

The Other Consumer: Exploring Caregiver Perspectives of Child Mental Health Services
in Arizona

by

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ABSTRACT

The purpose of this study is to understand and explore the perspectives of caregivers of children receiving mental health services in the Southwest. The data collected examines areas of caregiver satisfaction of services including, perceived barriers and agency's ability to effectively apply the System of Care model's core values. Participants (N=100) were interviewed using the *System of Care Practice Review, Revised*. Data results include descriptive quantitative analysis, correlation and means comparisons, and thematic analysis of qualitative responses. The research indicates that as a whole, caregivers are satisfied with child mental health services. Data suggests that providers should continue to strive for improvement and excellence in several areas of service, including intervention effectiveness, family participation, cultural competence, communication and interpersonal relationships.

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INTRODUCTION

One in every five children lives with a DSM-IV disorder, one third of which experience significant functional impairment; the prevalence of these cases among the population continues to grow (Tolan & Dodge, 2005; Goplan et al., 2010; Haung et al., 2005; Rodriguez, Southam-Gerow, O'Connor, & Allin, 2014). The majority of adults who currently struggle with a mental disorder experienced significant symptoms during their childhood or youth (Tolan & Dodge, 2005). There is a need to ensure children struggling with mental illness are receiving effective and efficient care. Mental health services at this time are not being provided to the majority of children with emotional or behavioral disorders (Huang et al., 2005). Parent involvement in services and their perspective on treatment is critical for positive outcomes, beyond their ability and willingness to engage the child in treatment (Haogwood, 2005; Macdonald et al., 2007). Service providers spend a limited amount of time with each child involved in child mental health services; parents see and interact with the child throughout the week, at different times of day, and in a variety of settings. Parents therefore offer a unique perspective on the child's progress, impact of treatment, and influences for treatment engagement and success (Macdonald et al., 2007; O'Reilly et al., 2013; Tarico, Low, Trupin, & Forsyth-Stephens, 1989).

Lack of parent involvement has been found to be a primary barrier to successful treatment (Goplan et al., 2010). Parents who are involved in care report that they have to self-initiate their involvement (LeCroy 2011; Tarico et al., 1989). Engagement in services arises in part from the belief that treatment is valuable and effective (Goplan et al., 2010).

Satisfaction and comfort with the child's health and behavior is directly correlated to the likelihood of continuing services (Bjorngaard, Andersson, Ose, & Hanssen-Bauer, 2008; Forrest, Riley, Viver, Gordon, & Starfield, 2004; Hoagwood, 2005). Family empowerment, self-efficacy, is a primary indicator for future improvement in child behaviors and the ability of the family to overcome struggles; empowerment is positively correlated with length of service engagement and service satisfaction (Hoagwood, 2005; Yatchmenoff, Koren, Friesen, Gordon, & Kinney, 1998). Parents are clients as well, and providers need to be sure to meet their needs as much as the child's to ensure treatment engagement (Macdonald et al., 2007; O'Reilly et al., 2013).

Despite knowledge of the importance of parent involvement and participation in services, there is little research exploring parent perspectives on child mental health service delivery. The research that is available is primarily conducted outside of the United States in other developed countries such as Canada, Australia, and a multitude of European nations (Bjorngaard et al., 2008; Geraghty, McCann, King, & Eichmann, 2011; Levac, McCay, Merka, & Reddon-D'Arcy, 2008; O'Reilly et al., 2013). The purpose of this study is to explore the current caregiver perspectives of children in the mental health care system on the care received by mental health providers in the Southwest. The study poses the question: what does caregiver satisfaction look like in regards to child mental health?

The researcher hopes that the information provided in the study will provide insight that will inform mental health care for children and their families for potential improvement of services. The study's findings will contribute data to further develop the

evidence base of parent and caregiver perspectives on the current practices in child mental health (O'Reilly et al., 2013). Understanding the experiences of families who are in the mental health care system is salient for social work professionals who seek for best outcomes during their work with children. The knowledge gained from the perspectives of caregivers will allow professionals in the many levels of child mental health service delivery to improve care for children and their families

REVIEW OF LITERATURE

PARENTING A MENTALLY ILL CHILD

Parents who have children struggling with DSM-IV qualifying signs and symptoms face a variety of challenges. A child's struggle with a mental disorder increases tension among the whole family, resulting in increased marital conflict and sibling trauma or anxiety (LeCroy, 2011; Tarico et al., 1989; Yatchmenoff et al., 1998). Feelings such as guilt, blame, anxiety, loss, confusion, and fear are common among parents of mentally ill children (Geraghty et al., 2011; Levac et al., 2008; Tarico et al., 1989). Parents can be overwhelmed by their child's symptoms and the complexity of mental health care, in a state of constant hyper vigilance (Baker-Ericzen, Jenkins, & Haine-Schlagel, 2013; Geraghty et al., 2011; Kratz, Uding, Trahms, Villareale, & Kieckhefer, 2009). The mental health of the parent can also be negatively impacted as they experience magnified stressors of normative parenthood that result in physical, emotional, and mental exhaustion (Geraghty et al., 2011; Kratz et al., 2009; Tarico et al., 1989; Tolan & Dodge, 2005; Yatchmenoff et al., 1998). Other challenges including the financial cost of treatment and medication need for transportation, and having to take

time off work also causes stress and instability for families (Geraghty et al., 2011).

Parents of children with mental illnesses express that their experience does give them a uniquely, positive, life meaning (LeCroy, 2011; Yatchmenoff et al., 1998). Nonetheless, the struggle for them is real and salient for child mental health service delivery.

While many parents identify as advocates for their children, parents of mentally ill children often need to take on a more intensified advocacy position as they work towards ensuring their children are receiving the services needed to meet their needs (LeCroy, 2011). Being an advocate for a child in the mental health system is a challenge. Parents describe having to be aggressive and persistent in their attempts to be advocates, and service providers who experience parents advocates perceive them as being difficult and instigating conflict resulting in possible increased negative and defensive encounters with case workers (Geraghty et al., 2011; LeCroy, 2011; Mackean, Thurston, & Scott, 2005). Individuals from lower socio-economic status, especially minorities, may not be aware of the services and supports they are entitled to or are afraid to ask (LeCroy, 2011).

THE PARENT PERSPECTIVE

There are a multitude of factors for child mental health service satisfaction of parents. Parents report a desire for services to be family based and familiar (Rodriguez et al., 2014; Tarico et al., 1989). Therapies and treatments that are family focused still leave parents dissatisfied and believing that the services and supports are not effective or helpful (Baker-Ericzen et al., 2013; LeCroy, 2011). Contributing factors to parent's disappointment in services include a perceived lack of public awareness and policies that support child mental health services (Tarico et al., 1989). Parents also report stress and

frustration due to the lack of coordination between service providers as well as ineffective integration of and inconsistent services (Baker-Ericzen et al., 2013; LeCroy, 2011; Tarico et al., 1989; Yatchmenoff et al., 1998). Parents of children with externalizing problems and parents of children over the age of 6 are overall less satisfied with services (Bjorngaard et al., 2008). A child's ability to better manage their behaviors has a significant positive effect the overall functioning and happiness of the family, and thus improves parent satisfaction of services (Levac et al., 2008). Initial wait time for child mental health service implementation has been found to have a negative correlation to parent satisfaction (Bjorngaard et al., 2008; Tarico, 1989). Parents involved and engaged in their child's services over a length of time are more likely to report satisfaction (Bjorngaard et al., 2008; Yatchmenoff et al., 1998). Critical issues and needs in child mental health services that have a significant impact on parent engagement and service satisfaction are described below.

Empathy, Validation, and the Therapeutic Alliance

Treatment success as well as parent satisfaction of services rely greatly on the interpersonal relationship between the parent and the service professionals (Bjorngaard et al., 2008; Geraghty et al., 2011; Hoagwood, 2005; Kratz et al., 2009; LeCroy, 2011; Mackean et al., 2005; Rodriguez et al., 2014). Parents are often blamed for their child's predicament, a stigma exacerbated by the prevalence of families who receive child mental and behavioral health services after the involvement of child protective service agencies (Baker-Ericzen et al., 2013; LeCroy, 2011; Tarico et al., 1989; Tolan & Dodge, 2005). In consequence, parents of children struggling with mental illnesses feel

negatively judged by extended family and the community; while they wish to be involved in treatment, parents are sensitive to negative assumptions (Baker-Ericzen et al., 2013; Geraghty et al., 2011). Parents who develop a fear of rejection look towards child mental and behavioral health service providers as a source of support, affirmation, and collaboration but are too often left disappointed (Geraghty et al., 2011). Even from service providers and professionals parents experience misjudgment, disrespect, and blame for their child's mental and behavioral health issues, creating a distrust of the system (Baker-Ericzen et al., 2013, Geraghty et al., 2011; LeCroy, 2011; Rodriguez et al., 2014). When parents experience disrespect and form negative therapeutic alliance, they are six times more likely to doubt the treatment's effectiveness and to perceive service barriers (Goplan et al., 2010). Parents desire better relationships with treatment staff, reporting that a shift in professional attitudes and behaviors requires a shift towards a more strength based approach for treatments to be effective (Geraghty et al., 2011; LeCroy, 2011).

Acceptance and supportive environments for parents are key aspects of effective services (Baker-Ericzen et al., 2013; LeCroy, 2011). Parents desire to be heard and validated in their experiences with their child (Baker-Ericzen et al., 2013). Positive relationships between parents and staff that increases service satisfaction and decrease stress are characterized by mutual trust and respect, expressed compassion, and the inclusion of parents in decision-making (Geraghty et al., 2011; Kratz et al., 2009; Tarico et al., 1989). Parents experience compassion when professionals are willing to hear about

their pain and despair, acknowledge their struggle and contribution, and provide genuine care for the child (Geraghty et al., 2011; LeCroy, 2011; Tarico et al., 1989).

A parent's perception of a provider's ability to meet their child's needs through both practical and emotional support is a greater indicator of positive experiences and continued service than clinician evaluated outcomes (Forrest et al., 2004; Geraghty et al., 2011; Tarico et al., 1989). The majority of parents report that they receive no referrals from service providers and believe that their case managers are not adequately advocating for their child's needs; instead parents believe that service providers are overlooking, minimizing, or denying their child's problems (Tarico et al., 1989). Professionals who demonstrate care for families and a desire to help beyond their professional duties are greatly appreciated by parents (Geraghty et al., 2011).

Parent Inclusion

Parent inclusion in service planning is invaluable, yet many parents believe their opinions and input are placed secondary to professionals' recommendations, despite their choices of treatment being incredibly similar (Hoagwood, 2005; Tarico et al., 1989). Parents feel that they have little choice over their roles in their child's treatment (Mackean et al., 2005). Parents desire to be involved but there is often an expectation of service providers that parents should initiate their involvement in treatment and service planning (Geraghty et al., 2011; LeCroy, 2011; Mackean et al., 2005). Some service providers who attempt to include the family in services are perceived as placing increased responsibility on parents when they are already overwhelmed (Mackean et al., 2005). Parents do not wish to be left out of their child's mental health care but at the same time

do not wish to be entirely responsible; parents prefer to be equal partners with their service providers (Geraghty et al., 2011). Parent satisfaction and engagement in services is increased when service providers and professionals implement policies that ensure treatment environments that encourage, accept, and realistically execute parent involvement, suggestions, and concerns (Baxter, 2010; Macdonald et al., 2007).

Communication

Parents desire open and regular communication with service providers (LeCroy, 2011; Levac et al., 2008; O'Reilly et al., 2013; Tarico et al., 1989). The intentional and engaging communication between service providers and families increases likelihood of continuing services (Hoagwood, 2005; Tarico et al., 1989). Service agencies that are unresponsive appear incompetent (LeCroy, 2011; Tarico et al., 1989). Parents desire to have as much information about their child's treatment, progress, and diagnosis as possible so they might be able to increase their understanding and have a security of knowledge (Tarico et al., 1989). Not only do parents wish to have input and information on treatment but they desire to share their experience with service providers and express appreciation for service providers who include them in services through effective communication (Geraghty et al., 2011). Increased communication between service providers and knowledge of that coordination is desired by parents (Baker-Ericzen et al., 2013; O'Reilly et al., 2013). In addition to being involved in service plans and goals, parents desire information surrounding the purposes and effectiveness of treatment strategies in order to make informed decisions (Baker-Ericzen et al., 2013).

Information for parents has to be presented multiple times and in different modalities so parents to ensure understanding and retention (Geraghty et al., 2011). Evidence suggests that service providers often communicate to parents during times of high arousal and that parents may not be able to always process and maintain the information at these times (Geraghty et al., 2011) In addition, clarity of information can be different for staff and parents, requiring providers to intentionally confirm that parents understand what is being told to them (Baxter, 2010). To ensure effective communication, providers should also be aware of any language barriers that the family may be experiencing and be sure to provide information in whichever language or modality is preferred (LeCroy, 2011).

Informal Supports

Informal support involvement impacts the stress and enrichment experiences of parents with mentally ill children (Yatchmenoff et al., 1998). For a multitude of reasons, parents of mentally ill children experience a significant amount of isolation. Whether it is due to stigma or a strain on old relationships, parents often have little social support and feel alone in their struggles (Geraghty et al., 2011; Kratz et al., 2009). Parents of mentally ill children desire to experience connection and understanding outside of their families (LeCroy, 2011). Support groups that aim to create relationships between parents provide opportunities for parents to experience connection and understanding (LeCroy, 2011; Levac et al., 2008).

Multi-family support groups are positively correlated with treatment engagement and completion (Hoagwood, 2005). Support groups provide environments in which

parents feel free to share their stories, having a decreased fear of judgment, and as a result of participating in these groups parents report decreased feelings of isolation and stress as well as an increased understanding of their child (Geraghty et al., 2011; Hoagwood, 2005; Levac et al., 2008). Due to increased feelings of being supported and understood, parents are more likely to participate in services that provide support groups than family focused services (Levac et al., 2008). In parent support groups, parents can give and receive support as well as ideas for coping, which in turn generates hope (Geraghty et al., 2011; LeCroy, 2011; Levac et al., 2008). The self-efficacy of parents rises when they are able to create partnerships and connect with one another (Hoagwood, 2005; Kratz et al., 2009). Services such as support groups that foster efficacy in parents are crucial for family empowerment and increases treatment engagement, satisfaction, and overall service efficacy (Kratz et al., 2009; Yatchmenoff et al., 1998).

BARRIERS

Parents experience a multitude of barriers that impact access to mental health services outside of those within the issues described above. Personal barriers and risk factors include family discord and stress, child temperament, child behaviors, child personality, poverty, single parent status, discipline effectiveness, and family attitudes (Hoagwood, 2005; Rodriguez et al., 2014;). Only 10% of ethnic and racial minorities receive services cultural appropriateness and language barriers (Goplan et al., 2010; LeCroy, 2011; Tarico et al., 1989). A parent's perception of barriers is one of the greatest predictors for treatment engagement and adherence; the greater the perceived barriers the less likely parents will continue treatment (Hoagwood, 2005).

THE SYSTEM OF CARE MODEL

As illustrated by parent perspectives of child mental health service treatment, there are a multitude of issues and barriers that are experienced by parents seeking efficacious services for their children. Researchers and professionals propose that service agencies need to organize and design comprehensive mental health services, advocating that there is a clear need for services that are developmentally appropriate and take into consideration the child's context (Tolan & Dodge, 2005). The need for successful implementation of comprehensive mental health services has begun to be addressed through the System of Care service model (Tolan & Dodge, 2005).

The System of Care model was designed as a framework and philosophy to guide child mental health organizations in improving the lives of the children they serve (Stroul, Blau, & Friedman, 2010). The model's creators describe it as a "coordinated network" of a wide variety of community services and supports that provide individualized care in environments that are as least restrictive as possible (Stroul et al., 2010). Services within the System of Care model are intended to be family and youth driven, with services seeking full participation and partnerships with youth and families (Stroul et al., 2010). System of Care inspired services place a high emphasis on informal and natural supports (Stroul et al., 2010). The System of Care model strives for cultural competency as it is a critical core value of child mental health services (Stroul et al., 2010; Tolan & Dodge, 2005). Continuous progress and improvement is important within the System of Care perspective, as even the model itself has been adjusted as continuing research establishes areas of need (Stroul et al., 2010). There are three core values within

the System of Care model: to be community based, family driven and youth guided, and culturally and linguistically competent (Stroul et al., 2010). Currently, there are federal initiatives to implement the System of Care model across the country, other states such as Maryland, Nebraska, New Jersey, Oklahoma, and Rhode Island have been successfully integrating the model into their child and family mental health services (Baxter, 2010; Stroul, Goldman, Pires, & Manteuffel, 2012).

Researchers have begun to study the System of Care model, and other multi-agency models such as the Child and Adolescent Mental Health Services in England and the Mental Health System Ecological model, in practice to determine if it is effective. Multi-system models can be challenging to implement outside of controlled research settings as different organizations have contrasting professional and organizational cultures, communication issues, differences in values, and insufficient training (O'Reilly et al., 2013; Rodriguez et al., 2014). Overall the multi-agency models have been viewed positively by clients so far; parents report improved communication and coordination between services (O'Reilly et al., 2013). Still, parents report that they remain excluded from treatment planning and decision making, indicating that service professionals need to increase intentionality partnering with parents from the very beginning, providing clear information about their roles and value on the Child and Family Team (Baxter, 2010; O'Reilly et al., 2013). Interventions within the System of Care model that successfully engage families include: calls and reminders, in person intakes, family advocates that assist with information and connection to other supports, psychoeducation, and motivational interviewing (Goplan et al., 2010). This study investigates caregiver

satisfaction of child mental health services that are currently implementing the System of Care model.

METHODOLOGY

Prior to beginning the study, permission was granted from the International Review Board to ensure ethical standards would be met and maintained. Due to the limitations in research and ethical considerations when gathering data from children involved in mental health services, this researcher utilized secondary data collected during the System of Care Practice Review as administered by Arizona's Department of Health Services/Division of Behavioral Health Services in partnership with a third party program evaluation agency. The purpose of the review was to determine service agencies' adherence to Child and Family Team (CFT) practices according to Arizona's 12 principles (LeCroy & Milligan Associates, 2014). After data was collected, the agencies received a summarized evaluation covering the findings and suggested opportunities for improvement (LeCroy & Milligan Associates, 2014). For the purposes of this study, only the interview responses provided by legal or appointed guardians identified in this study as "caregivers" were analyzed.

DATA COLLECTION AND INSTRUMENTATION

Data was collected using the System of Care Practice Review (see Appendix) designed by University of South Florida and Substance Abuse and Mental Health Services Administration (SAMHSA). In order to utilize the instrument, survey administrators received training designed by the developers of the System of Care Practice Review to minimize variance in instrument. Inclusion criteria for the study

included guardians who completed the System of Care Practice Review survey as given to them by the service provider. Out of the completed surveys collected over the course of a year, 100 were randomly selected for use of this study. Participants for the original survey were recruited by the service provider and received gift card incentives.

A selection of quantitative and qualitative questions that were believed to have the most potential for valuable findings was identified from the legal guardian section of the instrument and demographic information. After data was organized final items were selected for further examination due to their clarity and utility (Bjorngaard et al., 2008). Data was entered and organized using the Statistical Package for the Social Sciences (SPSS). Questionnaire items were coded as either quantitative or qualitative variables. Demographic information was coded per item identification (see demographic items 7, 10(1), 10(4), and 10(13)). Gender was coded as male (1) and female (2). Child grade was coded as not old enough (1), preschool (2), kindergarten (3), 1st grade (4), 2nd grade (5), 3rd grade (6), 4th grade (7), 5th grade (8), 6th grade (9), 7th grade (10), 8th grade (11), 9th grade (12), 10th grade (13), 11th grade (14), 12th grade (15), high school diploma or General Educational Development earned (16), and not currently in school (17). Language was coded as English (1), Spanish (2), and other (3). Demographic items 9, 11, and 12 were coded with response options as individual variables with 1 as selected and 2 as not selected. Caregiver questions were primarily in “yes or no” format and responses were coded as, yes-1 no-2. Any non-applicable (N/A) responses were coded as 3. Responses to the question regarding assessment thoroughness (item 6) were coded as “all of these areas” as 1, “some, but not all areas” as 2, and “just a few areas” as 3. Question

responses regarding service intensity (items 13 and 14) were coded “too intense” as 1, “not intense enough” as 2, and “just right” as 3. The final questions relating to impact of treatment and services were reported on a 5-point likert scale ranging from “not at all” to “very much”. All missing responses were recorded as -99.

DATA ANALYSIS

After data entry, the researcher further excluded items from final data analysis. Quantitative questions excluded from data analysis for a greater than 20% “missing system” response included questions about service goals if no formal plan was in place, and three questions inquiring about informal and natural support involvement in treatment. Due to time constraints and limited resources, only three qualitative questions were included in the final data analysis. The qualitative questions selected for data analysis were: “what are the reasons that informal helpers/natural supports are not involved in the formal services”, “what do you think has been most helpful about the services and supports provided to your child and family”, and “what do you think has been least helpful about the services and support provided to your child and family”.

The final selected quantitative questions were initially analyzed individually, organized by domain, through descriptive analysis to identify response frequencies and means. Questionnaire items were originally divided by four domains, three represent the core values of the System of Care model (Child and Family Centered, Community Based, and Culturally Competent) and the fourth was identified as “Impact”. These same four domains were used by the researcher to organize data. Three summation subscales were compiled based on similarity of question topic: “overall service satisfaction” (questions

46-51), “family participation” (questions 15b-15e), “number of services” (summation of answers for treatment and intervention question), and “cultural competency” (questions 37, 39-42). The Pearson correlation coefficient with a selected p value of .05 was utilized to explore the potential relationships between “overall service satisfaction” and the following: “family participation”, “cultural competency”, “number of services”, and “child’s age”. Pearson’s r equation determines the correlation between two continuing variables (Kremelberg, 2011). The ANOVA means test was then used to explore the relationship of “overall service satisfaction” in regards to the “caregiver relation to child”, “child race”, “caregiver race”, “child gender” and “length of treatment”. The ANOVA means test was also utilized to look at a few questions relating to service provider’s communication and relationship with clients as well as one question addressing the involvement of informal supports. The selected level of significance used for the ANOVA means test was .05. ANOVA variance analysis compares means to determine the presence of significant relationships between categorical variables (Kremelberg, 2011).

Qualitative data was analyzed through the established method of identifying presence of themes. All qualitative responses were reviewed by question, grouped by similar content themes, a theme needed to have at least two similar content responses to be determined as a theme. Themes with an abundance of responses that could be identified as more specific themes were then created into subject domains with more specific themes falling under each primary domain. A quantitative count was conducted

to measure the frequency of themes in participant responses and descriptions were developed to best capture the essence of the themes.

RESULTS

The results presented below include the descriptive statistics of the participant demographics and of the final selection of questions, organized by questionnaire domains. Additionally, some comparison analyses were conducted between impact of treatment and demographic information and created scales within the survey that measured categories of family participation, informal support inclusion, and cultural competency. All percentages listed and identified are valid percents due to the presence of missing data for nearly every item.

DEMOGRAPHIC INFORMATION

The sample was mainly female (91%), 9% male. Participants identified their race as White (57%), Hispanic or Latino (19%), Native American or American Indian (7%), Black or African American (6%), or Multi-Racial (6%). The primary language of most caregivers was identified as English (94.9%) while 4.1% reported Spanish as their primary language. Mother figures made up the majority of the sample: biological mother (31%), foster mother (20%), grandmother (20%), and adoptive mother (12 %).

Length of treatment or intervention involvement with agency varied from less than one month to over two years with the majority of participants having received services for more than one year ($N=55$). Caregivers identified the child and family services they were involved with, 98% reported they were receiving mental health services, 54% were receiving services in connection to child welfare, and 41% reported

receiving educational services. Other services reported were juvenile justice services (15%) and developmental disability services (13.1%). The highest used treatment or intervention type was case management (90.9%) with individual counseling as the second most used (78.8%). Family counseling was provided for 49.5% of families and family support was given to 43.4%. About half of the children represented in the sample were receiving treatment that included psychiatric medication ($N=51$).

The mean child age was 9.54 ($SD= 5.01$). Infants or preschool aged children made up 26.3% of the sample, 35.9% were between Kindergarten and 5th grade, 14.7% were in middle school, and 19% were in high school. Child gender was 60% female, 40% male. Participants reported their child's race as 44.9% white, 21.4% Hispanic or Latino, 12.2% Native American or American Indian, 7.1% black or African American, and 14.3% reported as multi-racial. Over half of the children had siblings, 55% had at least one sister and 47% had at least one brother. Twenty participants identified other family or non-family members as part of their family. Biological mothers were involved in 40% of cases, biological dads in 22%. Grandmothers were identified as included in the family more frequently (16 maternal grandmothers and 12 paternal grandmothers) than grandfathers (6 maternal grandfathers and 7 paternal grandfathers). The mean Global Assessment of Functioning (GAF) score reported for the children was 56.36 with 49% of children falling between the 51-60 range, the lowest GAF score was 31 while the highest was 80. There was a 64% reported comorbidity rate.

CHILD CENTERED AND FAMILY FOCUSED

The majority of participants (61.5 %) felt that the assessment process covered “all” areas for a thorough assessment, 34.4% reported that the assessment covered “some, but not all”, and 4.2% identified that the assessment covered “just a few”. Out of the sample, 67 participants (70.5%) believe they are receiving the help they currently need, 28 participants (29.5%) do not. The majority of participants believe service intensity is just right” (72.4%), while 25.5% believe that service intensity is “not intense enough” and 2% believe their service intensity is “too much”. For the amount of interaction the service providers have with the child and family: 68.7% feel the amount is “just right”, 30.3% perceive the amount as “not intense enough”, and 1% believe the amount of interaction is “too intense”. The average length of time it had been since the child and/or family had met with their case manager was 2.14 weeks. Almost half (47.9%) of participants report having met with their case manager the previous week, for 14.6% it had been two weeks, 21.9% reported three weeks, 7.3% indicated it had been four weeks, and 8.3% reported having not met with their case manager for longer than four weeks. Nearly half of the sample reported having at least one other case manager before their current case manager (47.6%). Participants were asked if they had been asked about their informal or natural supports, 61 participants (70.9%) said “yes” and 24 participants (27.9%) said “no”. Table 1 provides frequencies and percentages of all other Child Centered and Family Focused Domain, including those that address service goals, family participation, and case management.

Table 1

Responses to “yes/no” Items within the Child Centered and Family Focused Domain

Item	Yes (%) <i>n</i>	No (%) <i>n</i>
Service Goals		
10. Do these service plan goals reflect the needs that you identified for your child and family?	(92.8) 90	(7.2) 7
11. Can you tell from these goals what your child and family's strengths are?	(67.4) 64	(32.6) 31
11a. If the strengths are not formally incorporated into the goals and service plan, are they acknowledged in other ways?	(87.2) 82	(11.7) 11
Family Participation		
15b. Over the past year, have you regularly attended meetings to talk about your child's needs, and to plan with primary case coordinators and other providers?	(94.6) 87	(5.4) 5
15c. In your opinion, do your child and family seem to directly influence the final, formal plan that is developed and the goals that are set?	(92.4) 85	(7.6) 7
15d. Do your child and family understand the plan?	(94.6) 87	(5.4) 5
15e. Are the child and family in agreement with and enthusiastic about the plan?	(91.5) 86	(8.5) 8
Case Management		
17. Is this person helpful in coordinating the various services that your child and family receive?	(79.2) 76	(20.8) 20
18. Does this person have good working relationships with the other formal service providers and informal helpers/natural support who are involved with your child and family?	(98.9) 86	(1.1) 1
19. Does this person help to change the plan when you need or different kinds of help?	(81.3) 74	(17.6) 16

COMMUNITY BASED

Out of the 51 participants who identified that they needed support to increase their access to services, 31 participants reported they “get the support” they need while 9

participants report that they do not. The question asking whether information was provided in the participant’s primary language was answered by 80 participants all of which answered “yes”; the other 20 participants did not record a response. Fifty-one participants (57.3%) reported that they do not believe their child and family would have been better off if they had received help sooner from the service provider. Table 2 presents descriptive data for all other items in the Community Based Domain.

Table 2

Responses to “yes/no” Items within the Community Based Domain

Item	Yes (%) <i>n</i>	No (%) <i>n</i>
22. Did they identify additional concerns or needs?	(71.3) 57	(28.8) 23
25. Are the times when your child and family meet with the various service providers convenient for your child and family?	(89.8) 88	(10.2) 10
26. Are the locations of the meeting and services with your providers convenient for your child and family?	(90.4) 85	(9.6) 9
27. Does (<i>sic</i>) your child and family need any support to increase your access to services?	(42.7) 38	(57.3) 51
31. Are you comfortable spending time in the places where your child receives service?	(95.8) 91	(4.2) 4
33. Does it seem like all of the people you’ve mentioned are working together to help your child and your family?	(87.8) 86	(12.2) 12
34. Does it seem like there is a smooth and seamless process to link your child and family with additional services as needs arise?	(76.1) 67	(23.9) 21

CULTURALLY COMPETENT

There were 71 completed responses to the question asking about the ability of providers to help families sign their child up for activities, 51 participants (71.8%) reported “yes” while 20 participants (28.2%) reported “no”. When participants were asked if their participation or decisions would have been different if their knowledge of agencies and service systems were different, 52 answered “no” (59.8%) and 34 said “yes” (39.2%). Frequencies and percentages of responses to all other items from the Culturally Competent Domain are presented in Table 3.

Table 3

Responses to “yes/no” Items within the Culturally Competent Domain

Item	Yes (%) <i>n</i>	No (%) <i>n</i>
37. Do the people working with your child and family seem to understand your culture as you just described it?	(85.1) 80	(14.9) 14
39. Do the people working with your child and family seem to recognize and respect how your cultural background influences your preferences, decisions and participation?	(82.3) 79	(17.7) 17
40. Do your providers seem to recognize how their own cultural background influences their understanding, recommendations, and actions?	(70.7) 58	(29.3) 24
41. Do you believe they are aware of how cultural differences and similarities can influence how people get along and work together?	(90.2) 74	(9.8) 8
42. Do they seem to take your cultural background and identity into account when planning and providing services and supports for your child and family?	(79.1) 72	(20.9) 19
43a. Did anyone explain to Child & Family Team Practice to you and your family?	(81.4) 79	(18.6) 18
43b. Have you received any help in order to better understand and navigate the various agencies and organizations?	(67.8) 61	(32.2) 29

44. Do all of the people that help your family know about all of the different activities that kids your child’s age can get involved with in your area?	(72.7) 64	(27.3) 24
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IMPACT

The service satisfaction scale resulted with a mean score of 21.92 out of a possible 30 with a standard deviation of 5.92, a standard error of mean of .59, and a variance of 35.01. Means frequencies for each item in the “overall service satisfaction” subscale are presented in Table 4. Success in school was reported as having been helped by services and supports in 55 cases (66.3%) and living with the family was perceived as been helped by services and supports by 60 participants (72.3%). About a third of participants reported that staying out of trouble with the law (39%) and progressing toward successful adulthood (31.7%) was not applicable to their situation. Those who did answer whether services and supports helped their child stay out of trouble with the law reported 51.2% “yes” ($N=42$) and 9.8% “no” ($N=8$). Participants who responded to whether services and supports helped their child progress toward successful adulthood resulted in 53.7% “yes” ($N=44$) and 28.6% “no” ($N=12$).

Table 4

Response means for 5-point likert scale questions regarding service satisfaction

Item	Mean	Standard Deviation	Standard Error	Variance
46. My child has made progress towards meeting his/her goals.	3.35	1.17	0.59	1.36
47. My family has made progress towards meeting its goals.	3.64	1.09	0.12	1.18

48. I am better able to deal with my child's problems.	3.85	1.095	0.12	1.20
49. Services have improved my child's overall situation.	3.74	1.19	0.12	1.52
50. Services have improved my family's overall situation.	3.64	1.32	0.13	1.74
51. I am satisfied with the coordination of services in this case.	3.95	1.23	0.13	1.42

EXPLORATORY FINDINGS

Cultural Competency was found to have a positive correlation with service satisfaction, $r(48) = 0.461$, $p = .001$; indicating that services that have greater cultural competency result in increased caregiver satisfaction. Greater family participation in treatment was found to have a significant positive correlation with service satisfaction, $r(94) = 0.232$, $p = .023$. A significant relationship was found when comparing service satisfaction means scores for the yes/no question “have you been asked if there are relatives, friends, or neighbors who help or who might be able to help your child and family”, $F(1, 82) = 5.61$, $p = .020$. Those who answered “yes” had higher mean satisfaction scores than those who answered “no”. The participants perception whether or not their service provider was helpful in coordination with services was found to have a significant relationship with service satisfaction, $F(1,93) = 29.12$, $p = .000$; those who answered “yes” had higher mean satisfaction scores greater than those who answered “no”. A significant relationship between service satisfaction was also found with whether participants felt that all the people involved in services appear to be working together in

order to help the child and family, $F(1,95) = 13.36$, $p = .000$; participants who answered “yes” had greater satisfaction reports than those who answered “no”.

The number of services received by participants was not found to be significantly correlated with service satisfaction, $r(97) = -0.129$, $p = .274$. Child age was shown to not have a significant correlation with service satisfaction, $r(73) = -0.046$, $p = .693$. Child gender also did not have a significant relationship with service satisfaction, $F(1,97) = 1.45$, $p = .237$. Child’s race was not significantly related to service satisfaction, $F(1,63) = 0.012$, $p = .912$. Caregiver race was not found to have a significant relationship with service satisfaction, $F(1,73) = 0.00$, $p = .998$. Length of treatment did not have a significant correlation with service satisfaction, $F(4,70) = .032$, $p = .503$. Caregivers who identified their relation to the child as a type of mother had the highest mean scores for service satisfaction as compared to other caregivers, biological mothers ($M = 21.29$, $SD = 6.06$), adoptive mothers ($M = 21.25$, $SD = 4.94$), foster mothers ($M = 21.32$, $SD = 7.55$), paternal grandmothers ($M = 23.43$, $SD = 3.87$), and maternal grandmothers ($M = 24.6$, $SD = 4.56$). A variance analysis showed no significance of mother type on service satisfaction, $F(1,55) = 0.842$, $p = 0.188$. Length of time since the family was last contacted by the service provider’s case manager was not found to have a significant impact on service satisfaction, $F(4,90) = 0.904$, $p = .465$.

QUALITATIVE DATA

INFORMAL OR NATURAL SUPPORT INVOLVEMENT IN SERVICES

Caregivers reported reasons why informal or natural supports were not included in treatment; some participants indicated she did not wish to involve their friends or

family ($N=15$) but more caregivers responded that they may have considered or even desired to have informal supports incorporated in services but experienced barriers to implementation ($N=23$). The most cited reason that informal support was not part of the treatment plan was that the caregivers felt that they had no one to ask or that they were unable to do so. A biological mother (Native American or American Indian) expressed, “we’ve gone through them all”. Lack of knowledge due to either lack of discussion entirely with service provider or incomplete discussion was the second primary reason for the noninvolvement of informal or natural supports. An adoptive mother (White) explained that she had supports that were not close geographically and were unaware of possible options using technology stating that it, “wasn’t really described in that way”; respondent reflected that they, “would have liked them to” be involved if they had known. Other identified themes included: the case has high levels of intensity, problem severity, or needed strengthening of core family bond, absolute undesired involvement, perception of services as the family’s personal business, and lack of follow-through or coordination on the service providers behalf. Descriptions, examples, and frequencies of each theme are presented in Table 5.

Table 5

Responses to “why were informal or natural supports not involved in services”

Theme	Description	Examples	(%) <i>n</i>
None Available or Unable to Ask	There are either no identified sources of support available or the support network is too small. When there are supports available, they feel unable to ask.	- “gone through them all” <i>Biological Mother, Native American or American Indian</i> - “need respite, don’t know how to ask” <i>Foster Mother, White</i>	(26.3)10

Not Discussed with Service Provider	Informal or natural support involvement would have been considered but they were unaware of the options because their service provider either never asked or fully discussed options with them.	- “never thought of bringing to the CFT” <i>Biological Mother, White</i> - “that would have been good” <i>Biological Mother, White</i>	(23.7)9
Case Specific Issues	Case specific issues include problem severity and desire to work on the family bond.	“child’s problems too severe” <i>Adoptive Mother, White</i> “we feel we need to strengthen our bond before we involve others” <i>Other Female Relative, White</i>	(15.8)6
No Desire	Participant reports that they do not want to involve anyone else in services, some add that they are able to use their informal supports as needed without involving them in treatment.	- “we haven’t seen the need for it” <i>Maternal Grandmother, White</i> - “I don’t want to include anyone but remember that I have great neighbors, my son and the kids have friends here in the apartments” <i>Maternal Grandmother, White</i>	(13.2)5
Personal Business	Exclusion of informal support from services is attributed to a desire for privacy, to avoid burdening others, or a sense of support’s inability to understand.	- “I don’t trust people very well” <i>Biological Mother, White</i> - “don’t like to burden others” <i>Maternal Grandmother, Native American or American Indian</i>	(10.5)4
Lack of Follow-through or Coordination	Informal support involvement is desired but barriers such as an identified lack of follow through or coordination on part of the service provider or scheduling conflicts.	- “not sure why care provider hasn’t contacted them” <i>Paternal Grandmother, Race not Given</i> - “communication issues, lack of consistency” <i>Adoptive Mother, White</i>	(10.5)4
TOTAL			38

MOST AND LEAST HELPFUL ASPECTS OF SERVICE

Table 6

Responses to qualitative questions regarding most and least helpful aspects of service

Domain/ Theme	Description	Example	Most Helpful	Least Helpful	Total
Interventions			40	11	51
<i>Therapy</i>	Helpful therapy types include individual counseling and art therapy. Therapies that are helpful serve to provide a space for open communication, exploration, and learning coping strategies. Amount of therapy can be unhelpful.	- “art projects as an outlet for emotions” <i>Biological Mother, White</i> - “initial therapy she really loved” <i>Biological Mother, White</i>	10	1	11
<i>Medication</i>	Medications to assist in managing symptoms are seen as either effective or ineffective.	- “medications have been helpful” <i>Biological Mother, Race not Given</i> - “medication to control outburst” <i>Biological Father, White</i>	12	1	13
<i>Combination</i>	Multifaceted services that combine several intervention types such as: therapy, medication, case management, respite, behavior coaching, medical assistance, education support, etc.	- “a combination of everything, both behavioral and medical” <i>Foster Mother, White</i> - “case manager talking to her, counseling, matrix classes and all the	18	0	18

		supports” <i>Biological Mother, Native American or American Indian</i>			
<i>Not Received</i>	When services are not provided at all or specific ones are still needed to be implemented but have not happened.	- “he needs more services, social skills” <i>Other Female Relative, White</i> - “lack of other service, no mention of therapy” <i>Biological Mother, Hispanic or Latino</i>	0	6	6
<i>Unhelpful or Increase Problems</i>	Services result in an increase of problem behaviors or distress.	- “summer group, turns into an over dramatic nightmare” <i>Biological Mother, White</i>	0	3	3
Personnel			27	15	42
<i>Relationships and Interactions</i>	Service providers are identified as helpful or unhelpful aspects of services accordance to how they interacted and treated the parents, children, and families.	- “understanding of religion, patient” <i>Maternal Grandmother, Native American or American Indian</i> - “case manager’s compassion, commitment to our family her attitude is always positive” <i>Biological Mother, White</i>	4	3	7
<i>Availability</i>	Professionals make themselves available to	- “knowing they are there”	2	0	2

	families receiving services providing a sense of reliable support.	<i>Sister, White</i> - “availability, of personnel services, they are always available if I need anything” <i>Maternal Grandmother, White</i>			
<i>Approach</i>	Helpful identified approaches of professionals towards treatment, the child, and families include straightforwardness, positivity, and strengths-based.	- “case manager focusing on milestones and education” <i>Foster Mother, Hispanic or Latino</i> - “life coach, teach him some things from positive perspective” <i>Adoptive Father, Black or African American</i>	4	0	4
<i>Helpfulness and Effectiveness</i>	Helpful and effective professionals are able to help child open-up, provide good suggestions to the family, are developmentally appropriate, provide information, and do their best to meet identified needs. Unhelpful professionals lack competence and provide information without assistance.	- “very knowledgeable of so many different things, everything we’ve asked for they’ve jumped and provided” <i>Foster Mother, White</i> - “therapist, she is getting him to open up” <i>Adoptive Mother, White</i>	7	2	9
<i>Specific Person Named</i>	Specific professional type is identified as helpful or unhelpful and no reason is provided.	- “therapist is great” <i>Paternal Grandmother, Race not Given</i>	10	1	11

		- “behavior coach” <i>Foster Mother, Hispanic or Latino</i>			
<i>Turnover</i>	Staff transition and inconsistency is unhelpful and causes a sense of instability for parents.	- “lack of consistent staff” <i>Adoptive Mother, Hispanic or Latino</i> - “turnover, transition, not having stable team, both case managers, CPS and therapist” <i>Other Female Relative, White</i>	0	9	9
Process			11	22	33
<i>Coordination and Communication</i>	Service providers who are able to maintain consistent and open communication and smooth coordination are identified as helpful. When there is a lack of communication and services do not appear effectively coordinated they are identified as unhelpful.	- “communicate everything” <i>Foster Mother, White</i> - “everyone doing their job, coordination is poor” <i>Male Non-Relative, Multi-Racial</i>	5	7	12
<i>CFTs</i>	CFTs serve to maintain open and clear communication. Team member’s absence from meetings causes them to be ineffective.	- “CFTs they keep us all on the same page” <i>Paternal Grandmother, White</i> - “talking, everything together CFTs” <i>Adoptive Mother, White</i>	4	1	5
<i>Teamwork</i>	Service team works	- “most helpful	2	0	2

	together to ensure service helpfulness and effectiveness.	team put together, work well together, high level” <i>Adoptive Mother, White</i>			
<i>Lack of Follow-through or Focus</i>	Services are not being implemented or are inconsistent possibly due to slow or complicated process. Treatment does not appear to have clear goal or purpose.	- “it’s been a waste of time, no one is checking on the school, observations at the school” <i>Foster Father, Race not Given</i> - “behavior coaching didn’t happen” <i>Adoptive Mother, White</i>	0	7	7
<i>Barriers</i>	Barriers to treatment may include developmental inappropriateness of available services, service location, scheduling, and transportation.	- “transportation issue affects progress” <i>Biological Mother, Multi-Racial</i> - “timing, work schedule timing” <i>Biological Mother, Native American or American Indian</i>	0	7	7
Family Focus			12	0	12
<i>Services and Supports</i>	Services and supports include respite, family therapy, providing experiences to the child that were not affordable to the family, and any others that served to improve family functioning.	- “family therapy” <i>Maternal Grandmother, Hispanic or Latino</i> - “take kids out to places we couldn’t afford to take them” <i>Biological Mother, Multi-</i>	6	0	6

		<i>Racial</i>			
<i>Involvement</i>	Family participates in service planning, process, and treatment.	- “involved family” <i>Stepfather, White</i> - “they allow us to communicate and be a part of child’s treatment” <i>Maternal Grandmother, Race not Given</i>	3	0	3
<i>Skill Building</i>	Services have improved parent and family skills in coping and understanding child’s challenging symptoms and behaviors.	- “different techniques to help us deal with his thoughts, the people inside him, angry or sad” <i>Other Female Relative, Native American or American Indian</i> - “most helpful were classes understanding behaviors” <i>Paternal Grandmother, White</i>	3	0	3
	TOTAL		90	48	138

Primary domains of what has been the most helpful and least helpful about the services parents received were identified as: interventions, personnel, process, and family focus. Theme descriptions, examples, and frequencies are provided in Table 6.

Interventions

Participants with responses within the “interventions” domain identified the most and least helpful aspects of services in relation to the effectiveness of specific intervention methods. Combined interventions were identified as most helpful more frequently than therapy or medication specifically. One maternal grandmother (White) explained that helpfulness of services has, “been (a) combination, with child he has his hot mess, didn’t know what to start with or what to do, essentially no miracle cure, (I have to) take my time to be where he’s at, (they) helped sit me down to understand process, (we’ve) made so much progress”. Interventions were reported as least helpful when they were not implemented or increased problems. Caregivers described that they were either not receiving services they planned or expected to or that they believed that their child “needs more services” than are being provided. Some interventions increased problem behaviors; as one adoptive mother (Black or African American) describes that their child’s group therapy was unhelpful because, “she learns bad things in group”.

Personnel

Helpfulness or unhelpfulness of services was also reported in regards to experiences with professionals. Helpful professionals were identified as respectful, patient, effective, available, and compassionate. Caregivers reported that helpful professionals appear committed and ensure that the families are receiving services needed. Professionals who take the time to educate caregivers and share information through the process were also identified as helpful. Some caregivers noted that professionals who focused on strengths and were positive in their approach were helpful. Turnover was identified as the least helpful aspect of services for some caregivers

resulting in “not having a stable (or consistent) team”. Unhelpful professionals were identified as unknowledgeable or unwilling to provide additional explanation or assistance through the process. One biological mother (White) described, “other service provider doesn’t do anything they just gave us a list”. Some service professionals caused caregivers to feel “brushed away”.

Process

The process of service implementation has been identified as a domain of either most or least helpfulness. Teamwork was a reported area of helpfulness with caregiver’s referring to the treatment team’s ability to “work good together”. Coordination and communication was identified to be least helpful more often than most helpful. Caregiver responses indicate that the lack of coordination and communication during service delivery can be seen as the most unhelpful aspect of services is it interferes with meeting the family’s needs. As one other female relative (White) describes, they “did go through (a) phase of getting the run around, everyone pointing us in different directions”. The lack of follow-through on the service provider’s behalf was identified as an area of least helpfulness even leading to one foster mother’s (White) opinion, “I feel like they’re lazy, (they) do the minimum and that’s it”. Caregivers identified barriers as being least helpful aspects of services; barriers experienced by families were diverse, including: transportation issues, inconvenient location of services, scheduling issues, and lack of developmentally appropriate interventions. A biological mother (White) described that their child’s age limited his services because there was “no group for him to learn social skills, brother is in social skills group (age 11)”.

Family Focused

A domain that was also identified was the family focus of services. Some caregivers expressed that the family centeredness of services were the most helpful aspect. Caregivers reflected that supports and services offered and connected to families and parents were helpful in that they improved family functioning and cohesiveness. One biological mother (White) described that family support was the most helpful aspect of services as it succeeded in “rebuilding the family that was completely fractured”.

DISCUSSION AND CONCLUSION

The demographics and characteristics of the sample describe the parents, children, caregivers, and families who professionals will likely encounter in child mental health services. The majority of the caregivers are “mothers”, just about a third of the overall sample are biological mothers while foster mothers and grandmothers (combining maternal and paternal) each represent one fifth and adoptive mothers. The majority are white and English speaking. Being located in the southwest, this particular sample shows that the other primary ethnicity encountered is Hispanic or Latino. The age of children receiving services is diverse and balanced, indicating the necessity of service providers to be able to provide developmentally appropriate interventions for all ages.

Only 20 cases reported the inclusion of the biological father in the family suggesting that one out of five children seen in treatment lives without involvement of their father in their life. Biological mothers’ inclusion in the family makeup was reported in only 40 cases, less than half of the children receiving mental health services currently have their mother as an identified member of their family. Previous research indicates the

importance of biological parents for children's physical and mental health (Bramlett & Blumberg, 2007). Service providers will likely see many families in which the biological father and/or mother is absent. Over half of the children receiving services as siblings; the data does not provide information if these siblings are also included in or receiving their own treatment. Due to the impact of child mental illness on the whole family, those families with siblings would benefit from family services and supports (Tarico et al., 1989; Yatchmenoff et al., 1998). Future research could explore the impact or experience of sibling mental health treatment for these children. One fifth of caregivers reported other family members or non-family members as included in what they perceive as their family makeup, in at least one of five cases, professionals can work with families to utilize their extended family and friends as natural or informal supports.

The sample informs professionals that just over half of their clientele has been involved in mental health services for over a year, suggesting that professionals will need to be able to maintain long term therapeutic relationships with clients. Just about half of the cases are involved with child welfare, while this is consistent with reports that the "majority" of families involved in mental health services began due to involvement with child protective services the data shows that the other half of families who receive mental health services are not involved with child welfare yet may still be experiencing stigma in reference to it (Baker-Ericzen et al., 2013; Tolan & Dodge, 2005). Family therapy and other family focused services and supports are being provided to less than half of parents despite a central value of the System of Care Model being "youth driven and family focused" (Stroul et al., 2010). Half of the sample receives psychiatric medication,

reminding professionals the importance of being aware of what medications their clients may be on and how that may impact their situation. The majority of children experience comorbid disorders, suggesting that child mental health services need to plan treatment goals and plans to meet the complex and individual needs of children and their families.

In the child centered and family focused domain, caregivers report highest agreement that there is family participation in treatment and goal planning in that they report that they attend meetings, influence the plan and goals, understand the plan, and are in agreement with the plan. As to many families this is a critical piece to successful and satisfactory services, it can be counted as a good thing that nearly all caregivers feel that they are able to participate in services (Baxter, 2010; Geraghty et al., 2011; LeCroy, 2011; Mackean et al., 2005; Macdonald et al., 2007). However, at least ten participants do not. Service providers will need to continue to strive to be intentional about family involvement in service planning to reach those who still feel excluded.

The majority of caregivers believe that the service goals clearly include family and child strengths and even more report that their strengths are acknowledged in other ways. Most caregivers report that their case manager has a good working relationship with other service providers and supports, but less agree that the person is helpful in coordinating the various services or help to change the plan when needed. While services establish child centered and family focused practices, they appear to be less successful in coordinating or adapting services to meet the needs of children and their caregivers. Some aspects of services may be out of a single service provider's control, due to the

involvement and role of other agencies, but caregivers still see a need for improved coordination and adaptability (O'Reilly et al., 2013; Rodriguez et al., 2014).

Nearly all caregivers report that the treatment plan and goals address their needs; however, there is less agreement about whether services are actually meeting their needs. About a third of caregivers do not believe they are receiving the help they need. When asked about service intensity and amount of interaction, 25.5% reported that service intensity was not enough and 30.3% perceived the amount of interaction was not intense enough. Data indicates that caregivers desire an increase of service intensity to better meet their needs more than a decrease.

Under the community based domain, services are most effective in their efforts to have services be convenient for parents and families. Times and locations of services are reported as convenient for most caregivers. Nearly all caregivers feel comfortable at the location that they receive services. Comfort and accessibility are key aspects of keeping families engaged in treatment (Hoagwood, 2005). Caregivers report that the treatment teams work together to help the child and family. Mental health providers are not as successful in the ability to maintain a smooth and seamless process for caregivers. Caregivers for the most part agree that services cater towards caregiver involvement and convenience by decreasing potential barriers, yet fall short in actual service implementation and coordination.

The majority of caregivers identify that overall service providers are successfully practicing cultural competence. Service provider's abilities to demonstrate understanding of the child and family's culture and awareness of the influence of cultural differences

and similarities have on how people interact and work together received the highest percentages of agreement. Participants were less convinced whether service providers recognize the influence of their own backgrounds on their understanding, recommendations, and actions during treatment. While caregivers experience the awareness service professionals have of other's cultures and demonstrate sensitivities towards them, service providers are less successful in demonstrating to parents that they are able to consider the impact of their own culture. This may indicate that while service providers are increasing their cultural competency, services may continue to be culturally inappropriate for some cultures who may view service providers as not being aware of how their cultural identity impacts the child's treatment plan, goals, and family's relationship with the professional.

Caregivers are also less in agreement that service providers have provided help in navigating child mental health agencies or whether service providers know about community resources. Most caregivers still believe that their decisions about treatment would not have been any different if their knowledge of service agencies were different than those who reported that different knowledge would have changed their decisions. Yet literature suggests that the mental health care system can overwhelm those who do not understand it (Geraghty et al., 2011). Service providers need to be intentional in helping caregivers and families navigate the system.

Overall impact responses indicate that the System of Care model is generally successful in improving family function and coping behaviors. Caregivers report highest satisfaction in overall service coordination. Means indicate that most caregiver

satisfaction levels are between “some” and “pretty much”, leaving room for service provider improvement but overall success in meeting child and family needs. For now it is difficult to determine if the Systems of Care approach is improving child mental health practices in Arizona, while average scores indicate more people are satisfied with services than unsatisfied there is certainly room for improvement.

One finding of interest was that maternal grandmother’s reported the highest levels of overall treatment satisfaction compared to other caregivers and even compared to other isolated factors (i.e. race and gender). Maternal grandmothers reported a mean of 24.62 for impact of treatment while other mothers had a combined mean of 21.82; despite this difference of scores no significant relationship was found between caregiver’s relation to the child and their satisfaction of services. There is limited research that explains this finding. One study found that grandmothers have a more positive outlook on their experience with a grandchild with special needs than mothers perceive the relationship between the grandmother and child (Sullivan, Winograd, Verkuilen, & Fish, 2012). Another study indicates that grandmothers also report the need to be more included in service planning and provided with supports to learn skills and once these needs are met that grandmothers saw improvement in the child (Gallagher, Kresak, & Rhodes, 2010). In the same study, grandmothers reported the joy and hope they experience while raising their grandchild (Gallagher et al., 2010). Perhaps grandmothers have a more positive outlook on their grandchild’s improvements and therefore report greater levels of service satisfaction. Another possibility is that some grandmothers may be the caregiver for their grandchild due to child welfare involvement and desire to be as

compliant and positive as possible to help the child return home to the parent, the grandparents child. Further research could test more specifically if a caregiver's relationship with a child has an impact on their satisfaction and explore the differences of those caregiver's experience, perspective or opinions of treatment to determine why the difference exists.

Significant relationships were found between family participation and impact of treatment, supporting research that caregivers who are involved in treatment have higher levels of overall satisfaction of care (Baxter, 2010; Goplan et al., 2010; Hoagwood, 2005; Macdonald et al., 2007; Mackean et al., 2005; Tarico et al., 1989). Cultural competency and family participation in treatment both had significant positive correlations, further supporting the need to intentionally make services both culturally competent and involving of family in decision making and service planning (Geraghty et al., 2011; Goplan et al., 2010; LeCroy, 2011; Mackean et al., 2005).

Few participants answered all of the informal and natural support questions to be able to create a scale, the significant relationship between the question of whether caregivers had been asked if they desire to involve any informal supports in the treatment plan with impact of treatment suggests that services should be sure to utilize and explore options of informal and natural supports. Informal supports are critical not only for parent satisfaction but for child and family outcomes (Kratz et al., 2009; Yatchmenoff et al., 1998). Service providers need to be intentional about including the option of informal support involvement in services during the early phases of services. The question addressing caregiver communication with service providers was not found to be

significantly related to treatment impact; further research would need to be conducted to explore the importance and value of communication in child mental health. A consideration may be made that perhaps parents and caregivers prefer quality communication even more than quantity (Baker-Ericzen et al., 2013; Geraghty et al., 2011; Hoagwood, 2005). The significant relationship of caregiver perspectives of their case manager and service provider's ability and intention to help the child and family with impact of treatment supports previous research indicating that the personal relationships involved in treatment have great impact on a parent's opinion of services (Baker-Ericzen et al. 2013).

Qualitative data provides some insight to areas that were unable to be fully addressed through the quantitative responses. The themes that were present in the responses for why informal support was not desired by caregivers suggests areas for practitioners to explore with clients and researchers to continue research to determine more specifically what barriers are preventing families from including informal supports in their services and treatment plans. Service providers will need to increase their intentionality of addressing informal supports to ensure parents and caregivers are able to make decisions about whether they desire to include family and friends in treatment with full knowledge of the options and benefits. With increased discussion, service professionals could also assist families in problem solving and brainstorming how to address barriers such as geographical distance or the vulnerability of having to ask for help. Service professionals can work towards decreasing the impact of stigma on this decision by exploring with families their concerns of privacy.

Previous research indicated that parent's satisfaction weighs heavily on the therapeutic relationship, family inclusion, communication, and the presence of informal support. More caregivers in this study referred to themes that are related to the treatment intervention when selecting most and least helpful aspects of services rather than those related to service personnel, treatment process, or family-centeredness of treatment. Therefore, this study demonstrates that caregivers do take into consideration intervention effectiveness and helpfulness and may look towards the actual intervention as an indicator of whether services have been helpful or not.

The majority of participants identified service providers as having met expectations and standards under the core value domains of the System of Care model. The System of Care model's core values remain critical in child mental health service provision as family participation, cultural competency, options for informal support involvement, and helpfulness of professionals had the most significant relationships. The findings of this study suggest that the System of Care model, as it is currently implemented in Arizona, meets identified needs and barriers that parents have expressed in past studies better than in the past (Tarico et al., 1989). While it is important for service providers to work towards increasing family participation, decreasing barriers, and culturally competent practice, effective and successful service implementation cannot afford to fall short. There is less caregiver agreement that service coordination is effective and smoothly executed. Service providers need to find a way to improve relationships with families while also ensuring service implementation is effective and efficient; there is still room for improvement.

LIMITATIONS

The missing data in this study possess multiple limitations. Although the study was intended to be exploratory, the amount of missing data across items and overall small sample size limits the ability to draw conclusions that can be generalized from the data or hypothesize relationships across domains. The significant correlation found between cultural competency and caregiver's service satisfaction has limits due to only half of respondents fully responding to the cultural competency scale. The extensiveness of the missing data could be for many reasons such as survey structure or sensitive topics. Language may have been a factor as 20 participants did not answer the language section, possibly due to the fact that it was not in their language to begin with. To address these issues, the research proposes that future research endeavors have specific focuses on areas that may have an impact on parent engagement in treatment and satisfaction of services and be intentional about decreasing language barriers.

Disconnect between the literature and results can be partially explained by sample characteristics. While the literature discussed studies in terms of "parents", this study looked at legal or appointed guardians, "caregivers". The sample included foster parents, adoptive parents, and extended family therefore results may represent a different perspective than if the sample had been strictly biological parents. Similarly, it is unclear whether results were skewed either by limited experience with the child; there is no way of telling how long the child was in the caregiver's custody, or by the inclusion of participants who had been receiving services for a short time. Caregivers with limited experience with the child or less involvement in services may not be able to perceive

benefits and positive outcomes. As mentioned in the literature, the longer individuals are in services, the more likely they are to be satisfied (Bjorngaard et al., 2008; Forrest et al., 2004; Hoagwood, 2005). Most literature on parent perspectives and satisfaction collected utilized qualitative data. Therefore differences between the literature and this study's results may also be partially attributed to the difference in data types. It is difficult to determine whether the data from this study demonstrates improved scores when most available studies are qualitative not quantitative as our satisfaction data is. The quantitative study that was found was conducted over two decades ago. So while scores are improved from that study, there is no way to determine if it was caused by the System of Care model (Tarico et al., 1989). Social desirability may also play a part as the data was originally collected as a means of service evaluation and the participants provided identifying information. Participants may have been more lenient with their scores knowing that their service providers would be evaluated based on their responses, or because they feared possible repercussions for them or their child if the service provider discovered that they gave low scores.

The use of secondary data limited researcher control of data collection. Despite training, there still may have been a difference in how data was collected, impacting study validity. Also, there is no way to account for the difference in System of Care implementation across individuals and agencies included in the study. Blind random selection of cases leaves possibility that cases were not evenly distributed across agencies or locations meaning there is no way to account for unbalanced representation. Further research is needed on parent perspectives on child mental health services to provide valid

conclusions and implications for policy and practice. Despite the limitations of this study, the exploratory data found can continue to build a foundation towards further research and demonstrates the value of the parent and caregiver perspective.

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APPENDIX A
SYSTEM OF CARE PRACTICE REVIEW

DEMOGRAPHIC INFORMATION

1. Name of Child: _____
2. Date of Review: _____
Year Month Day
3. Date of Birth: _____
Year Month Day
4. Child's Age: _____
5. Gender: Male _____ Female _____
6. School Grade: _____
7. Race:
 1. White _____
 2. Black/African-American _____
 3. Asian/Asian-American _____
 4. Pacific Islander/Native Hawaiian _____
 5. Hispanic/Latino _____
 6. Native American/American Indian _____
 7. Multi-Racial _____
8. Child's Language(s):
 1. Child's Primary Language: _____
 2. Child's Preferred Language: _____
 3. Language(s) spoken at home: _____

9. Who makes up the child's immediate family? (circle ALL that apply)

1. Biological Mother	6. Foster Father	11. Paternal Grandfather
2. Biological Father	7. Sister	12. Maternal Grandfather
3. Stepmother	8. Brother	13. Adoptive Mother
4. Stepfather	9. Paternal Grandmother	14. Adoptive Father
5. Foster Mother	10. Maternal Grandmother	15. Other Relative(s)
		16. Non-relative(s)
10. Child's Primary Caregiver (enter information only for the caregiver identified as Primary, even if more than one caregiver is interviewed).
 1. Name: _____
 2. Relation to child:

1. Biological Mother	6. Foster Father	11. Paternal Grandfather
2. Biological Father	7. Sister	12. Maternal Grandfather
3. Stepmother	8. Brother	13. Adoptive Mother
4. Stepfather	9. Paternal Grandmother	14. Adoptive Father
5. Foster Mother	10. Maternal Grandmother	15. Other Relative(s)
		16. Non-relative(s)
 3. Gender : Male _____ Female _____
 4. Race:
 1. White _____
 2. Black/African-American _____
 3. Asian/Asian-American _____
 4. Pacific Islander/Native Hawaiian _____
 5. Hispanic/Latino _____
 6. Native American/American Indian _____
 7. Multi-Racial _____
 5. Caregiver's Language(s):
 1. Caregiver's Primary Language: _____

	2. Caregiver's Preferred Language: _____ 3. Language(s) spoken at home: _____
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<p>11. Service Systems Utilized: (circle all that apply)</p> <table style="width: 100%;"> <tr> <td>1. Mental Health</td> <td>5. Developmental Disabilities</td> </tr> <tr> <td>2. Child Welfare</td> <td>6. Other _____</td> </tr> <tr> <td>3. Juvenile Justice</td> <td></td> </tr> <tr> <td>4. Educational</td> <td></td> </tr> </table>	1. Mental Health	5. Developmental Disabilities	2. Child Welfare	6. Other _____	3. Juvenile Justice		4. Educational		<p>14. Clinical Diagnosis:</p> <p>Axis I:</p> <p>Axis II:</p> <p>Axis III:</p> <p>Axis IV:</p> <p>Axis V: GAF:</p> <p>CASII Level: (as identified at the time sample is pulled)</p>
1. Mental Health	5. Developmental Disabilities								
2. Child Welfare	6. Other _____								
3. Juvenile Justice									
4. Educational									
<p>12. Treatment/Intervention: (circle all that apply)</p> <ol style="list-style-type: none"> 1. Individual Counseling 2. Family Counseling 3. Group Counseling 4. Substance Abuse Counseling 5. Psychiatric Medication 6. Family Support 7. Peer Support 8. Skills Development/Training 9. Respite 10. Home Care Training to Home Care Client (TFC) 11. Case Management 12. Psychiatric Hospitalization 13. Level I Residential Treatment 14. Level II Behavioral Health Residential 15. Level III Behavioral Health Residential 16. Other : _____ 									
<p>13. Length of treatment/intervention with agency participating in the study:</p>									

<ol style="list-style-type: none"> 1. 1-2 months 2. 3-4 months 3. 5-12 months 4. >1 year 5. >2 years 	
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Name/Role of Respondent: _____

Date: _____

DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided	
1A. INDIVIDUALIZED – The development of a unique service plan for each child and family in which their needs and strengths are assessed, prioritized and addressed across life domains.	
Read aloud to informant: Thanks for agreeing to participate in this review. I'm going to ask you a number of questions about the services that your child and family are currently receiving. I will ask you to describe the service planning and delivery processes, and also to share your opinions about the services and supports that are being provided. In the end, we will talk about the successes that your child and family have experienced so far. Do you have any questions? (answer any questions asked by the informant) Okay, then, first, I'd like to get a sense of what makes your child and family unique.	
STRENGTHS: CHILD	STRENGTHS: FAMILY
<ol style="list-style-type: none"> 1. Tell me a little bit about your child's strengths. <ul style="list-style-type: none"> • What do you like best about your child? • What are his/her interests? • What does he/she do well? 	<ol style="list-style-type: none"> 2. Tell me a little bit about your family's strengths. <ul style="list-style-type: none"> • What do you like best about your family? • What are its strengths?

CONCERNS: CHILD AND FAMILY	NEEDS: CHILD AND FAMILY
<p>3. Do you have any current concerns about your child or family? <i>If no concerns are reported ask:</i></p> <ul style="list-style-type: none"> • What were the concerns that caused you to get help for your child and family? 	<p>4. What are your child and family’s current needs? <i>If no needs are reported ask:</i></p> <ul style="list-style-type: none"> • What needs did your child and family have when you first started getting help?



System of Care Practice Review

<p>DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided</p>	
<p>1A. INDIVIDUALIZED – The development of a unique service plan for each child and family in which their needs and strengths are assessed, prioritized and addressed across life domains.</p>	
<p>ASSESSMENT METHOD</p>	
<p>5. Do the people who are providing your child and family with services and supports know about the strengths, concerns and needs that you have just described?</p> <ul style="list-style-type: none"> • How did they find out about them? • Did your child and family receive a thorough assessment or inventory? • Did you and your child help develop your family’s Strengths, Needs, and Culture Discovery? <p>Probe for formal/informal assessment across full range of life domains:</p>	<p>6. When we think about a thorough assessment of all the areas of a child and family’s life, we think about all of these areas: <i>(Hand primary caregiver List of Assessment Areas on page 113)</i></p> <p>Did the assessment process to identify your child and family’s needs and strengths seem to cover:</p> <p>___ all of these areas ___ some, but not all areas or ___ just a few areas</p> <ul style="list-style-type: none"> • Did your child and family develop a crisis plan? • Have you and your child reviewed it with your team?

	<p>Explain:</p>
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<p>DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided</p>	
<p>1A. INDIVIDUALIZED – The development of a unique service plan for each child and family in which their needs and strengths are assessed, prioritized and addressed across life domains.</p>	
<p>SUMMARY OF CURRENT GOALS AND SERVICES</p>	<p>IF NO EVIDENCE OF INFORMAL HELPERS/NATURAL SUPPORTS</p>
<p><i>For the following section, review the Summary of Goals, Services, & Supports (page 11) that was created during the Document Review and revise as needed, based on feedback from primary caregiver.</i></p> <p><i>Consider the following questions to guide the review:</i></p> <p>7. Let's review this summary together to make sure it accurately reflects your understanding of the current goals, services, and supports that are being provided to your child and family. Are these the goals your child and family have set?</p> <ul style="list-style-type: none"> • Are any of the listed services/support not actually being delivered as described? • Are there any additional formal services that are not reflected in this summary? • Are there any informal/natural or community supports that are not reflected in this summary? <p><i>Record any additional services and supports on pg. 11.</i></p>	<p><i>If no informal helpers/natural supports are identified on the Summary of Goals, Services, and Supports, ask:</i></p> <p>9. Have you been asked if there are relatives, friends, or neighbors who help or might be able to help your child and family? Yes___ No___</p> <ul style="list-style-type: none"> • Do you want to involve these people in the formal services that your child and family are receiving? Yes___ No___ • Have these people been contacted and asked to help out? Yes___ No___ • Are any of these informal helpers/natural supports involved in the formal services that your child and family receive? Yes___ No___ • In which services is each informal helper/natural support involved?

IF NO EVIDENCE OF A FORMAL PLAN	
<p>8. If there is no evidence of a formal plan in the records ask:</p> <ul style="list-style-type: none"> • Is there a plan that identifies specific services and supports to address specific goals? Yes___ No___ • Are all the providers (including mental health, school, medical, and others) working from the same plan? Yes___ No___ • Are plans coordinated to reflect family and system goals? Yes___ No___ 	<ul style="list-style-type: none"> • If no informal helpers/natural supports are involved: What are the reasons that informal helpers/natural supports are not involved in the formal services?



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<p>DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided</p>
<p>1A. INDIVIDUALIZED – The development of a unique service plan for each child and family in which their needs and strengths are assessed, prioritized and addressed across like domains.</p>
<p>Read aloud to informant: Now let's talk about how the service plan relates to the needs and strengths you described earlier.</p>
<p style="text-align: center;">SERVICE GOALS</p>

<p>10. Do the service plan <u>goals</u> reflect the <u>needs</u> that you identified for your child and family? (Reference goals on pg. 11 and restate needs if Primary Caregiver forgets them) Yes ___ No ___ If yes, how?</p> <p>If no, what is missing?</p>	<p>11. Can you tell from these goals what your child and family's strengths are? (Restate strengths if primary caregiver forgets) Yes ___ No ___ Explain:</p> <p>11a. Do you believe the strengths of your child and family are acknowledged in other ways? (For example, are providers strengths-based in their interactions with you and your child?) Yes ___ No ___ Explain:</p>
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For summative ratings, consider goals listed on page 11.

SERVICE TYPES

Now let's focus on the types of services that your child and family are receiving. (Refer to the Summary of Goals, Services, & Supports that was created during the Document Review and emphasize "service type" column.)

12. Do you think your child and family are getting the kind of help you need right now?
 Yes ___ No ___ What would you change?

SERVICE INTENSITY

<p>13. Do you think the current combination of services and supports is too intense, not intense enough, or just right for your child and family? ___ Too intense ___ Not intense enough ___ Just Right Explain:</p>	<p>14. Do you think the amount of interaction that service providers have with your child and family is too intense, not intense enough, or just right? ___ Too intense ___ Not intense enough ___ Just Right Explain:</p>
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DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided

1B. FULL PARTICIPATION – The child and family, along with formal providers and informal helpers/natural supports, participate in developing, implementing and evaluating the service plan.

Read aloud to informant: Now let's talk about the service planning process.

FAMILY PARTICIPATION

15. First, who are the people and agencies involved in the service planning process? List:

15a. How are your **child and family involved** in the service planning process?

15b. Over the past year, have you regularly attended meetings to talk about your child's needs, and to plan with primary case coordinators and other providers?

Yes ___ No ___ Explain:

- Have your child and family been involved in service plan reviews and updates since the initial plan?
- Are you asked what needs to be changed in the plan?
- Does the plan get updated promptly as your child and family's needs change?
- How comfortable do you feel when asking questions at these meetings?
- Do you feel like the people attending these meetings truly understand and are respectful of you and your child?

Yes ___ No ___ Explain:

15c. In your opinion, do your child and family seem to directly influence the final, formal plan that is developed and the goals that are set?

- How do you influence the plan and goals?
- Are your wishes included in the final, formal plan?
- Is your child asked about what he/she thinks is best for him/her?
- Were you able to choose services for your child and family?
Are there any good examples of this?

Yes ___ No ___ Explain:

15d. Do your child and family understand the plan?

- Was the plan explained to your child and family?
- Did you sign the plan?
- Was your family provided with a copy of the plan in the language you prefer?
Are there any good examples of this?

Yes ___ No ___ Explain:

15e. Are your child and family in agreement with and enthusiastic about the plan?
Are there any good examples of this?

<p>DOMAIN 1: Child-Centered and Family-Focused: The needs of the child and family determine the type and mix of services provided</p>	
<p>1C. CASE MANAGEMENT – Support is provided to the child and family to ensure that they receive services in a coordinated manner, that the type and intensity of services are appropriate, and the service plan is responsive to the child and family’s changing needs over time.</p>	
<p>Read aloud to informant: Now let’s discuss any help you receive to coordinate all of the services. Is there a specific person responsible for helping you get and coordinate the services for your child and family? Who is this person? _____ How long have you been working with this person?</p>	
<p>16. When was the last time this person met with your child and family?</p>	<p>17. Is this person helpful in coordinating the various services that your child and family receive?</p>
<p>18. Does this person have good working relationships with the other formal service providers and informal helpers/natural supports who are involved with your child and family? Yes ____ No ____ Please describe:</p>	<p>19. Does this person help to change the plan when you need new or different kinds of help? Yes ____ No ____</p> <ul style="list-style-type: none"> • If yes, in what ways? • If no, what more could he/she do?

20. Before this person, did anyone else help you coordinate services?
If yes, how helpful were they?



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DOMAIN 2: Community-Based: Services are provided within or close to the child’s home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers.

2A. EARLY INTERVENTION – Services are provided in a timely manner, before problems escalate, to prevent future emotional disturbances, maladaptive behaviors or serious negative outcomes. Services are provided in early childhood when risks are identified and/or as soon as problems emerge.

Read aloud to informant: Let’s talk about how your child and family were linked up with services and supports. For this section, please think about the period of time beginning when anyone from the current group of service providers first started working with your child and family.

21. How long did it take for the current providers to assess and clarify your family’s initial concerns and needs?

- Did the people working with your family figure out what you needed right away, or did it take them a while?
- If there were immediate crisis or safety concerns, were they identified and addressed?

22. Did they identify additional concerns or needs (e.g. crisis planning, transition concerns)? Yes___ No___

- How long did it take them to identify these additional concerns or needs?
- Did any of the providers suggest additional services or supports to address these concerns or needs?
- When did they make these suggestions?
- Was you family receptive?

<p>23. Once the providers clarified your needs, how long did it take before your child and family started getting help?</p>	<p>24. Do you think your child and family would be better off if you had received help sooner from systems of providers in the community? Yes____ No____</p> <ul style="list-style-type: none"> • What would be different if you received help sooner?
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<p>DOMAIN 2: Community-Based: Services are provided within or close to the child’s home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers.</p>	
<p>2B. ACCESS TO SERVICES – The child and family have access to a comprehensive range of services that are flexible enough for the child and family to integrate the services into their daily routines.</p>	
<p>Read aloud to informant: I have a few questions about access to all of these different services (<i>list the service types again here, page 11</i>).</p>	
<p>CONVENIENT TIMES</p>	<p>CONVENIENT LOCATIONS</p>
<p>25. Are the times when your child and family meet with the various service providers convenient for your child and family? Yes ____ No ____ Explain:</p>	<p>26. Are the locations of the meeting and services with your providers convenient for your child and family? Yes ____ No ____ Explain:</p>

	<p>27. Does your child and family need any support to increase your access to services? Yes _____ No _____ Explain:</p> <p><i>If yes:</i> Do you get the support you need? Yes _____ No _____ Explain:</p>
APPROPRIATE LANGUAGE	
<p>28. What is the primary language of your child and family? <i>Child:</i></p> <p><i>Family:</i></p>	<p>30. Is the written information provided to your child and family in your primary language? Yes _____ No _____</p> <p>Explain:</p>
<p>29. What language do the people who help your family speak when they meet with you?</p> <ul style="list-style-type: none"> • <i>If the language spoken is not the child or family's primary language:</i> What are the reasons for using this language (<i>instead of your family's language</i>) • <i>If the language spoken is the child or family's primary language:</i> If there is evidence the child and/or family needs additional support in order to understand and communicate with the people helping them (developmental needs, speech and language accommodations, etc.) was that support provided? • <i>If the child's primary language is not the same as that of the caregiver:</i> Are accommodations necessary and if so, are they provided? • Is the language used in communication with the family, "Family/youth friendly", free of professional jargon and easily understood? 	



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<p>DOMAIN 2: Community-Based: Services are provided within or close to the child's home community, in the least restrictive setting possible, and are coordinated and delivered through linkages between public and private providers.</p>
<p>2C. MINIMAL RESTRICTIVENESS – The child and family are served in as normal an environment as possible, in the least intrusive manner possible, so that families can continue their day to day routines as much as possible.</p>
<p>2D. INTEGRATION AND COORDINATION – There is coordination among providers, continuity of services and integration of components of the service system the child and family can easily move within and through the system.</p>
MINIMAL RESTRICTIVENESS

<p>31. Are you comfortable spending time in the places where your child receives services? Yes ____ No ____ Explain:</p>	<p>32. To what extent are the services for your child and family provided in the least restrictive, while also most appropriate environment(s) possible? • Are the service environments carefully matched to your family's needs and strengths, or are they limited to whatever is available?</p>
<p>INTEGRATION AND COORDINATION</p>	
<p>33. Does it seem like all of the people you've mentioned are working together to help your child and your family? Yes ____ No ____ Explain:</p>	
<p>34. How do the different service providers integrate and coordinate their work with each other? • Who gets involved in service planning and how do they participate? • Do the various service providers and informal helpers/natural supports directly communicate with one another between service plan updates? • How are your child and family involved in the communication that occurs among and between the different service providers/informal helpers/natural supports?</p>	<p>35. Does it seem like there is a smooth and seamless process to link your child and family with additional services as needs arise? • Transition issues (e.g., new school, new neighborhood, turning 18 years of age) Yes ____ No ____ Explain:</p>



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DOMAIN 3: Culturally Competent: Services are attuned to the cultural, racial, and ethnic background and identity of the child and family.

3A. AWARENESS – Providers within the system are aware of the impact of their own culture, the culture of the child and family, and cultural context in general on the delivery of services. Providers accept cultural differences and recognize cultural dynamics.

AWARENESS OF CHILD/FAMILY'S CULTURE	
<p>36. What is your culture?</p> <ul style="list-style-type: none"> • What does your family believe in? • What are your family traditions and celebrations? • Who do you think makes up a family (e.g. mother, father, siblings, grandparents, godparents)? • What does your family think makes a person healthy or sick? 	<p>37. Do the people working with your child and family seem to understand your culture as you just described it? Yes ____ No ____ Explain:</p>
<p>38. Do the people helping your family understand what things are like in your neighborhood?</p>	<p>39. Do the people working with your child and family seem to recognize and respect how your cultural background influences your preferences, decisions and participation? Yes ____ No ____ Explain:</p>
AWARENESS OF PROVIDERS' CULTURE	AWARENESS OF CULTURAL DYNAMICS
<p>40. Do your providers seem to recognize how their own cultural background influences their understanding, recommendations, and actions? Yes ____ No ____ Explain:</p>	<p>41. Do you believe they are aware of how cultural differences and similarities can influence how people get along and work together? Yes ____ No ____ Explain:</p>

<p>DOMAIN 3: Culturally Competent: Services are attuned to the cultural, racial, and ethnic background and identity of the child and family.</p> <p>3B. RESPONSIVENESS – Services are adapted to the cultural context of the child and family.</p> <p>3C. AGENCY CULTURE – The child and family are assisted in understanding the cultures of the agencies providing them with services, in terms of how the agencies and system operate, the rules and regulations and what is expected of them.</p> <p>3D. INFORMAL/NATURAL SUPPORTS – The family’s informal or natural sources of support are included in service planning and delivery. Service providers are knowledgeable about informal resources that may be used on behalf of the child and family and are able to access them.</p>	
<p>SENSITIVITY AND RESPONSIVENESS</p>	
<p>42. Do they seem to take your cultural background and identity into account when planning and providing services and supports for your child and family? Yes ___ No ___ Explain:</p>	
<p>AGENCY CULTURE</p>	<p>INFORMAL/NATURAL SUPPORTS</p>
<p>43. Does your family understand how the different agencies and organizations work (e.g. hours, regulations, service guidelines)?</p> <ul style="list-style-type: none"> • Did anyone explain Child & Family Team Practice to you and your family? Would you please describe this practice? Yes ___ No ___ Explain: • Have you received any help in order to better understand and navigate the various agencies and organizations? 	<p>44. Do all of the people that help your family know about all of the different activities that kids your child’s age can get involved with in your area? (This includes things like sports, clubs, churches/temples/mosques, and after-school activities.) Yes ___ No ___ Explain:</p>

Yes ___ No ___

Explain:

- Do you think your participation or decisions would be any different if your knowledge about the agencies and how they work was different?

Yes ___ No ___

Explain

45. Are they able to help you sign up for these activities?

- If no, what makes it tough for them to help you get connected with these activities?

Yes ___ No ___

Explain:

For summative ratings, also see # 28 - #30 (plans and services provided in preferred language)



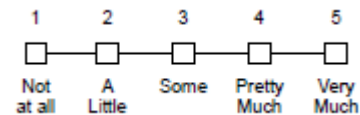
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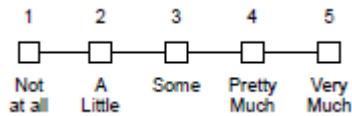
DOMAIN 4: Impact: The impact that services and supports have had on this child and family.

4A. IMPROVEMENT – Services that have had a positive impact on the child and family have enabled the child and family to improve their situation.

Read aloud to informant: The final questions relate to the impact that services and supports have had on your child and family. For the next 6 questions, please use the following 1-5 rating scale:

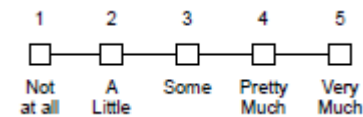


46. My child has made progress towards meeting his/her goals.



Explain:

47. My family has made progress towards meeting its goals.



Explain:

48. I am better able to deal with my child's problems.

1 2 3 4 5

— — — —

Not A Some Pretty Very

at all Little Much Much

Explain:

49. Services have improved my child's overall situation.

1 2 3 4 5

— — — —

Not A Some Pretty Very

at all Little Much Much

Explain:

50. Services have improved my family's overall situation.

1 2 3 4 5

— — — —

Not A Some Pretty Very

at all Little Much Much

Explain:

DOMAIN 4: Impact: The impact that services and supports have had on this child and family.

4B. APPROPRIATENESS - Services that have had a positive impact on the child and family have been appropriate for meeting the needs of the child and family.

51. I am satisfied with the coordination of services in this case

1	2	3	4	5
□	□	□	□	□
Not at all	A Little	Some	Pretty Much	Very Much

Explain:

52. What do you think has been most helpful about the services and supports provided to your child and family?

- Have services and supports helped in these areas?
 - Success in school
Yes ____ No ____
 - Living with the family
Yes ____ No ____
 - Staying out of trouble with the law
Yes ____ No ____
 - Progressing toward successful adulthood
Yes ____ No ____

53. What do you think has been least helpful about the services and support provided to your child and family?

54. Is there anything else you think would be important for me to know about your child and family or the services you have been receiving?

- Is there anything you think your community should know about what kids and families who live here need?
- What is working and what is not working for kids and families who live in your community?

For summative ratings, also see questions re: Service Type and Intensity (1A), Family Involvement (1B), Access to Services (2B), and Cultural Responsiveness (3B).

Thanks for taking time to talk with me! Is there anything you would like to ask me?