Well, a lot of it is proving ourselves time after time.
E: …you see it once or twice…
A: He [psychiatrist] may disagree and we'll say, "no, I really think it's the environment," you know, "it's a behavioral thing," you know, and I think eventually he comes around and he starts to see it once we start
E: …and now he asks us, you know, "E, what do you think is going on?" "What do you think we should do?" "What do you think that family is doing?" Um, you know, and I think that, that's something a lot of, they don't have to ask us or me, you know what I mean, that's a big deal to me.

Shared treatment goals

Positive collaboration among professionals within the agencies led to cooperation and shared goals in treatment.

> "I think it's just, I mean, what helps is that, one, because there's so much collaboration in this clinic we know, you know, we know what everyone is doing, so no one is working against the other one, so, everyone knows what's happening, everyone's on the same page, so everyone's working towards that ultimate goal

with this client, or at least the three or four goals that we have with this client, everyone's working towards that. Someone isn't over here working on something else. So, everything that everyone does in this client, you know, we're working to the good of the client, and everyone is aware of what everyone else is doing, so there's no confusion and you're not, you know, you're not trying to take a step forward while someone's coming and knocking you six steps back, um, and I think, I think that's one of the biggest ways that the collaboration in the clinic helps." (D)

United front

Collaboration among professionals within the agency resulted in a united front both to the families as well as towards outside systems such as schools and courts.

- "You know, I think that we have such a great rapport with Dr. V that, you know, if we got a family that's talking smack about us, Dr. V would be like, "we don't talk about E that way..." (E)
- "The collaboration within the clinic is united front to the collaboration outside the client when we have to deal with multiple systems outside to, for the good of the client. So, they're not saying, "oh, well the therapist said this, so why are you saying that?" So, we're an entity and they're an entity and we're all on the same page here so when we approach them to work with them, they understand that the therapist isn't gonna come out and say something different than we do." (C)

Successes with clients and families

Clients and families benefited from a successful treatment process supported by collaborative activities. The most often mentioned successes related to children being able to stay at home and off medication.

B: Our best one, I mean, [client], I mean, Dr. M wanted a permanent institution, the courts went to the point to find an institution…
E: Now, the mom is our parent advocate, the kid is off all his medicine, he does great, he's in regular schools, I mean, it's sick our cool it is…

<u>Benefits for professionals</u>
Maintain morale

Interestingly, informants from both county offices invariantly used the metaphor of a family to describe the supportive culture at their agency:

"Here, I mean it is, you know, if you're having a bad day, they'll say anything, I mean, anything to get you to cheer up, or if they, if you've got something that's bothering you whether it's on a case, or whatever, um, you know, there's plenty of therapist here, you can go to that therapist and you can talk to them about that case, and say, you know, "what can we do, what do we need to do differently?" Whether it's on the lunch hour or ten minutes in between two appointments, or, you

know, in the hallway, or whatever, I mean, it's definitely a family, a family culture here." (D)

Positive intra-agency collaboration fostered a culture in which staff enjoyed coming to work, and felt supported.

- "And we've all been here for awhile now, and that makes me feel good, but I mean, that makes me feel like coming to work." (A)
- "We have a good time at work." (D)
- "And, I can add to that. Uh, I volunteer for the crisis center in Ross County also, and the directors down there says this [the county office] is a happy place." (G)

Prevent burnout

Positive intra-agency collaboration functioned as a buffer to burnout in ICBP case managers. Informants shared the nature of their work as "easy to burn out and high stress" because "especially with these parents, you know, I mean you see what they're doing wrong, and that they admit that they need help, but they're not willing to change. And, that happens, you know, daily." (B) The positive intra-agency collaboration among case managers, as well as between staff and the center director, served as an effective buffer to burnout

E: And especially when you get discouraged.
B: We have, I mean, we use each other to vent, and lots of times when we're venting, that's when they say, "well, we should try this, or…" you know.
E: There's been times where, I think I've told *A*, "I don't think I want to work here anymore, I don't think I can do that anymore." I think *B*'s said that to me, like, "I'm just getting' burnt out on it," and if you don't have somebody to talk to, you just will end up quitting. And, typically, people don't go to their boss and say, "hey, I'm thinking of quitting now," you know what I mean, they just end up doing it. But, I think she's probably talked everyone out of it at one time or another. I think she's talked me out of it before, so I'm sure she has everyone else.
B: "Oh, you couldn't do this job if you didn't have collaboration. You couldn't come to work everyday."

The power of positive intra-agency collaboration is expressed through the discussion that B and F chose to stay with the agency despite the possibility of getting a higher pay or status job because they liked the team. F could have sought a job with higher status monetary compensation.

A: I mean…you (F) becoming a psychologist, right? You're working on your masters?
E: She (F) already has her masters.
B: I think you would be the one to live for a higher paying job.
F: I like this team a lot.

B could have also tripled his salary:

B: Because I could triple my money without a doubt.
I: And so they're [A and E] worth that?
M: Yeah, and the kids. I mean, it's the whole package.

Agency professionals just felt proud of themselves as a team.
E: Don't even get us started. We're just good! (lots of laughter)
A: They tooted our horn too much.
B: I mean we've got brains, we've got looks…

Definitions and key ingredients of collaboration

We asked informants how they would define collaboration and its key ingredients. E provided a succinct definition of collaboration:

> "Like to define it…what collaboration means? To communicate, to work together, and not to be too shy about your own opinions and what you feel is really going on in the case and listen, and being able to listen to the other person, and just because it's not what you think, still doing that and still trying to collaborate and listen to what they have to say about it, because 9 times our of 10 we are both wrong, and when we talk, we usually can figure it out. And, that to me is true collaboration because not one person has it, but when you go to talk light bulbs go off and it's a big, you know." (E)

Informants defined intra-agency collaboration primarily as an interpersonal and relational activity. Suggested key ingredients of a successful collaboration process within the agency focused on communication skills as well as attitudes toward collaboration. Communication skills involved not only being able communicate and assert opinions, but also to listen and, more importantly, listen despite differences, and "agree to disagree."

- Communicate: To communicate (B)
- Listen: To listen (A)
- Listen despite differences: "Being able to listen to the other person, and just because it's not what you think, still doing that and still trying to collaborate and listen to what they have to say about it." (E)
- Agree to disagree: And there's been a lot of times when we really could potentially really got pissed off at one another, um, but you can't, you know what I mean, you can't, you can't be that way, you can not, ["B, you are a goof."], you can't disregard, or try to sabotage something because you don't believe that's the way it should be, you know what I mean? (E)
- Assertive: Not to be too shy about your own opinions and what you feel is really going on in the case. (E)
- Work together: To work together (C)

Other key ingredients emphasized attitudes and perceptions toward collaboration and interpersonal relations.

Appreciation of collaboration

- Team wisdom: “And, that to me is true collaboration because not one person has it, but when you go to talk light bulbs go off and it’s a big, you know." (E)
- Complementary roles: “And so we all know what role we play and what we are extremely good at, and that you know, and that’s amazing, you know what I mean, to know what each person does and as long as you can get those people to keep working and keep staying at the same job.” (A)

Interpersonal-related attitudes

- Willingness to cooperate: “Cooperate” (A)
- Respect differences: “And, I see it as just giving in to that other person, especially if it’s someone new coming on, and they, and you’re getting used to the way they do things and the way they work, you have to give in to some of their quirks… There’re things about everybody, about me, that we don’t like about each other, and there’s quirks there, but you have to say, ‘well, that’s the person that they are, that’s how they do their job.’” (A)
- Willingness to trust: "I mean we trust each other." (A); “’No, I’ve actually had Dr. A, our child psychiatrist, pull me into one of her sessions and say, “what is your opinion?’ I think they value our opinions, they respect our opinion because we’re in the home so much, and we see, we see, we’re in, we see everything that goes on in the home, in the school, everywhere with this child, and they trust that and they trust our opinion, and, um, you know, from day one when I came here, you know, I’ve been here like I said, a little over a year, it’s always been, I never, I never knew anything of them not trusting our opinions, or not wanting, or not having that collaboration.”
- Mutual respect (C)
- Nonjudgmental (A)

Other suggested key ingredients were contextual and idiosyncratic, and they revolved around personal relationships and shared faith.

- Personal relationship: “I mean it is relationships, because there ain’t no one in here, well, I know F personal background, I know some of A personal background…”(B)

- Shared faith:

A: I hate to say this too, but I think a lot of us has got a lot of faith in God.
E: Well, you’ve gotta have some faith to get some of these people turned around, you know what I’m saying, you gotta believe in something.

B: This goes back to God, but each and every one of use care, I mean, when we see a kid

Obstacles to intra-agency collaboration

The primary obstacles mentioned by informants revolved around caseload, productivity, and time. Because of high caseloads for non-ICBP case managers, therapists just did not have enough time to do their job. While ICBP case managers carried a caseload of no more than 10-12, E, a child case manager, had a caseload of 100 and F carried a caseload of 120. A negative consequence was that ICBP case managers and other professionals were not be able to find time to meet each other for collaborative activities.

- High caseload: “Having a caseload that’s too big. Cause you don’t have enough time.” (F)
- Lacking time to get together: “It used to be, um, time because of, the therapist are usually booked solid all day long. But, we’ve been able to, um, handle that problem with the hall and the staff lounge. We do a lot of consultations during lunch, sometimes when we need to. We also can check the uh, the appointment book and say, “oh, did their appointment show up?” And, usually right on the hour I’ll go out to the appointment book, if I’m waiting for somebody, and I’ll look at my watch and I’ll say, “okay,” and I’ll go out and look at the book, “did their 10:00 show up?” “Well, no they didn’t.” “Good.” And into the office you go. So, it’s not, uh, that they don’t want to talk to us, cause they do, but, it’s just, you know, it’s just a time constraint and a productivity thing. So, but we’ve found ways to get by, pretty fast.” (C)

Another obstacle primary existed between ICBP case managers and the psychiatrists. While most psychiatrists were partners in the collaboration, there was a minority with whom the case managers found it hard to communicate and cooperate. The barrier appeared to be more idiosyncratic rather than systemic.

"Dr. X is here three days a week and she’s an adult doctor…but none of us, has that kind of relationship with her, see, when she comes to our Christmas parties, she comes to our luncheons a lot and stuff, but it ain’t even close to a connection there." (B)

Observed patterns as revealed by narrative descriptions

Three other themes consistently emerged from the narratives but were not directly in response to the semi-structured interview questions of the focus groups. These themes, however, underscored the practice of collaboration among diverse professionals within the agency.

Intensive Community Based Program as an integral part of services

Informants described, in various ways, the intensive community-based program as an integral part of services offered by the agency in which everyone was involved. The following was a description provided by E, who is a child case manager,

> "And usually, it's always, I think that me, and B [adult counselor], and [name of a substance abuse counselor], which would be the ones who referred them to these two [ICBP case managers], we probably, I'm almost positive, we sit there and struggle, struggle, struggle with the case, and the whole time we're probably talking to [ICBP case managers] about it, it's just not in the program yet, and then we'll sit there and talk to [center director] about it during our supervision and our meeting with her, and then we'll discuss that this needs the intensive program, and then we get it these two [ICBP case managers] involved in it, and then we talk about it with [clinical consultant], and then it becomes this legendary case that we talk about all the time. It's like that all the time with every case." (E)

ICBP case managers also expressed their feelings about being at the "center" of the treatment process because of their close contact with and knowledge of the families. C, an ICBP case manager, described how she felt like being at the center of the treatment process:

> " They figure we know everything from all angles, cause we're involved in the schools and in the community as well, so pretty much anything that's around these kids we know about, so we do sit in on doctor's appointments if we need to, and they do request that we do so. Um, therapists as well, you know, they'll say, "well the kids coming in, can you sit in." Um, of course we get stopped in the hall, you know." (C)

The extent of collaboration between ICBP case managers and other team members can be elucidated by the following quote,

> "As far as, I mean, we do communicate well, but just like if *A* comes, got a kid I haven't even seen before, and *A* comes in here in crisis [client's crisis], and about anyone on the kid team can meet with them and could understand what's going on." (B)

ICBP was perceived as neither an isolated aspect of services nor a "stepchild" of the agency. Everybody was involved to the extent of perceiving themselves as playing a central role in providing direct services, as well as coordinating needed services, for the families.

A parallel process of non-hierarchal collaboration: Agency culture

While recognizing differences in position and power among different professionals in the agency, one theme that was been consistently underscored in the narratives of ICBP case managers was the aspiration for a non-hierarchical collaboration relationship.

With Supervisor

The following scenario describes a situation where ICBP case managers and other staff involved their supervisor in figuring out treatment orientation with families. The description was clearly more collegial than hierarchal or formal.

E: And we gather a lot with (center director). And it will be, especially when we get really excited about something that just happened, like when me and Julie went out together…we're like, "(Supervisor), boom, boom, boom, boom, boom!" And then other team members will walk by and see us and be like, "what're you guys doing?" then we'll all start talking about…and that happens all the time, like on a daily basis. We can't get any work done.

With clinical consultant

A: He doesn't make you feel like a little peon.
E: Yeah, that's it, he does not make us feel like we are underneath him
G: [Consultant] is easy to talk to. I mean, just seems to be, not up here, he's not way up here, he's on our level.

With psychiatrist

A: But the counselors and everybody talks to us, I mean the doctors, they'll even ask us, you know, "what do you think is going on with this family?" and you know…
A: That's a butt hole that never, you know, I mean he (the psychiatrist) treats us just like (clinical consultant) does or (center director), you know, he doesn't put himself up on a pedestal either.

The trickling down effect is a parallel process in treatment where the ICBP case managers were able to take a non-expert position in collaborating with their families. The following is a vivid description of the how the case managers perceived their interaction with clients and families.

E: ..in order to teach people how to do this, you have to take, you have to be able to, to first join with the family, and sometimes that means taking a step down, and using their language, and dressing like they do, or sitting like they do, and getting to know them on a personal level, and maybe not so much jumping into all the mental health diagnosis, and not getting so preoccupied with things that are not that important that you want them to change... You have to give into, "we're not gonna have all the answers, and we have to join with these people in order to get them to do it."
B: Lots of time, when I go to home visits, I will not take my notebook with me.
E: No, you just sit there…and, you know, there's plenty of times you go out to eat with them, and you have to be willing to be seen in public with these people, and you have to be willing to sit in a stink-ass house, you know what I mean, and not want to touch anything, you have to be willing to be like, "this is okay with me," and relax, and you have to be willing to let them vent. And, I think all those things comes from people who, um, aren't snotty, you know what I mean, and who aren't saying, "we have all the answers here, here," you know what I mean, and to not have them coming into the clinic and to come to their homes and see what they're family's like, and go out places with them, and helping them, and building that relationship, and things that aren't important, you know, treatment wise are extremely important to them, you know what I mean.

<u>The role of policy or procedures in intra-agency collaboration: Collaboration as relational</u>

Intra-agency collaboration as portrayed by informants appeared to be a relational phenomenon rather than being a result of a policy or procedure. Narratives regarding the characteristics, patterns, key ingredients, and process of intra-agency collaboration focused on the relational aspect of interaction. When asked about the role of policy and procedures in intra-agency collaboration, C responded,

> "Well, yeah, of course if you meet with somebody because of regulations, that's not collaboration. That meeting the regulation. So, no, I don't think policies or procedures have anything to do with it." (C)

It appears that collaboration, as a relational activity, cannot be prescribed by policy or regulation. On the other hand, the characteristics of obstacles to intra-agency collaboration were all related to policy and procedures, i.e., caseload, productivity demands, and time. Apparently, policy and procedures facilitate or hinder intra-agency collaboration, not in a prescriptive manner, but indirectly, through providing a "space" for professionals to engage in positive collaboration activities.

Summary and Discussion of Findings

Quantitative Inquiry

The study examined the effectiveness of I-FAST for treating families with children who were at risk of out-of-home placement. The study measured fidelity by using the I-FAST Checklist to rate videotaped or audiotaped sessions of family sessions and consultation sessions. We used intraclass correlation to assess inter-rater reliability of I-FAST. The findings of ICC showed a satisfactory level of inter-rater reliability. The intraclass coefficient based on family treatment sessions for therapeutic alliance was .84, for second-order change was .86, and for systems collaboration was .88. The intraclass coefficient based on consultation sessions for therapeutic alliance was .82, for second-order change was .88, and for systems collaboration was .80, with ICC for the overall I-FAST as .88.

Findings of the project provided initial empirical evidence that supported the effectiveness of I-FAST for improving a child's functioning, reducing out-of-home placements, improving family functioning, and parental competence with their children. In terms of child's behavioral outcomes, findings indicated that there was a significant improvement in the child's behavior in terms of a significant decrease in problem severity and a significant increase in the level of functioning from initial assessment to termination as reported by parents, case managers, and the youth. Children were able to maintain their positive changes at 6-month follow-up. There was also a significant increase in parental hopefulness regarding their parenting role from initial assessment to termination. Youth also reported significant increases in their hopefulness about their future as well as satisfaction with the treatment from initial assessment to termination. Youth participants were able to maintain the reported positive changes at 6-month follow-up.

In addition, there was a significant decrease in the number of children in out-of-home placement at termination than before treatment. Despite significantly more children were placed in out-of-home placement at 6-month follow-up than at termination, the number was still significantly less than the number of children in out-of-home placement before they participated in the program.

In terms of family functioning, findings from FACESII showed significant increases in the level of cohesion and adaptability in these families. Specifically, there was a trend of families becoming more connected and less separated and/or disengaged, more flexible and less rigid, more balanced and less extreme with treatment. All observed changes were significant from initial assessment to termination and/or from initial assessment to six-month follow-up. In addition, families were able to maintain these positive changes at six-month follow-up.

Regarding parental competence with children, parents became significantly more competent in addressing problems with their children from initial assessment to

termination, and they were able to maintain these positive changes at 6-month follow-up.

Findings regarding parenting competence with service providers and family participation in the treatment process indicated a high level of satisfaction and participation throughout the evaluation period. In addition, there was significantly greater family participation in treatment from initial assessment to 6-month follow-up.

Therapeutic alliance is one of the three core treatment components of I-FAST. Findings based on the Family Alliance Scale indicated that participating parents perceived a high quality therapeutic alliance with case managers throughout treatment.

Systems collaboration constitutes another of the core treatment components of I-FAST. Overall, case managers collaborated most often with mental health professionals, psychiatrists, schools, Children Services, and the Court. Case managers in general found mental health professionals, psychiatrists, and schools as more cooperative and helpful in the collaborative process. Despite differential perceptions of the degree of cooperation and helpfulness of diverse institutions, approximately two-thirds of all collaborative activities attained or partly met the goal of the collaboration.

The study used SEM to develop a model that accounted for outcomes in children. Findings based on AMOS indicated that Therapeutic alliance and Systems Collaboration with School were predictive of positive outcomes in terms of reduced level of problem severity and improved level of functioning in children as well as increased parental competence with children and improved family functioning. Parental Competence with Children also mediated the positive impact of Therapeutic alliance and systems collaboration with school on child outcomes.

The study provided preliminary cost analyses of using I-FAST in providing intensive community-based services. The program cost of ICBP at Scioto Paint Valley Mental Health Center was approximately 1100.00-1200.00 for each family. This amount was reflective of the cost of the evaluated I-FAST as most participating families in the present study received services from SPVMHC.

Qualitative Inquiry

Findings based on qualitative inquiry of systems collaboration provided useful descriptions regarding the process of developing beneficial collaboration between intensive community-based programs and other involved professionals from diverse disciplines or institutions at the inter-agency level. Collaboration was perceived as a relational and/or interpersonal activity. The narratives of informants who were collaborators from diverse institutions and disciplines described a developmental process of building the collaborative relationships that was preceded by a testing period where there was only superficial or administrative contact. The successful collaborative relationships were initiated by a process of developing trust, which led to relationship building and collaboration in providing services to families. The process of developing

trust was facilitated by effective treatment outcomes in addition to particular relational and communication skills of case managers. Key ingredients and/or core skills of collaboration included different aspects of interpersonal skills (e.g., available, responsive, being visible, sharing, mutual support, honesty, ability to work together, listening skills, etc), attitudes (e.g., trust, mutual respect, willing to accommodate, working together, etc), professional qualities (e.g., confidentiality, follow-through, competence, advocate for community, dependable, work hard, etc), and contextual factors (community characteristics, inter-agency dynamics, etc).

Successful inter-agency collaboration not only benefited the families that led to positive outcomes and effective treatment, it also benefited the collaborating professionals both professionally and personally. Perceived obstacles of collaboration mostly related to concerns about resources, inherent differences in the mandates, philosophies, and practices among institutions and/or disciplines, and problems in communication.

Collaboration between ICBP case managers and other professionals within the agency shared similarities and differences with collaboration at the inter-agency level. Informants, who were mostly ICBP case managers, described a similar process of developing trust that was facilitated by a similar set of skills and attitudes as narrated by inter-agency collaborators. In addition, informants described similar benefits of successful collaboration that positively affected the families as well as the collaborating professionals. In particular, the mutual sharing and support among professionals within the agency, as well as positive outcomes for families, served as an effective buffer to burnout for collaborating professionals, particularly the case managers. Collaboration was clearly described as a relational activity that did not easily lend itself to be prescribed or regulated by policies.

Narratives of informants pertaining to intra-agency collaboration, however, emphasized the value of and aspiration for non-hierarchal collaboration. Such a narration was largely absent in the narratives about systems collaboration at the inter-agency level. It is plausible that such a difference is related to the different players of collaboration at the inter-agency and intra-agency levels. While the major players of collaboration at the inter-agency level included professionals from schools, the court, and Children Services; the primary players of collaboration at the intra-agency level consisted of the center director, clinical consultants, other mental health professionals, psychologists, and psychiatrists. Different players of collaboration naturally resulted in differences in the characteristics and patterns of collaboration at the inter-agency and intra-agency levels.

Informants described both inter-agency and intra-agency collaboration as interpersonal or relational acts. ICBP case managers initiated the collaborative process by actively engaging collaborators on personal levels. Such a collaborative process also was anchored in effective and realistic treatment. In addition, case managers played a central linking role in the collaborating process that positively affected treatment outcomes for families.

Conclusion

Integrative Family and Systems Treatment (I-FAST) is a home-based model that was developed and implemented from within the community mental health system. I-FAST was developed from evidence-based common factors to intervene with at-risk families and their children and adolescents. By focusing on interventions that were developed based on evidence-based effective treatment components, treatment can be made as simple as possible, allowing case managers to utilize their own expertise in the treatment process and bring beneficial changes to families. This focused, evidenced-based, integrative home-based model also facilitates the process of training and allows agencies to develop and consolidate their expertise in home-based treatment. The focus on providing ongoing clinical support and consultation to case managers is in line with the spirit of allowing agencies to develop expertise and organizational experts who can pass the treatment culture to other staff, thereby facilitating the continuation of expertise in home-based treatment at the agency level. Such an integrative approach can readily mesh with the realities of everyday practice demands of local mental health agencies and frontline service providers to provide effective home-based services for families.

Findings of the outcome study provided initial evidence that I-FAST was effective in improving children's outcomes, reducing out-of-home placement, improving family functioning, enhancing parental competence in addressing problems in children, and facilitating family participation in treatment. The treatment components of I-FAST, including therapeutic alliance and systems collaboration, were predictive of the child's outcomes.

Findings based on qualitative inquiry of systems collaboration provided useful and detailed descriptions about the process of developing beneficial collaboration between home-based programs and other involved institutions as well as within the agency level. Systems collaboration was clearly described as a relational activity. Recognizing the inherent difficulties of collaboration among different disciplines and institutions, informants described a particular set of skills and attitudes that were facilitative of successful collaboration in providing home-based treatment. The development of trust is essential in the collaborative process; it leads to successful collaboration between diverse institutions and disciplines and brings diverse benefits to both the collaborating professionals and the families.

Limitations of this study must be acknowledged. Firstly, the sample size was limited and it was a purposeful sample. In addition, there was no control or comparison group with randomized assignment procedures to compare the effectiveness of this approach with other established models of treatment. Another limitation of the present study was the use of self-reports to measure most studied variables. Hence, findings could be affected by the problem of reporting bias. On the other hand, self-report is a valid and commonly used method to examine respondents' self-assessment of their experience.

In addition, the study used multiple reporting sources for child's outcomes so that findings from diverse reporting sources, including the parents, case managers, and youth clients, could be cross-validated. Third, the study only included 77 families out of 125 families who consented to participate in the study at pre-treatment because of attrition or incomplete data for 48 families. Although there were no significant differences between the two groups in demographic variables, level of problem severity, and level of functioning of children at pre-treatment, findings could still be influenced by the problem of measurement attrition (Fraser, 2004). Fourth, there was a lack of standardized instrument to measure Second-order Change Strategies, which constituted one of the three core treatment components of I-FAST. Fifth, participating agencies primarily served rural areas of Ohio. While many families were Appalachian populations, other ethnic groups, including African, Asian, and Hispanic American populations, were largely underrepresented. Specific recommendations for future investigations include: (1) use a larger sample size; (2) include control or comparison groups using randomized assignment procedures; (3) carefully monitor the data collection process to reduce problems in measurement attrition; (4) include standardized measurements for each treatment component of I-FAST for refined testing of I-FAST as a home-based treatment model, and (5) include research sites that serve urban and more ethnically/racially diverse populations.

Potential contributions of the study should be understood in the context of advancement and challenges of intervention research (Fraser 2004). The present study can be considered as an efficacy trial of I-FAST as a home-based treatment model in which we maximized treatment efforts and examined fidelity and treatment outcomes. The effectiveness of I-FAST will still need to be tested further in a large-scale study with an experimental design that will provide more conclusive evidence of I-FAST as an alternative, feasible, and effective home-based treatment model; a model that is developed within the local mental health systems and can successfully address the challenge of cost containment, facilitate continuity of expertise in home-based treatment at the agency level, and meet realities of practice demands to serve families with children at risk of out-of-home placement.

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Appendix 1: The I-FAST Checklist

I-FAST Treatment Checklist

Code: _____

	No	Some	Excellent
Therapeutic Alliance	0	1	2
Development of Bonds			
1. Empathic responding.	0	1	2
2. Maintenance (initially accepting and maintaining the family's way of interacting).	0	1	2
3. Mimesis (adapting to the family's or individual's style, more on non-verbal behaviors).	0	1	2
4. Tracking the family's content and process.	0	1	2
5. Using the family's language (figures of speech, metaphors, theory of problem formation and change, frames of reference, beliefs).	0	1	2
6. Identifying and amplifying the family's strengths, competencies, and resources.	0	1	2
7. Joins with involved individuals who have different perspectives (positions) on the presenting situation.	0	1	2
Assessment and Defining Goals			
<u>Problem Definition</u>			
8. The problem is specifically and behaviorally defined	0	1	2
9. The list of identified problems is clearly prioritized.	0	1	2
10. The therapist/case manager and the family/child mutually agree upon the defined problems.	0	1	2
<u>Interactional Assessment</u>			
11. The attempts to solve the problem that are maintaining the problem (attempted solutions) are specifically and behaviorally described and identified.	0	1	2
12. Problem is understood as part of the context of family patterns.	0	1	2
<u>Goal Setting</u>			
13. The goals are defined in specific, observable and behavioral terms.	0	1	2

14. Goals are defined as desired future outcomes (are future-oriented and outcome-oriented).	0	1	2
15. Goals are defined in the positive (the presence of the desired outcome) rather than in the negative (the absence of the problem).	0	1	2
16. The therapist/case manager and the family/child mutually agree to the described goals.	0	1	2
17. Goals are agreed upon that satisfy different constituencies.	0	1	2

Assignment of Tasks

18. The therapist/case manager and the family/child mutually agree upon tasks to be accomplished.	0	1	2
19. The therapist/case manager demonstrates competence in task assignment.	0	1	2
20. The assigned task matches the family's/child's stage of change (customer, complainant, or visitor).	0	1	2

Second Order Change Strategies	No 0	Some 1	Excellent 2
21. Therapists/case managers align with a family and suggest actions (tasks) that are inconsistent with the premises of the system of interaction around a problem, e.g., prescribe the symptom, exaggerate the symptoms, pretend having a symptom.	0	1	2
22. Positioning: Therapist/case managers take a position that is unexpected or inconsistent with expectations for how people are supposed to behave in a system of interaction, e.g., taking a one-down position, being pessimistic rather than optimistic.	0	1	2
23. Therapist/case managers offer different or alternative meanings to problem situations, e.g., reframing.	0	1	2

24. Families/children reframe problematic situations through the interaction that they have with the therapist/case manager.	0	1	2
25. The therapist/case manager observes and tracks the family system's response to the intervention and change.	0	1	2

Systems Collaboration	No 0	Some 1	Excellent 2
26. Therapists/case managers include professionals from other agencies who are involved with the family in a collaborative effort.	0	1	2
27. Therapists/case managers include informal support systems who are involved with the family in the collaborative effort.	0	1	2
28. Therapists/case managers negotiate and strive for mutually agreed upon goals of treatment with other involved systems.	0	1	2
29. Therapists/case managers demonstrate open and ongoing communication with other involved systems.	0	1	2
30. Therapists/case managers coordinate their treatment efforts with other involved systems.	0	1	2
31. Therapists/case managers focus and utilize the strengths of partner systems and positive aspects of collaboration.	0	1	2

Appendix 2: Family Alliance Scale

Date: _____

Code: _____

Please rate the following statements about your relationship with your therapist

1 Completely agree
2 Strongly agree
3 Agree
4 Neutral
5 Disagree
6 Strongly disagree
7 Completely disagree

____ The therapist cares about me as a person.
____ The therapist and I are not in agreement about the goals for this treatment.
____ The other members of my family and I help each other in this treatment.
____ Some of the other members of my family and I do not feel the same way about what we want to get out of this treatment.
____ I trust the therapist.
____ The therapist lacks the skills and ability to help my family.
____ All the other members of my family feel accepted by the therapist.
____ The therapist does not understand my family.
____ The therapist understands the goals in therapy.
____ Some of the other members of my family are not in agreement with the therapist about the goals for this treatment.
____ All the other members of my family care about the therapist as a person.
____ Some of the other members of my family and I do not feel safe with each other in this treatment.
____ The other members of my family and I understand each other's goals in this treatment.
____ The therapist does not understand my family's goals for this treatment.
____ All the other members of my family are in agreement with the therapist about the way the therapy is being conducted.
____ The therapist does not understand me.
____ The therapist is helping my family.
____ I me not satisfied with the treatment.
____ The other members of my family and I understand what each of us is doing in this treatment.
____ Some of the other members of my family and I do no accept each other in this treatment.
____ The therapist understands the goals that all the other members of my family have for this treatment.
____ I do not feel accepted by the therapist.
____ The therapist and I are in agreement about the way that therapy is being conducted.

_____ The therapist is not helping me.
_____ The therapist is in agreement with my family's goals for this treatment.
_____ The therapist does not care personally about some of the other members of my family.
_____ The other members of my family and I are in agreement with each other about the goals of this treatment.
_____ Some of the other members of my family and I are not in agreement about what each of us needs to do in this therapy.
_____ The therapist has the skills and ability to help me.
_____ The therapist is not helping some of the other members of my family.
_____ All the other members of my family are satisfied with the treatment.
_____ I do not care about the therapist as a person.
_____ The therapist has the skills and ability to help all the other members of my family.
_____ Some of the other members of my family and I are not pleased with the things that each of us are doing in this treatment.
_____ The other members of my family and I trust each other in this treatment.
_____ Some of the other members of my family distrust the therapist.
_____ The therapist cares about my family.
_____ The therapist does not understand some of the other members of my family
_____ The other members of my family and I care about each other in this treatment.
_____ The therapist does not appreciate how important my relationships with some of the members of my family are to me.

Family Therapy Alliance Scale. Permission of use from William M. Pinsof, Ph.D.

Appendix 3: Systems Collaboration Scale

Systems Collaboration Scale

Code : _____

Position :_____

Agency: _____ **Date:** _____

Systems contacted	**Purpose** (e.g., referral, case consultation, case conference, information sharing, etc.)	Degree of cooperation 1. Very cooperative 2. Cooperative 3. Not cooperative	Goal accomplishment 1. Goal met 2. Goal partially met 3. Goal unmet	Degree of Helpfulness 1. Very helpful 2. Helpful 3. Unhelpful
Children services: Case manager				
Juvenile court: Probation officer				
Schools				
Psychiatrist				
Professional at mental health agencies				
Hospital/medical personnel				
Residential facilities				
Drug and alcohol treatment facilities				
MRDD facilities				
Others				

* Developed and complied by Professor Mo Yee Lee and Professor Gilbert J. Greene, 2002

Appendix 4: Parental competence Scale

Parents' Competence Questionnaire complied by Dr. Mo Yee Lee, 2002. Items partly adapted and modified from Parental Locus of Control (PLOC) and Family Empowerment Scale (FES) with permission of use from the authors.

Indicate your agreement or disagreement with each statement by circling the appropriate number.

	1 Strongly Disagree	2 Somewhat Disagree	3 Neither Agree nor Disagree	4 Somewhat Agree	5 Strongly Agree
1. I have a good understanding of the service system that I and my child(ren) are involved in.	1	2	3	4	5
2. I know the steps to take when I am concerned about the services I and my child(ren) receives.	1	2	3	4	5
3. I am able to make good decisions about what services my child needs.	1	2	3	4	5
4. I am able to work with agencies and professionals that I and my child(ren) are involved in.	1	2	3	4	5
5. I make sure I stay in regular contact with professionals who are providing services to me and my child(ren).	1	2	3	4	5
6. My opinion is just as important as professional's opinions in deciding what services my child needs.	1	2	3	4	5
7. I am able to calmly discuss with social service professionals even if I do not agree with their opinion.	1	2	3	4	5
8. I make sure that professionals understand my opinions about what services my child(ren) needs.	1	2	3	4	5
9. I share with professionals what I think about services being provided to my child(ren).	1	2	3	4	5
10. I know what services my child(ren) needs.	1	2	3	4	5
11. When necessary, I take the initiative in looking for services for me and my child(ren).	1	2	3	4	5
12. When I ask my child to do something, I am almost certain that I can help him/her to do it.	1	2	3	4	5
13 I am often able to guess what my child will do in a certain situation.	1	2	3	4	5
14. When my child gets angry I can usually deal with him/her if I stay calm.	1	2	3	4	5
15. What I do has little effect on my child's behavior.	1	2	3	4	5
16. No matter how hard a parent tries, some children will never learn to mind.	1	2	3	4	5
17. My child usually ends up getting his/her way, so why try.	1	2	3	4	5
18. When something goes wrong between me and my child, there is little I can do to fix it.	1	2	3	4	5
19. Parents should take care of problems with their children because ignoring them won't make them go away.	1	2	3	4	5
20. I shouldn't expect too much from my child because many things turns out to be a matter of good or bad luck anyway.	1	2	3	4	5
21. If your child throws tantrums no matter what you try, you might as well give up.	1	2	3	4	5

Appendix 5: Family Participation Scale

To What Extent…

	4 A Lot	3 Some	2 A Little	1 Not at All
1. Were your ideas valued in planning services for your child?				
2. Were your family's values and culture taken into account when planning for your child?				
3. Did you agree with the service planning for your child?				
4. Were the needs/circumstances of your family considered in this planning?				
5. Were you able to influence planning for your child's treatment or services?				
6. How much did staff listen to your ideas about ways to change or improve treatment or service planning?				
7. How much did staff make changes in the service plan for your child as a results of your suggestions?				

Family Participation Measure: Service/Treatment Planning Version

Appendix 6: FACESII

Please use the following scale to answer the questions

	1 Almost never	2 Once in a while	3 Sometimes	4 Frequently	5 Almost always
1. Family members are supportive of each other during difficult times.	1	2	3	4	5
2. In our family, it is easy for everyone to express his/her opinion.	1	2	3	4	5
3. It is easier to discuss problems with people outside the family than with other family members.	1	2	3	4	5
4. Each family member has input regarding major family decisions.	1	2	3	4	5
5. Our family gathers together in the same room.	1	2	3	4	5
6. Children have a say in their discipline.	1	2	3	4	5
7. Our family does things together.	1	2	3	4	5
8. Family members discuss problems and feel good about the solutions.	1	2	3	4	5
9. In our family, everyone goes his/her own way.	1	2	3	4	5
10. We shift household responsibilities from person to person.	1	2	3	4	5
11. Family members know each other's close friends.	1	2	3	4	5
12. It is hard to know what the rules are in our family.	1	2	3	4	5
13. Family members consult other family members on personal decisions.	1	2	3	4	5
14. Family members say what they want.	1	2	3	4	5
15. We have difficulty thinking of things to do as family.	1	2	3	4	5
16. In solving problems, the children's suggestions are followed.	1	2	3	4	5
17. Family members feel very close to each other.	1	2	3	4	5
18. Discipline is fair in our family.	1	2	3	4	5
19. Family members feel closer to people outside the family than to other family members.	1	2	3	4	5
20. Our family tries new ways of dealing with problems.	1	2	3	4	5
21. Family members go along with what the family decides to do.	1	2	3	4	5
22. In our family, everyone shares responsibilities.	1	2	3	4	5
23. Family members like to spend their free time with each other.	1	2	3	4	5
24. It is difficult to get a rule changed in our family.	1	2	3	4	5
25. Family members avoid each other at home.	1	2	3	4	5
26. When problems arise, we compromise.	1	2	3	4	5
	1	2	3	4	5
28. Family members are afraid to say what is on their minds.	1	2	3	4	5
29. Family members pair up rather than do things as a total family.	1	2	3	4	5
30. Family members share interests and hobbies with each other.	1	2	3	4	5

FACES-II , permission of use from David H. Olson, Joyce Portner & Richard Bell

Appendix 7: The Ohio Scales

Please refer to the attached PDF files

Appendix 8: Child's Placement Status

Code: _____

Date: _____

1. How many children do you have?

_____

2. Do you currently have any children who are in foster care or residential placement?

How many _____

3. How many children in your family are currently receiving intensive community-based services?

_____

4 Was the child that you brought for intensive services placed in any of the following settings?
If so, for how many days?

Psychiatric _____ Number of days: _____
Residential _____ Number of days: _____
Foster care_____ Number of days: _____
Boot camp _____ Number of days: _____
JDC _____ Number of days: _____
Department of Youth Services _____ Number of days: _____
Other youth treatment facility _____ Number of days: _____
Court ordered placement with family, friends, or others _____ Number of days: _____

If you checked any of these, please answer the following questions:

3a. When did the placement happened?

Before receiving Intensive Community-Based Services _____
During receiving Intensive Community-Based Services _____
After receiving Intensive Community-Based Services _____

3b. How many times were the child being placed? _____

*** If you have more than one child in the Intensive Community-Based Program, please complete question#3 for each child. Thank you.**

Appendix 9: Inter-agency Systems Collaboration Discussion Guide

Systems Collaboration Survey
Intensive Community-Based Program

Institution: _____ Informant's Title: _____

Date: _____

1. In what context were you in touch with the case manager/therapist/personnel of Scioto Paint Valley Mental Health Center SPVMHC?

2. Please describe your current professional relationship with the case manager/ therapist at SPVMHC.

3. Please describe a scenario (or activity) that typically represents your collaboration with the case manager/ therapist at SPVMHC.

4. In your own words, how would you describe the meaning of collaboration?

5. Please describe your relationship with them prior to the current collaborative relationship.

6. Describe the actions that have taken place to create this collaborate relationship. (give specific actions or events)

7. What key persons from your institution or SPVMHC were involved in creating the collaborative relationship? What was the time frame in creating the collaborative relationship?

8. How has the collaborative relationship been helpful or unhelpful to the student/client/family?

9. How has this collaborative relationship helpful or unhelpful to your professional work?

10. What had been some obstacles that stood in the way of this collaborating process?

11. Based on your experience, what are the key ingredients in creating a beneficial collaborative relationship?

Who did you collaborate with at SPVMHC?	**Purpose of collaboration** (e.g., referral, case consultation, case conference, information sharing, etc.)	**Degree of cooperation** 1. Very cooperative 2. Cooperative 3. Not cooperative	**Goal accomplishment** 1. Goal met 2. Goal partially met 3. Goal unmet	**Degree of Helpfulness** 1. Very helpful 2. Helpful 3. Unhelpful

Please check the organizations or institutions that you represent:

_____ Court
_____ Children Services
_____ Schools
_____ Special education
_____ Job and Family Services
_____ Hospitals
_____ MRDD
_____ Other agencies or institutions. Please specify: _____

Appendix 10: Intra-agency Systems Collaboration Discussion

Intra-agency Collaboration Focus Group
Intensive Community-Based Program

Site: _____ Informant's Title: _____

Date: _____

1. Under what context you collaborate with other staff at Scioto Paint Valley Mental Health Center in providing ICBP services to families?

2. Who do you collaborate with?

3. Please describe a scenario (or activity) that typically represents your collaboration with your collaborators within SPVMHC.

4. Please describe your current professional relationship with your collaborator in SPVMHC.

5. Describe the actions that have taken place to create this collaborate relationship. Please provide specific actions or events.

6. How has the collaborative relationship been helpful or unhelpful to service provision of ICBP?

7. How has this collaborative relationship helpful or unhelpful to your professional work?

8. What had been some obstacles that stood in the way of this collaborating process?

9. In your own words, how would you describe "collaboration?" What does "intra-agency collaboration" mean at your agency?

10. What is the climate/culture of intra-agency collaboration at your office? In your view, what are agency policies, procedures, or practices that facilitate or hinder intra-agency collaboration?

11. Based on your experience, what are the key ingredients in creating a beneficial collaborative relationship?

Who did you collaborate with at SPVMHC?	**Purpose of collaboration** (e.g., referral, case consultation, case conference, information sharing, etc.)	**Degree of cooperation** 1. Very cooperative 2. Cooperative 3. Not cooperative	**Goal accomplishment** 1. Goal met 2. Goal partially met 3. Goal unmet	**Degree of Helpfulness** 1. Very helpful 2. Helpful 3. Unhelpful

What is your position at SPVMHC: _____