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An Evaluation of the Norfolk Interagency Consortium's Community-Based System of Care for At-Risk Youth

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AN EVALUATION OF THE NORFOLK INTERAGENCY CONSORTIUM'S COMMUNITY-BASED SYSTEM OF CARE FOR AT-RISK YOUTH

by

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ABSTRACT

AN EVALUATION OF THE NORFOLK INTERAGENCY CONSORTIUM'S COMMUNITY-BASED SYSTEM OF CARE FOR AT-RISK YOUTH

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The primary purpose of this research was to design and to implement an evaluation model for the Norfolk Interagency Consortium (NIC). The research design employed in this study focused on four areas of investigation: program clarification, processes and activities, outcomes, and cost. The study utilized qualitative and quantitative methods and procedures.

The program clarification stage of the research served as a pre-evaluative phase. An evaluability assessment was incorporated to define and clarify the NIC's program components and goals, and determine which goals were evaluable. Data regarding the target population also was collected.

The processes and activities investigation used a survey instrument adapted from the questionnaire, "Assessing Local Service Systems for Chronically Mentally Ill Persons". Survey participants included 149 NIC personnel. Participants assessed the organization's activities related to availability and accessibility and coordination of services and information. Respondents also provided information regarding NIC's challenges and accomplishments with regard to

at-risk youth. A series of ANOVAs indicated significant differences in the assessment of NIC activities by organizational levels.

The outcomes research included both client and community effects. Client effects were measured using a restrictiveness of living environment scale (ROLES). An overall restrictiveness score was calculated for 40 young people to give an indication of the NIC's ability to maintain or lower its clients' ROLES score over a period of three years. The ROLES scores were also used in a multiple regression analysis to determine if age, parent involvement, or previous out-of-home placements (POOH) could be used to predict a lowered ROLES. POOH reported a low, but significant predictive value ($\underline{R}^2 = .24$). The results of community effects indicated that the NIC has had a positive impact on developing a continuum of care in Norfolk and in encouraging agency integration.

Cost research employed survey instruments to examine NIC's fiscal practices and utilized ROLES scores in a correlation analysis with Virginia's Comprehensive Services Act (CSA) funds. The correlation results suggested a significant, but small relationship between ROLES and CSA funds.

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CHAPTER I

Introduction

Overview

Estimates indicate that half of the adolescents in this country, fourteen million young people, are in danger of not reaching adulthood as healthy and productive citizens (Dryfoos, 1990; Carnegie Council on Adolescent Development, 1989). Half of this large number of at-risk youth are considered to be in critical jeopardy for a variety of reasons, including family structure and stability, poverty, mental/emotional health, and drug and alcohol use (Carnegie Council on Adolescent Development, 1989). As many as a million young people annually become runaways or are homeless (Rothman, 1991). Of these transient young people, 75 percent engage in criminal activity and 50 percent become involved in prostitution. While this large number of at-risk youth poses critical problems for our country, alleviating their problems is challenging. This chapter will discuss the challenge of effectively assisting these young people and the potential ramifications of not addressing their needs and the needs of their families. In addition, this chapter will examine comprehensive systems of care (CSCs) as a delivery model for interventions to troubled youth, identify the theoretical basis for these systems of care, and focus on a

local CSC, the Norfolk Interagency Consortium (NIC).

Background

In reflecting on the difficulties at-risk youth face, Maya Angelou wrote the following:

> Having tried, like most people, so desperately to grow up, and like most people, having failed miserably and miserably often, I am convinced that emerging from the chrysalis of youth as a whole loving adult is the first and greatest challenge which faces the human being... (Angelou, cited in Edna McConnell Clark Foundation, 1985, *intro.*)

Ms. Angelou's poignant reflection regarding the challenge of growing up seems well supported with empirical evidence. Not only are there a large number of youth with varying emotional, mental, physical, and social problems, there are few organizations or systems designed to meet their specific needs. In addition to the lack of systematic care, there is a paucity of trained professionals available to work with this age group. While 30 percent of our population are under 18, The American Psychological Association calculates that, excluding school psychologists, less than one percent of psychologists are devoted primarily to serving children (as cited in Knitzer, 1990). This lack of personnel and resources have prompted estimates that sixty-six to seventy-five percent of youth with critical needs receive either no services or inappropriate treatments (Joint Commission of Health of Children, 1969; President's Commission on Mental Health, 1978; Knitzer, 1982; U.S. Office of Technology Assessment, 1991).

Concerns for these troubled youth and the lack of appropriate services prompted the establishment of categorical programs directed at alleviating specific situations such as school dropouts, teenage pregnancy, substance abuse, child abuse, homelessness, and suicide. While these single-issue programs have not been futile, their fragmented services have affected little positive impact on the complex and interrelated problems of at-risk youth (Dryfoos, 1990; National Research Council [NRC], 1993; Repetto, 1990; Rothman, 1991; Schorr, 1995).

The lack of success from these isolated programs has forced communities to consider other treatment alternatives. In a discussion of alternative services, the National Center for Service Integration [NCSI] (1995) stated:

> There is a growing understanding of the need for comprehensive, cross-system, and collaborative strategies to achieve success where current systems fail. No one agency, department, or intervention alone can guarantee success over the spectrum of desired outcomes for families and children it serves ... Individual responsibility for achieving separate, specific objectives must give way to collective responsibility for achieving broader outcomes (p. 5).

Recognizing the need to coordinate their services to at-risk children and address the complex, broader issues, many communities have developed and implemented an integrated model of service delivery. This new service integration model has been manifest most widely in an inter-agency organizational structure referred to as a comprehensive system of care (CSC). CSCs operate through the combined efforts of local human resource agencies

including schools, social service agencies, community mental health boards, juvenile court systems, and public health centers. These agencies, in various collaborative arrangements, provide a wide range of services created to address the physical, emotional, social, and educational needs of at-risk youth and their families. While varying in design and format, CSCs emphasize providing treatments and services in the least restrictive environment, preferably the child's home or community (Stroul and Friedman, 1994).

Yelton (1991) notes that providing services in the least restrictive environment marks a paradigm shift, particularly in the way "mental health services are traditionally delivered" (p. 7). She further states that the change in delivery has been accompanied by a change in treatment expectations. Rather than seeking a "cure", case workers and clinicians are focusing more on stabilizing the family through improved adaptive skills, inter-family relationships, and community support. Strengths of participating families are analyzed and individualized interventions are planned collaboratively by professionals and family members. These individualized services are essential due to the range of needs and diversity of children and families. Services may include treatments and/or services to the at-risk child, his parents or other adults residing in the household, and siblings.

While widely considered the most appropriate service delivery system for at-risk youth, the genesis of CSCs is a fairly recent phenomenon. According to Weiss (1988),

family-oriented programs have only been in existence since the late 1960's and first were employed to assist families who had children with mental health problems. The Community Health and Mental Retardation Facilities Construction Act of 1963, which mandated deinstitutionalization and community integration of people with developmental disabilities, may have prompted the need for community-based, family-oriented service models (Mallory & Herrick, 1987).

In an examination of contemporary U.S. systems of comprehensive care, Stroul & Friedman (1994) noted that while no single model has been identified as an ideal or standard, there is widespread agreement in both literature and practice regarding the values and philosophy which CSCs should exemplify. These authors identified three core values which epitomize the philosophical framework of this service integration model. The values are: 1) Being child-centered and family-focused; 2) Providing services in a community setting, preferably the child's own home; and 3) Understanding and honoring cultural differences.

While these core values were created from input by those actively engaged in work with CSCs, there is also a strong theoretical basis for their existence. This theoretical foundation can be found in the works of Bronfenbrenner (1979), Minuchin (1974), and in the field of Social Science.

Bronfenbrenner's ecological perspective, based on the theories of Piaget's concepts of accommodation and

assimilation, stated that a child and his environment interact with each other. In The Ecology of Human Development, Bronfenbrenner stated that this interactional environment included both the immediate social context (family, school, friends, etc.) and the larger social network (neighborhood, parent's work place, cultural mores, etc.). As either the child or the environment changes, the other must accommodate to that change to maintain an ecological balance. Because of this strong inter-relationship, those who wish to assist and to support children must intervene with both the child and their surroundings. To isolate a child and provide treatment apart from family and community is to treat only a portion of the problem. Bronfenbrenner not only argued against interventions which failed to acknowledge this ecological relationship, but implied that "helping a child outside her context is not only impractical, but may do as much harm as good" (Dym, 1988, p.479).

Since the early 1960's, family therapists have also advocated an ecological approach through the practice of Structural Family Therapy (SFT) (Dym, 1988). Minuchin, a leader in SFT research, has investigated the inter-relationship in families and the corresponding need for accommodation between children, their families, and changes in their environment. According to Minuchin (1974), therapists should diagnosis a family's interactions and specify interactional patterns of behavior. Negative patterns of behavior, those which interfere with individual

family members' developmental processes, are identified and targeted for treatment during interventions. As with Bronfenbrenner's ecological theory, SFT recognizes the need to deliver all services in the context of the family setting. Dym (1988) stated:

> Whereas traditional child therapy minimized the importance of cultural imagery, norms, institutions, and community networks, and tried temporarily to isolate the patient from his environment, SFT saw family and community linkages as providing both understanding of the child's behavior and leverage for his treatment (p.481).

According to Mawhinney (1994), "variations of SFT have been widely applied in family service programs, and have provided the foundation for the more recent development of ecological theories of family interventions" (p. 36).

In the field of Social Science, the core values of CSCs theoretically are supported by the General Systems Theory (van Gigch, 1974). This theory uses the analogy of a "system" to assess and to interpret families. According to Hartman and Laird (1983), a system is "a whole that is composed of interrelated and interdependent parts ... A change in one part of the system affects the system as a whole and all of its parts" (pp. 62-63). Biological systems have boundaries and are either open or closed. Open systems are healthy and growing because their boundaries are permeable and allow the transfer of matter and energy. Closed systems have closed or restricted boundaries which allow little life-giving energy to flow between themselves and their external environment.

In General Systems Theory, these system

characteristics are applied to families. Families, like systems, are comprised of parts which have an impact on each other. "Even a minor change in the family's environment or in one individual's behavior or communication may reverberate throughout the family system" (Hartman & Laird, 1983, p. 73).

"Open" families are those that will accept information and support, thereby allowing themselves the potential for growth and change. These families have a degree of what Cannon (1932) called homeostasis, or balance (Hartman & Laird, 1983). Meaningful assistance helps the family unit achieve or maintain this stable condition.

"Closed" families, on the other hand, are familial groups who are isolated. This isolation may be due to environmental factors such as age, income, or social status. Lack of interaction with the external environment inhibits opportunities for growth, change or stability.

To affect change on a system, one must recognize and understand the system's interrelated parts and the degree of interaction the parts have with the whole, as well as the interaction the whole has with its environment. Correspondingly, an individual "cannot be understood outside the context of the ... family; and a family can be understood only in the context of the larger environment" (Hartman & Laird, 1983, p. 70).

Theoretical work which supports the three CSC core values also can be identified in the work of educational researchers such as Comer (1980) and Crowson

and Boyd (1993). In examining the relationship between families, schools, and communities, these investigators contended that successful development is predicated on the need to integrate the child and his total environment.

The tenets of these ecological theories support the operational foundation of CSCs and have been widely incorporated into its practices. A continuum of care, featuring varied service options, is utilized to maintain the child within the home. When it is not possible to keep the child with his parents, an array of family-related service options are employed to provide a setting analogous to a family/community environment. These service options facilitate intervention in a less restrictive environment than traditional residential placements.

NIC, like other CSCs, seeks to reduce residential placements and maintain its clients in the least restrictive living environment. One of the components of this study will assess this organization's effectiveness at decreasing the restrictiveness of living environment scores (ROLES) for at-risk youth in its program.

The Norfolk CSC Experience

Norfolk, Virginia, with its population of 261,000, is part of Hampton Roads, a region which is the 29th largest metropolitan area in the country. Of the six cities that comprise this region, census data indicated Norfolk has the lowest mean family income. This statistic is related to the fact that, of surrounding municipalities, Norfolk has the

highest percentage of single female-run households and the greatest percentage of children under the age of five.

Approximately 19 percent of all people in Norfolk live below the poverty level. Additionally, 55 percent of female-headed households with related children and nearly 33 percent of the African American population live below the poverty level. Norfolk also has a large, young Navy population which live at or near poverty levels (Stroul, Lourie, Goldman, and Katz-Leavy, 1992).

This low socioeconomic population creates a demand for a variety of human services, including many services related to at-risk young people. Because the various public and private service options operated independently, a child with multiple needs might receive treatment from several agencies and vendors. This fragmented service delivery led to competition, overlapping treatments, and neglect to children who were misplaced or overlooked in the transfer of paperwork (Stroul, et al., 1992).

In 1987 and 1988, "community leaders were disillusioned by the fragmentation of services and by the fact that there had been a startling, related growth in the use and cost of residential services by child welfare and juvenile justice clients" (Stroul, et al., 1992, p. 31). In 1988, the City Manager's office and the Virginia Treatment Center for Children worked together to design a community-based system of care for severely emotionally disturbed children and adolescents. The Chief Judge of the Juvenile and Domestic Relations Court mandated an inter-

agency meeting of local child-serving public agencies, including Juvenile Court Services, Social Services, and the Community Services Board. After this initial mandatory meeting, this group, called the Ad Hoc Planning Committee, continued discussions regarding the need to create new services for at-risk youth, as well as the need to integrate the efforts of established programs.

These needs became acutely apparent in February, 1989, when The Division of Youth Services' High Risk Indicator Report revealed that Norfolk had the second highest number of youth in poverty and of adolescent pregnancies in Virginia. The city was also third in the state for number of delinquent and child-in-need-of-services petitions and fourth in both school dropouts and founded child abuse complaints (Norfolk Youth Network, 1993). Realizing no agency alone could provide an adequate response to the spectrum of problems these statistics revealed, the Ad Hoc Committee sought both to expand and to integrate services.

In 1989, the Norfolk City Council gave the Ad Hoc Committee a grant of $200,000 to develop new services for at-risk children and their families. At the same time, the committee was also seeking funding from the Robert Wood Johnson Foundation (RWJF), which provided monies for the creation and implementation of CSCs and new services. Although their grant application to RWJF was denied, the grant process helped the committee conceptualize a formalized system of care and identify service needs. As a result of the grant-seeking process, the Ad Hoc group

decided to use the $200,000 to establish intensive in-home treatment programs. Because this new service helped all agencies involved with their respective populations, "the service became 'ours' rather than 'mine'", (Stroul, et al., 1992, p. 32).

The grant process and the joint decision making regarding city funds created greater consensus between agencies within the Ad Hoc group, helped define committee members' vision for a formalized system of care, and affirmed the need for more family-oriented, community-based services (Stroul, et al., 1992). As a result, on June 16, 1989, committee members signed an inter-agency agreement creating the Norfolk Youth Network (NYN).

The NYN combined the six major child-serving agencies in the city in a formal agreement to provide services to at-risk youth through interagency collaboration. The six agencies were: Norfolk Public Schools, Norfolk Community Services Board, Norfolk Juvenile Court Services, Norfolk Division of Social Services, Norfolk Health Department, and the Norfolk Juvenile Services Board.

The newly formed NYN had two levels of operation: the Norfolk Interagency Consortium (NIC), which was responsible for administrative and operational decisions and Community Assessment Teams (CATs), which facilitated service delivery. NIC was staffed by the administrative heads from each of the participating agencies while CATs were composed of middle level agency representatives, who held supervisory or Master's level positions. In 1993, NYN

changed its organizational structure to include a third level, the Recommendations Review Board (RRB).

This middle management tier is composed of senior representatives from each of the participating agencies. Their primary task is to serve as a "gatekeeper" for out-of-home placements. While CATs may recommend out-of-home care, approval for these placements must come from the RRB. The RRB meets twice a month to review the cases of young people who have been recommended for out-of-home placement and those youth currently in out-of-home placements. Their goal is to design a treatment plan which will serve the child in the least restrictive environment.

Agencies demonstrated their commitment to this collaborative effort by donating the monthly time their personnel spent in the NYN process. In addition, before monies were available for paid staff, the Norfolk Public Schools donated a half-time position to serve as a coordinator of the NYN.

In 1990, the NYN was selected to serve as a state demonstration site. Virginia, desiring to investigate the feasibility and effectiveness of interagency systems, had selected five localities and awarded them grants to establish CSCs. These funds made it possible for the NYN to expand services to include transitional home-based services, intensive probation, therapeutic respite, therapeutic family homes, and a preschool prevention program. The expansion of services and new approach to service delivery was positive. Stroul, et al.(1992) stated:

> The Network has allowed workers at all levels in community agencies to work together and to share resources for those families who, in the past, had been served inadequately. Not only has this coordination and integration of services benefited children and families, but it has improved morale in the involved agencies (p. 33).

Encouraged by the initial findings of demonstration grant sites such as Norfolk, the Commonwealth of Virginia adopted the Comprehensive Services Act (CSA) for At-Risk Youth and Their Families. According to the Virginia Acts of the Assembly, Chapter 880, the intent of the CSA is to "create a collaborative system of services and funding that is child-centered, family-focused, and community-based." Its purposes are to:

> Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public; and Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes (2.1-745).

This legislation, passed in 1992, seeks to accomplish its purposes by the formation of collaborative, interagency teams within each locality. These teams are comprised of representatives of the local Social Services, Juvenile Court Services, Public Health, Community Service Boards, parents, private care providers, and school systems. Categorical funding from four state agencies is pooled for distribution to the localities on a formula basis.

With the inception of the CSA, the NYN initiated administrative reorganizations to align itself with state

requirements. As part of this reorganization, the name, Norfolk Youth Network, was eliminated and the title of their administrative level, Norfolk Interagency Consortium, was adopted as the system's title. Agencies still donated their employees' time to all three levels of the NIC, but matching local funds made it possible to employ one full time executive director, a network coordinator, and clerical staff.

Although most young people who enter the NIC process have received services from various agencies, one of the six participating agencies assumes responsibility for initiating referral. Participating NIC agencies are required to hold an "in-house" meeting on each child referred to confirm the child's eligibility. A common intake form, used by all agencies for NIC referral, provides information regarding the child, their family, and the presenting problems (see Appendix A). Once a referral is received and accepted by the network coordinator, the child is assigned to one of 11 CATs. While this assignment is usually on a random basis, there are two CATs designated for specific cases. CAT Nine handles all juvenile justice cases committed to the Department of Corrections. CAT Eleven manages clients who have been identified as special education youth and require private educational placement.

Cases are presented to CATs by the agency personnel who is familiar or currently engaged with the child and family. This agency person often becomes the child's case manager. NIC's system of case management is a brokerage

arrangement whereby the case manager does not provide direct services, but purchases, arranges, and monitors services with private and public vendors.

Once a child has an established treatment plan, the case manager is responsible for ensuring appropriate services are contracted and received. CATs schedule follow-ups on every child to review the effectiveness of interventions and modify the intervention plan as deemed necessary. Cases which may require some form of out-of-home placement may be referred to the RRB for further consideration.

The program theory of NIC is that the synergy created in its interagency system will enable its personnel to maintain or lower the ROLES of their at-risk clients. It is assumed this ecological perspective provides the most appropriate and effective treatment option.

Statement of the Problem

As previously stated, there are fourteen million young people in the US at-risk for not reaching adulthood as healthy and productive citizens. This large number of troubled youth and their families has become a critical issue for our nation. Not only will this country be affected by the potential human loss, but by an increased demand for funding and services in areas such as remediation and protection (Marshall, 1991). In a discussion of the national repercussions of at-risk youth and families, Marshall stated that, "It is vitally

important for economic and social policy makers to recognize that the quality of a nation's human resources depends significantly on what happens to its families ... the economy [of our country] and the well-being of families are inextricably linked in a close, symbiotic relationship" (p. 1).

Recognizing the seriousness of untreated families and youth, contemporary professionals have shifted from the use of single programs and agencies to a comprehensive, interagency system of care. CSCs not only provide a network of services, but a philosophy about how services should be delivered. They are regarded widely as the most appropriate means to facilitate interventions to at-risk young people and their families (Alper, et.al., 1994; Dryfoos, 1990; NRC, 1993; Repetto, 1990; Stroul,1993).

The problem is that while CSCs are considered the premier way to provide treatments to at-risk children, there is limited knowledge regarding their effectiveness (Friedman, 1994; Bickman, 1995). The acceptance of this interagency model of service delivery has been so rapid, program evaluation has not kept pace with program development (Cannon, 1993).

The lack of empirical evidence regarding CSCs is serious. Millions of families and children are dependent upon the ability of CSC professionals to provide assistance for their explicit situation, yet little is known regarding the efficacy of specific theoretical assumptions, system structures, processes, or procedures.

The lack of empirical data is also a problem at NIC. While there have been assessment efforts, NIC never has participated in a formal program evaluation. The investigations which have been conducted include NIC's participation in a statewide evaluation conducted by the Virginia Department of Mental Health, Mental component Retardation, and Substance Abuse Services (VDMHMRSAS). While this was an extensive evaluation, much of the data analysis was performed on aggregated numbers and information from six locations across the state. In addition, this study was undertaken from 1990-1993 while NIC was a demonstration project and program changes have occurred since that time.

In 1994, NIC participated in a study entitled, "Report on the Gaps in Services available to the NIC". The purpose of this research, completed by the Norfolk Office on Youth and the Norfolk Youth Services Citizen Advisory Board, was to identify the service options which are most needed to support a continuum of care for at-risk youth in Norfolk.

In April, 1994, an evaluator was engaged to assist NIC in establishing organization policies and procedures. This evaluation endeavor resulted in the creation of a manual which currently guides NIC in maintaining standards and consistency in administrative functions.

The purpose of this research is to provide a comprehensive program assessment which will extend previous research and examine components of NIC which have not been evaluated. Results of the study will provide both formative

and summative information. Evaluation questions and criteria have been established collaboratively by the researcher, NIC personnel, interagency staff who are involved in various levels of the NIC structure, and stakeholders at both the state and local level. The evaluation design is closely aligned with a model developed specifically for CSC assessment known as, "The Five-Tiered Approach to Evaluation" (Jacobs, 1988).

Purpose of the Study

The purpose of this study was to develop and implement an evaluation model to examine the effectiveness of a local CSC, the Norfolk Interagency Consortium. The research focused on four areas of assessment: program clarification, process, outcomes, and cost factors.

The program clarification phase included an evaluability assessment (EA) and an identification of the characteristics of the participating NIC population. The process phase examined the efficacy of NIC's activities in the areas of availability and access to service and coordination of services and information.

The outcomes study focused on NIC's progress toward accomplishing its objectives and goals. Only those objectives and goals which were determined to be measurable by the EA were examined. Indicators which were used to evaluate goals focused on individual client progress and community impact. Individual progress was measured by examining the overall restrictiveness of living environment

score (ROLES) of NIC clients. Community impact was measured by examining the development of a continuum of care and interagency integration. The final area of investigation, cost factors, sought to determine the relationship between CSA funds and client ROLES, as well as evaluate the fiscal management practices which have been established to ensure efficient use of funding.

Significance of the Study

In The State of Families, 3, Marshall (1991) noted that "the family, like the surrounding economy and society, is much less stable than it was earlier in this century" (p. 3). Marshall's premise that families are unstable and at-risk is a concern that is being repeated by many professionals associated with youth and family services (Friedman, 1993; Kagan, et al., 1987; Bradley, 1992; Dryfoos, 1990; Carnegie Council on Adolescent Development, 1989). In 1994, the National Center for Service Integration not only reiterated concerns regarding the current state of families, but revealed that trends indicated children and families will continue to be at risk for experiencing "poor outcomes" (p. 5). Knitzer, who has studied at-risk adolescents for over two decades, corroborated NCSI's statement by her observation that "childhood is increasingly a time of distress" (1993, p. 8).

There is a growing body of data which substantiates these negative perspectives regarding at-risk children and their families. Friedman (1994a) stated that mental health

disorders in adolescents appear to be increasing with each successive generation. Earls (1989) reported that young people in the U.S. are experiencing earlier onsets of several clinical problems such as bipolar disorders, depression, alcoholism, and anorexia and have higher rates of completed suicides. Kagan, et al. (1987) added that deleterious changes in family restructuring and organization have heightened anxiety over the wellness of the family and the nation.

In addition to the social tragedy of troubled families and children, the economic costs to our country are great. Marshall (1991) asserted, "In a technologically sophisticated world, people will either be economic assets or liabilities. Healthy, educated, motivated people are virtually unlimited assets, but people without these characteristics are likely to be serious economic liabilities" (p. 2).

Recognizing the serious, inherent consequences of untreated at-risk youth and families has motivated federal, state, and local governments to develop new perspectives regarding interventions and services for this population. Many of these government entities have combined the efforts and resources of their child and family human service agencies to create comprehensive systems of care. These CSCs utilize inter-agency collaboration and individualized community-based treatment to address the critical needs of at-risk families.

While this service delivery model has been embraced

nationally, there is little empirical information to affirm, to inform, or to guide the leaders in the CSC movement (Friedman, 1994; Bickman, 1995). Because this model is the primary mechanism currently used to address the needs of at-risk youth, the evaluation and assessment of CSCs is significant.

One of the reasons this assessment is important is to enhance human service professionals' ability to address the problems of at-risk youth and their families. When CSCs are cognizant of strategies or vendors which may be effective, it will strengthen their capacity to readily provide appropriate client services. Expeditiously employing successful strategies is crucial not only because of the current critical needs of young people and their families, but because of the potential cost of untreated adolescents to our country in the future.

Second, this investigation is important because it will add to the body of knowledge regarding systems of care, particularly Virginia's CSA Model. This comprehensive program evaluation will yield both process and outcome information. The data regarding process will promote program efficiency by giving feedback on potential service obstacles. Outcome data will provide NIC with measurable information regarding the impact of their current programs. This combination of data will assist program leaders in assessing the overall effectiveness of their organization.

Third, this evaluation is timely for Norfolk because of the phenomenal increase in the numbers of children

needing assistance. Larger than expected numbers of at-risk children nationwide have created concerns regarding CSC program efficiency. Friedman (1995) contended that CSCs were established on the assumption that the number of children needing their specialized services would be small. He also stated that it was anticipated the problems of at-risk youth would be well-defined, readily treatable in a system of integrated services and a continuum of care. In contrast to expectations, there are an extensive number of youth requiring CSC assistance and their problems are extremely complex. Due to the unanticipated quantity of young people, as well as their complicated circumstances, Friedman stated that systems of care have "been unable to keep pace" and are engaged in "efforts to bring about major reform in virtually every system serving children and families" (pp.7-8).

NIC, like systems nationwide, will need to reexamine its program goals and components to determine the adequacy of their model for the population they serve. The comprehensive data generated from this study will help NIC program directors assess the total organizational system and its effectiveness on the growing number of at-risk children in their program. Information generated included data regarding the type of client NIC serves, the number of new cases annually, and referral sources.

A fourth reason this evaluation model and its findings are significant is related to Virginia's 1992 Comprehensive Services Act for At-Risk Children and Their Families. This

act mandated that all localities within the state create an inter-agency system of care for at-risk children. It is unknown if these newly formed CSCs are operating effectively or if the desired outcomes are being affected. This evaluation may serve as a prototype for either the state or other localities in the state who desire an assessment tool.

A fifth reason assessment of CSCs is significant is related to funding concerns. In the federal government's current efforts to balance the budget, government funds for all areas are being scrutinized. Because of this, many social service programs are at-risk for funding losses. To justify their existence and continued support, programs will increasingly be required to provide empirical data demonstrating attainment or movement toward goals and objectives.

Cost data is particularly critical for CSCs because a primary reason they gained immediate, widespread support, particularly among policy-makers, was because they were believed to be cost-efficient in both short and long term measures (Friedman, 1995; Knoll, et. al.,1992). The current unanimous support for this service delivery model is likely to wane if CSCs are no more effective than traditional intervention methods or, as Bickman (1995) suggested, they are more costly than traditional service providers. Information regarding program effectiveness and cost analysis will most certainly impact state and national funding sources.

Funding concerns are also important in considering program efficiency. "The pattern of diminishing resources for human services in this country heightens the need for prudent expenditure of available funds" (Powell, 1987). Distinguishing program features which produce desired outcomes or improved service will help CSCs utilize budgetary monies more judiciously.

A sixth reason CSC program evaluations are significant is because they may influence decisions regarding family-related policies. Due to the previously stated relationship between our country's economic state and the health of families, federal, state, and local governments are interested in constructing or identifying policies and legislation which support and sustain the family and are cost-effective. Weiss (1988) stated that if systems of care are not to be just another "short-lived and faddish panacea for social ills" (p. 4), CSCs evaluations must provide information which is relevant to policy-makers. Assessments should recognize the political players as a valuable stakeholder and include their concerns in evaluative efforts.

A seventh reason this evaluation is important is the need to increase public awareness of family issues and the efforts of family-oriented systems of care. Program evaluations, such as this, focus greater attention on both the needs of families, the importance of the community, and the innovative endeavors in this field. Evaluation findings may provide data which will facilitate greater

understanding of the needs of at-risk families and generate increased local involvement and community advocacy for familial issues.

An eighth reason CSC program evaluations are substantial is related to women. Most at-risk youth are in single parent families and these single parents are primarily women (Marshall, 1991). Identifying ways to help CSCs strengthen and support these single parent families is of consequence to feminine issues.

Last, while the problems of at-risk youth and their families present a significant challenge to our nation, urban areas experience this challenge most acutely. These metropolitan districts have higher rates of school dropouts, child neglect and abuse, homelessness, drug and alcohol addiction, and poverty than do their suburban and rural counterparts (NRC, 1993). Friedman & Hernandez (1993) stated that while there are families in need across our country, the expansive needs of the nation's inner-cities are critical. Investigations such as this may be particularly vital to urban areas in their efforts to develop services and delivery models which address the extensive needs of their large at-risk populations.

Research Design

The intricate characteristics of CSCs can be challenging for evaluators. These systems are comprised of numerous stakeholders, system levels, and agencies, each with varying modes of operation and service paradigms.

Intervention delivery is also complex because clients and their families receive multiple treatments, by different providers, for varying time frames, in more than one environment. It is difficult to identify dependent or independent variables, and even more difficult to suggest causality. In discussing these research challenges, Knapp (1995) noted that, "given limited knowledge about these complex interactions, they will best be understood through studies that are strongly conceptualized, descriptive, comparative, constructively skeptical, positioned from the bottom up, and (when appropriate) collaborative" (p.5).

The NIC Evaluative Model created for this evaluation combined Knapp's suggestions with components of a five-tiered evaluation model created by Jacobs (1988). Although the Jacob's model had five tiers, this evaluation did not incorporate her preimplementation phase as the NIC had been in operation for several years. The remaining four tiers served as a guide in the formation of the structure of this evaluation.

In addition, the NIC Evaluation Model incorporated four of Jacob's (1988) assumptions regarding program evaluation. These assumptions are: (a) evaluations should contain program data which systematically is collected and analyzed; (b) evaluation is essential to all programs; (c) assess only those programs components which are well established and ready to be evaluated; and (d) evaluations should be useful to the stakeholders.

In an effort to address these assumptions, the

researcher made on-site visits and observed all NIC processes, conducted focus groups with members from various levels of the NIC organization, and interviewed stakeholders at both the state and local level. Additional input was solicited from the Research and Training Center for Children's Mental Health, University of South Florida; and the Research and Evaluation Center in Richmond, Virginia.

Concerns and information needs which emerged from these various interactions with stakeholders were translated into research questions. These research queries were examined for feasibility in regard to the data available and the components of NIC which were well-defined, established, and evaluable. The research questions which resulted from this initial investigation included both quantitative and qualitative inquiries and were grouped into four categories. Hypotheses were formulated for questions where appropriate. Table 1 depicted an overview of all four areas of this evaluation research.

Program Clarification

The first research category was program clarification (PC). The purpose of this group of questions was to accurately describe the program's operation, document the target population, and determine the components of NIC which were evaluable. To accomplish these goals, the researcher utilized an evaluability assessment (EA) and a records analysis. The EA engaged stakeholders in the evaluative process and was a set of practices which defined

Table 1

Overview of Four Areas of Investigation

Area of Research	Variable Being Examined	Data Collection	Research Process
PROGRAM CLARIFICATION	PC1. Program Model	Eval. Assessment	Qualitative
	PC2. Program Theory	Eval. Assessment	Qualitative
	PC3. Evaluability	Eval. Assessment	Qualitative
	PC4. Target Pop.	Records Analysis	Quantitative
PROCESSES & ACTIVITIES	PA1. Availability & Assessibility	NIC Survey Q. 2.01-2.08	Quantitative
	PA2. Coordination	NIC Survey Q.2.09-2.15	Quantitative
	PA3. NIC Accomplishments	NIC Survey Q.4.01	Qualitative
	PA4. NIC challenges	NIC Survey Q.4.02	Qualitative
OUTCOMES	OC1. Restrictiveness of Living Environment	ROLES	Quantitative
	OC2. Roles Predictors	NIC Records	Quantitative
	OC3. Continuum of Care	NIC Survey Q.1.01-1.22 NIC Records Interviews	Qualitative Quantitative
	OC4. Integration	Interviews Program Documents	Qualitative
COST FACTORS	OC1. CSA Funding	NIC Records ROLES Scores	Quantitative
	OC2. Fiscal Management	NIC Survey Q.3.01-3.06	Quantitative

and clarified program theory, program goals, and helped "judge whether or not they can be evaluated" (Berk & Rossi, 1990, p. 15). This portion of the study was completed first and the results were utilized in determining those aspects of NIC which were included in the remaining three categories.

The records analysis yielded information regarding the NIC population to whom services are currently provided. This data established the kinds of young people the program was serving and provided numbers which provided a baseline to compare types and quantities of clients over time. In addition, this information may be used in developing a NIC "client typology" (Feldman, 1990, p. 17). Specific research questions for this category were:

PC1. To what extent is the Norfolk Interagency Consortium operating as designed?

PC2. What is the program's theory?

PC3. What components of NIC can be assessed?

PC4. What are the characteristics of the target population served by NIC? What are the characteristics of the youth within each NIC category?

Processes and Activities

The second category, processes and activities (PA), was formulated to provide program staff with information regarding the effectiveness of the program. This phase of the investigation examined organizational activities and sought to identify NIC's accomplishments and challenges.

Glaser and Erez (1988) stated that the addition of a focus on the process improves program evaluations "because the ability to improve outcomes is based on understanding the strengths and weaknesses of the program operation" (p. 24). Data was obtained on processes and activities through the development of a survey which was distributed to all personnel involved in the NIC process. The research questions and hypotheses in this category were:

PA1. How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services?

Related null hypothesis. There is no significant difference in the assessment of availability and accessibility of services with respect to NIC organizational level or gender.

PA2. How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There is no significant difference in the assessment of coordination of activities and information with respect to NIC organizational level or gender.

PA3. What are the major accomplishments NIC has achieved in regard to services for at-risk youth and their families?

PA4. What are challenges of NIC in regard to services for at-risk youth and their families?

Outcomes

The purpose of the third category, outcomes (OC), was to obtain feedback regarding NIC objectives which had been deemed evaluable by the EA. Additional consideration was given to the "recommendation that outcome measures reflect the increasingly ecological focus of programs" (Jacobs, 1988, p. 45). Burns and Friedman (1990) reiterated the ecological emphasis by stating that since the CSC philosophy is to provide services in the least restrictive environment, research should make determinations about the potential to reduce the level and amount of care.

Measures that reflected the living environment of NIC clients and the NIC's ability to exit children from their process became the focus of the outcomes study. The Restrictiveness of Living Environment Scale (ROLES) developed by Hawkins, Almeida, Fabry, & Reitz (1992) was utilized in this evaluation phase. This scale provided a process for measuring a child's living environment, giving lower ratings to more ecological, family-oriented environments and higher ratings to more restrictive, isolated settings.

Other indicators of ecological outcomes included an examination of the influence NIC has had on the local community. Questions were created that addressed the impact NIC has had on the development of a continuum of care and on the collaborative arrangements between agencies. The research questions for this category were:

OC1. Has the NIC process affected the overall

Restrictiveness of Living Environment Scale (ROLES) of its clients? If so, are some CATs more effective at maintaining or lowering the ROLES scores of NIC youth?

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES of NIC youth.

OC2. What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and the criterion variable of ROLES.

OC3. What is the community impact of the NIC with regard to the implementation of new services and the creation of a continuum of care?

OC4. What is the community impact of the NIC in regard to agency integration?

Cost

The last category of questions, the cost study, sought to explore the relationship between NIC's ecological orientation and the distribution of CSA funding. This phase of the evaluation also assessed the fiscal management practices NIC has incorporated. The research questions and hypotheses for this section were:

CO1. What is the relationship between the restrictiveness of living environment scores (ROLES) and the distribution of the Comprehensive Services Act (CSA)

funding?

Related null hypothesis. There is no significant relationship between the ROLES index of NIC youth and the distribution of CSA funds.

CO2. What management practices have been utilized by the NIC to ensure the most judicious use of funding?

Related null hypothesis. There is no significant difference in the assessment of fiscal management practices with respect to NIC Organizational Level or Gender

Definition of Terms

Restrictiveness of living environment - This concept is measured on the following components:

> 1. the physical facility, including the location separate versus integrated), the appearance (size or institutional look), the internal structure (layout, privacy of bathing and sleeping), and the equipment (locks, and kitchen facilities);
> 2. the rules and requirements that promote or limit relationships, responsibilities, personal choice, and contact with other environments; and
> 3. the voluntary nature with which individual enter or leave the setting (Thomlison and Krysik, p.211, 1992)

At-risk youth - young people who, on the basis of several risk factors, are not likely to acquire the requisite skills or emotional stability necessary to function as an independent, productive adult.

Comprehensive System of Care (CSC) - a system which provides a continuum of care options and multiple services organized in a collaborative network to meet the needs of at-risk youth and their families.

Family - the social unit with which an individual is

intimately involved. This unit is not limited by generational or physical boundaries (Weiss, Walker, and Crocker, p. 154, 1988).

Community - is a set of interlocking physical, social, political, economic, cultural, and interpersonal systems. This interdependent system is not static and within its boundaries, the individual's behavior is shaped, needs are satisfied, and major functions of life are carried out (adapted from Allen, p. 32, 1987).

Limitations

This study was designed to develop and to implement an evaluation model to assess the NIC and its services to at-risk youth in Norfolk. The conditions of the investigation necessitated the use of a causal-comparative design and caution should be exercised in evaluating the findings due to limitations in this research design. Although randomization of subjects was utilized, the lack of any purposeful manipulation of variables precluded the inference of any cause and effect relationship. There was no separate control group since participants served as their own control in repeated measures of the ROLES variable.

As the causal-comparative design of this study included the use of existing data, efforts were made to triangulate information whenever possible. Although cross-validation of data was accomplished through this process, it should be noted that the information examined in some

phases of the investigation included reports, agency records, and other documentation which had not been collected systematically for evaluation purposes.

Threats to the internal validity of this study include concerns regarding maturation. As the repeated measures on the ROLES variable were collected over a period of years, decreased means may be due to the child's maturing and becoming more able to cope with personal and family-related problems. It may be inferred, however, that all members of the ROLES population were affected equally by maturation and that the relationships examined in this study have greater validity.

Another threat to the internal validity of this study is statistical regression. The young people who are part of the NIC process have been referred to NIC because the originating agency has not been able to provide adequate help, they are an immediate danger to themselves or others, and/or they are at-risk for being removed from their home environment. NIC administrators are cognizant that they receive the most complex and difficult at-risk cases. Because these youth are extreme situations, lowered ROLES scores may be affected by a natural regression toward the mean.

History may also be a threat to the ROLES outcomes. Helping a child and his family deal with critical situations is a very complex process. Events which occurred during the child's involvement in the NIC process may have affected his living environment. These events may have

included changes in family stability and structure, the services and quality of services available at any given time, the duration of services, and the interactions with case managers.

While the evaluation model created may be adapted and replicated, the findings may not be generalizable to any other CSC or their population. Because youth in the NIC process are exposed to a continuum of care and inter-agency teams which are unique to the Norfolk area, it would be difficult to assume findings would be applicable to other settings.

It is difficult to ascertain the actual costs of treating a child in the NIC process. Records are not kept on expenditures which are paid for by private providers, Medicare, Medicaid, or individuals. Due to the lack of data regarding actual costs, it should be noted that the funds used in Research Question CO1 were limited to funds spent from Comprehensive Services Act money.

Although all levels of NIC were involved in the assessment of the NIC process, this study did not solicit the opinions of parents or clients. It is recommended that future studies include an evaluative component which can examine everyone affected by program participation to obtain a more comprehensive perspective.

Although the design of this study has limitations, the findings generated from this study will provide valuable information to the limited body of knowledge regarding CSCs and their interventions with at-risk youth.

Indicators suggested that the numbers of young people in our country who need assistance are growing and their problems are becoming more complex. Any knowledge gleaned from this investigation will be helpful in advancing a more efficient way to address the problems of at-risk youth and their families. This study also provided information which can be used to support and extend additional research in this critical area.

Summary

This chapter discussed the challenges in assisting at-risk youth and their families. Not only are the numbers of young people large and their problems complex, there is little definitive information to guide professionals currently working in this area of human services. While there is a strong theoretical foundation to use the systems of care concept in at-risk youth interventions, CSCs and their community-based strategies have not been validated empirically (Friedman, 1994; Bickman, 1995).

Chapter Two will investigate the CSC concept further by providing an in-depth literature review of the development and evolution of family support programs, as well as the core values which mobilize these programs. Additionally, the next chapter will examine the historical treatment of at-risk young people, societal attitudes which have affected their treatment, cost concerns which may affect interventions to at-risk youth, and pivotal legislation related to young people and children.

CHAPTER II

Literature Review

Historical Treatment of At-Risk Children

The emphasis of CSCs, providing quality service alternatives to at-risk youth within their family and community, is a relatively new concept. Historically, those who suffered emotional, social, behavioral, or mental disorders have been ostracized, neglected, abused, and regarded with fear (Abbott and Sapsford, 1987; Alper, Schloss, and Schloss, 1994). The lack of understanding regarding the problems of these young people caused many to attribute their disablements to demon possession, evil spirits, or as retribution for immoral behavior (Alper, et.al.).

In addition to being the recipient of superstitious beliefs and negative attitudes, young people, prior to the middle eighteenth century, had few treatment options available. Abbott and Sapsford (1987) noted that those who caused no problems were often left in their community with family or "to fend for themselves" (p. 14). Those who were unable to care for themselves or had no one to care for them faced various placement alternatives. Youth who could work might be sold into indentured servitude (Scherenberger, 1983) or assigned to workhouses. Other options included jail, boarding houses, or mental

hospitals.

Workhouses of this time were little more than corrective "labor camps" (Abbott and Sapsford, 1987, p. 11). Boarding houses were private homes whose owners were paid for keeping a person with mental disabilities. Boarding houses were identified through a bidding process. Home owners who bid lowest were hired to provide room and board. The care provided in these homes was not only inadequate, but often cruel (Abbott and Sapsford).

In the eighteenth century additional treatment facilities were created in the U.S. with the establishment of the first two mental hospitals: the Pennsylvanian Hospital, 1756 and the Virginian Hospital, 1773 (Abbott and Sapsford, 1987). Unfortunately, these institutions did not provide improved care for their patients. The Pennsylvanian Hospital, following European tradition, used its population to amuse wealthy citizens. Those who were willing to pay an admission fee could visit residents and be entertained by their insanity (Abbott and Sapsford).

The rationale to continue these grim treatment practices for at-risk youth was sustained by attitudes developed in the preindustrial society of the early nineteenth century. Abbott and Sapsford (1987) revealed that the people in this time began to view at-risk youth and adults, including the poor, delinquent, mentally impaired, morally degenerant, or criminal, as a threat to society. This unfounded fear generated continued acceptance that this troubled population not only be shut away, but

"prevented from breeding for the protection of society" (Abbott and Sapsford, p. 16). The acceptance of institutionalization was so widespread that families who questioned this practice were considered pathological (Greenbaum and Markel, 1990).

Institutionalization for children and youth was further expedited with the development of Houses of Refuge in New York (1826) and Philadelphia (1829) and the first reform school in Massachusetts in 1847. While the original goal of these institutions was to provide correction and remediation, the diversity of youth assigned to these facilities made this task difficult. Rothman (1991) stated that young people who simply "varied from the norm ... were placed in institutional residences with those who had enacted serious and appalling criminal offenses" (p.13). Although they were created to assist youth, Houses of Refuge and Reform Schools quickly evolved into little more than depositories for all at-risk young people (Rothman).

In 1874, another form of institutional confinement began with the founding of the Society for the Prevention of Cruelty to Children. The Edna McConnell Clark Foundation (1985) reported that this society's goal was to "seek out and rescue from the dens and slums of the city, the little unfortunates whose lives were rendered miserable ... by the human brutes who happened to possess the custody and control of them" (p. 2).

While compelled by a worthy goal, these societies "filled an expanding number of asylums with children of the

poor"(Edna McConnell Clark Foundation, 1985, p. 2). Prejudices toward poverty, as well as certain ethnic and religious groups, were used as the rationale for the society's inappropriate removal of many children from their own homes (Edna McConnell Clark Foundation).

The ongoing practice of institutionalization was challenged in the early twentieth century when community studies discovered that some institutionalized patients could be maintained effectively within the family and community setting (Abbott and Sapsford, 1987). Furthermore, psychological and sociological research in the 1950s and 1960s indicated that children developed better, cognitively and emotionally, if cared for in the family setting (Abbott and Sapsford). This scientific information was used to advocate community treatment and also served to alleviate the public's fears concerning the at-risk population.

The concept of keeping young people in a family or community setting was strengthened as the existence of inhumane institutional treatment methods became known (Alper, et.al., 1994). Senate Committee hearings characterized state juvenile correctional facilities as "crime hatcheries where children are tutored in crime, if they are not assaulted by other inmates or the guards first" (Joint Commission on Mental Health of Children, 1969, p. 5). In addition, emerging reports from various mental hospitals were so horrid and dehumanizing that it lead a professor at the University of Alberta to say:

> Criminals and prisoners of war are protected against such procedures ... but individuals labeled as handicapped do not enjoy the same protection. Being handicapped is not a crime. If it were, society would be forced to treat people with handicaps as well as it treats criminals- undoubtedly a major improvement" (cited in Warren and Warren, p. 58).

While disclosures such as the preceeding evoked an outcry to eliminate residential placements, few alternative facilities or treatment practices existed. With annual arrests of 1,500,000 youth under the age of 18 in 1950, there were few options available and the practice of institutionalizing children inappropriately continued (Rothman, 1991). The Juvenile Court System, which had been in operation since 1899, compounded this problem by repeating the earlier practice of combining runaways, disobedient teens, or those who had participated in immoral conduct with serious youthful criminal offenders (Rothman). Bronfenbrenner (1979) remarked that courts would residentially commit "out of error or ... sheer desperation, perfectly normal children" (p. xii).

Concerns for this large number of improper commitments lead to the passage of legal mandates which provided greater protection for at-risk young people facing commitment. According to Mallory and Herrick (1987), the mandate which began deinstitutionalization and community integration was the Community Mental Health and Mental Retardation Facilities Construction Act of 1963.

Several additional judicial statues and litigations provided further protection for at-risk youth. According to

Rothman (1991), these included: Gault ruling (1967) which required procedural guarantees for children facing commitment by the court; Wyatt v. Stickney (1971) which stated that institutionalization without appropriate treatment was considered incarceration and the New York Family Court Act of 1963 which instituted a new legal category for children whose behavior was only illegal because they were not adults. This new category was referred to as Persons in Need of Supervision (PINS). While other states quickly followed New York's lead, this new status had limited impact. Although it differentiated between criminals and PINS prior to sentencing, it was not utilized widely post adjudication due to lack of appropriate treatment centers or living facilities (Rothman, 1991). While the legal judgments necessary for the protection of at-risk young people were in place, lack of facilities once again prompted improper residential assignment.

Rothman (1991) stated that a dramatic alteration to the treatment of PINS occurred in 1974 with the passage of the Juvenile Justice and Delinquency Prevention Act. This act required governments to deinstitutionalize status offenders and limited further commitments to "secure facilities such as detention centers, jails, or juvenile training centers" (Eamon, 1994a, p.590). PINS could no longer be combined with criminals in any facility. This act also promoted the use of community-based resources and recommended rehabilitation in place of criminal justice

processes. This and other statues passed during the 1970s created fundamental modifications in the treatment and services at-risk children and youth were expected to receive (Alper, et al., 1994).

Despite the judicial mandates and broad support for deinstitutionalization, the lack of facilities, treatment options, and trained personnel continued to affect the placement of at-risk youth. In Unclaimed Children (1982), Knitzer's affirmed the ongoing use of institutional care. She reported that very few at-risk young people were being served appropriately and many were in residential settings. She further noted that less than 50 percent of the states had a staff person responsible for the supervision of children's mental health.

Further evidence of the continued use of institutional placement can be cited in data collected from the National Institute of Mental Health (NIMH). Eamon (1994a) reported that NIMH data revealed psychiatric admissions in private hospitals, for youth under 18, increased by 60 percent from 1980 to 1986. Responding to demand, the number of private psychiatric institutions burgeoned from 184 in 1984 to 450 in 1992 (Eamon). While at-risk youth had been given judicial protection against placement in other forms of institutional care, residential mental hospitals appeared to be an acceptable alternative. It was evident, once again, that this country did not have the knowledge, the facilities, or service delivery models necessary to implement the concept of community-based treatment.

The Development of Family and Community Services

Mobilized by a desire to assist the underprivileged and right social injustices, American leaders, in the 1960s, began aggressively creating programs which incorporated community-based services (Zigler and Freedman, 1987b). Head Start, regarded by many to be the immediate precursor of CSCs, was one of the preeminent programs established during this time (Weiss,1988; Weissbourd,1987; Zigler and Freedman,1987b; Hobbs, et al., 1984). Prompted by a negative initial assessment, Head Start's program directors expanded their primary emphasis on cognition and emphasized family oriented components such as parenting skills, nutrition, and health services. These additional components were later integrated into a unique transitional program. This transitional program was designed to assist children in Head Start's preschool program to assimilate successfully into elementary school. Successful transitions were accomplished by working with each family to develop an individualized plan for their child. Zigler and Freedman remarked that the implementation of this individualized transitional approach was a "pioneer of family support's ecological approach to intervention" (p. 59).

The potential benefits of utilizing family and community resources was readily acknowledged in the 1970s and prompted an "explosion of parent education" (Weissbourd, 1987, p. 51). Hospitals began establishing family resource units, Minnesota and Missouri instituted statewide parent support programs, Head Start extended its

services to families with children aged three, and Pennsylvania became the first state to implement a family support project (Bradley, 1992a). In addition, Weissbourd noted that across the nation, groups of people, concerned with assisting parents, informally created programs whose goals were to strengthen families. Many of these grassroots programs were very successful. Program leaders were given the opportunity to disseminate their successes, ideas, and challenges in the first Family Resource Coalition Network Conference, held in Evanston, Illinois, in 1981.

From Head Start's transitional program to the creation of a national family conference, our country had begun to recognize the importance of families. This recognition prompted changes in the attitudes of many human service personnel toward the parents of at-risk children. Kutash, Duchnowski, et al., 1994, noted that the practice of blaming families of at-risk children shifted to understanding the needs of parents and including them in collaborative partnerships in their child's intervention process.

As individual human service agencies began incorporating families and communities in their treatment plans, they became increasingly aware of overlaps in services between their organizations. Furthermore, Stroul and Friedman (1986) stated that professionals referring children for services at other agencies found conflicting procedures and bureaucracy difficult to manage. As a result, children received inadequate care or were lost in

the transfer of paperwork (Stroul and Friedman). The realization of this inefficiency, as well as an understanding of the complexity of the children and families they served, encouraged agencies to examine the possibility of working with each other. This interest in collaboration led to the development of integrated models of service delivery. While there are many different structures and combinations of organizations, inter-agency operation has become a basic characteristic of CSCs.

The CSC concept, which now included the core values of family, community, and inter-agency cooperation, received endorsement from the Federal government in 1984 with the creation of the Child and Adolescent System Services Program CASSP). The CASSP, a national technical assistance center at Georgetown University, was established by the National Institute of Mental Health (NIMH). This organization provides grant monies and technical assistance to states and localities involved in creating or expanding their systems of care for at-risk youth and families. Further federal support was given when NIMH, in conjunction with the United Stated Department of Education, established two research and training centers at the Florida Mental Health Institute, University of South Florida, and the Regional Research Institute of Portland State University. These two centers support family and community work through ongoing research. Annual conferences, initiated in 1988, are held to disseminate data and information gathered from various CSC sites.

Since the inception of Head Start in the 1960s, the concept of helping children by helping families has evolved into a national movement, incorporating the philosophy of inter-agency cooperation and community-based intervention. The next section of this chapter will investigate the evolution of CSCs, their core values, their successes and challenges, and the population they serve.

Comprehensive Systems of Care: An Overview

Since the first family assistance program in Pennsylvania in 1972 (Bradley, 1992a), support for CSCs and their family-oriented philosophy has grown. Currently, researchers and practitioners alike have affirmed the importance of promoting and utilizing CSCs as the delivery model for services to at-risk youth and their families (NRC, 1993; Minton, 1995; Friedman, 1994; American Public Welfare Association and National Association of State Mental Health Directors, 1994).

This affirmation was so widespread that, by 1992, every state in the US had received at least one federal grant to establish or expand CSCs and had articulated a vision for this service integration model (Davis, Yelton, and Katz-Leavy, 1994). In addition, a consortium of 16 national organizations, in testimony to the Labor and Human Resources Committee of the U.S. Senate, indicated that, "there currently is widespread consensus that community-based systems of care represent the state-of-the-art in treating children with serious emotional disorders, and the

development of such systems has become a national goal" (Testimony, 1993, p. 3, cited in Friedman, 1994).

Private foundations also have joined the cadre of professionals and organizations advocating CSCs. In "Unclaimed Children Revisited" (1994), the authors stated that foundations such as Edna McConnell Clark's has supported this movement in all states. The Robert Wood Johnson Foundation supports systems of care in ten states and the Annie E. Casey Foundation currently is engaged in an innovative community-based effort in six urban inner cities.

This broad base of approval for CSCs may be attributed to the philosophy which has mobilized these inter-agency organizations. This philosophy, defined by three core values, is: maintaining a focus on the family, providing services within the context of the client's community, and valuing and honoring cultural diversity (Stroul and Freedman, 1986). These core values have been epitomized as the national standard for CSCs and recently were reiterated in a joint publication of the American Public Welfare Association (APWA) and the National Association of State Mental Health Program Directors (NASMHPD)(1994).

The first value, focusing on the family, is embodied in processes which honor and dignify the family. This includes recognition that parents have the most information about their child and therefore must be involved in collaborative decision-making with professionals regarding the resources and treatments they need (Warren and Warren,

1989). The knowledge base parents possess may also be valuable in other decision-making arenas of CSCs.

In addition, a focus on the family acknowledges that the "first and primary natural environment for members of any society is the family" (Bradley, 1992a). Motivated by this recognition, CSCs seek to provide whatever assistance necessary to keep children in their own home or to reunite them with family in the future. Whenever this is not possible, permanent, stable settings should be identified in the least restrictive environment (APWA and NASMHPD, 1994).

The second core value, community-based service, is a philosophical position which has been advocated widely in both Europe and the U.S. the last thirty years (Abbott and Sapsford, 1987). Support for this value has been ameliorated by the belief that services to at-risk children and their families should be delivered in the least restrictive environment appropriate to individualized needs. While noting that institutional care is sometimes appropriate, CSC professionals will first seek to identify effective treatments and services which can be delivered in the child's home or community setting. Recognizing the ecological importance of social networks and extended support groups, CSC personnel help their clients make connections with resources and assistance in their immediate geographical environment.

The third core value, honoring cultural diversity, is exemplified when CSCs serve children and families within

their own unique and specific contexts. Those contexts include the mores and beliefs of the families' cultural and ethnic heritage (Stroul and Friedman, 1986). Gibbs and Huang (1989) underscored the effect ethnicity has on services by noting that one's culture affects the understanding of what mental health is, defines the behaviors which are acceptable or nonacceptable, and influences parental help-seeking patterns and responses to treatments. These culturally-influenced factors are integral to the success of any intervention plan and respect and understanding for them must be a part of effective CSC practice.

While there is a universal consensus regarding these philosophical values, there is less definitive agreement regarding the individuals to whom CSCs should offer services. Terminology used in the literature refers to target populations as children and youth who are severely emotionally disturbed, have serious emotional disabilities, are developmentally delayed, have mental and/or emotional disorders, or are simply at-risk. The most common term appears to be severely emotionally disturbed (SED) although there are varying interpretations of what this term means. Disagreement on the SED definition is contingent upon the degree of clinically identifiable problems a CSC client should have to qualify for program participation.

Kutash, Duchnowski, Meyers, and King (1993) stated that recent advocacy efforts have proposed definitions which exclude children with anti-social behavior or

problems resulting from an impoverished environment. The National Alliance for the Mentally Ill (NAMI) concurred with this exclusion by endorsing different terminology and a definition which targeted children and youth with a mental illness "biological in nature and genetically transmitted" (Kutash, Duchnowski, Meyers, et al., 1993, p. 6) such as schizophrenia, depression, and bipolar disorders.

The ambiguity regarding what degree of clinical challenges should constitute SED becomes readily apparent in an examination of studies of adolescents in residential psychiatric wards. Eamon (1994a) indicated that fewer than one third of inpatient "SED" juveniles were diagnosed with severe or acute mental disorders such as NAMI suggested. Nor did the behavior of these young people warrant residential care for protection either from self or to others. Research findings indicated that the majority of these hospitalized youth were "reacting to troubled or inadequate family situations; they were rebellious, disruptive, or noncompliant" (p. 590).

The CASSP, whose definition has served as a national model for several years, utilizes the term SED. While emphasizing services for youth who are the most seriously impaired, their definition includes children with anti-social behaviors and emotional problems due to family and/or environmental settings (Kutash, Duchnowski, Meyers, et al., 1993).

Affirming the CASSP's broad interpretation of SED, the

Center for Mental Health Services (CMHS) developed the following standardized definition for the U.S. Congress. Their definition, published in the Federal Register, on May 20, 1993, stated:

> Children with a serious emotional disturbance (SEDs) are persons from birth up to age 18 who currently, or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R[2], that resulted in functional impairment which substantially interfere with or limits the child's role or functioning in family, school or community activities (cited in Kutash, et al., 1993, p. 7).

The inclusion of disorders related to behavior and emotional duress, in this nationally recognized definition, provide the basis for CSC treatment to the majority of seriously troubled youth.

While NAMI desires to restrict the population being served, there is a growing sentiment from other professionals to expand the number of youth CSCs target and serve. Because all families appear to be experiencing additional demands and stress, Kagan et al.(1987) indicated there is a growing sentiment CSC services should be more accessible to the general population. The current broad interpretation of SED may be indicative of support for offering services to all families and youth who need assistance.

Research will continue to focus on identifying the children who may be most positively impacted by a CSC approach. Until more conclusive evidence is indicated, the

definition and terminology for populations served by CSCs will vary between cites, depending on program emphasis. Because all current terminology is interpreted broadly, this researcher will use the NIC term "at-risk" in discussing the children and youth served in CSCs. This term, defined by the Virginia Comprehensive Services Act (CSA), means youth ...

> ...who have emotional or behavior problems that are, or are projected to be, long-term and which are disabling, requiring services that go beyond usual agency capacities and requiring service delivery and coordination across agencies; who have emotional or behavioral problems that require services which go beyond usual agency capacities and that require service delivery and coordination across agencies in order to return from or to prevent placement in residential care; who require placement in a private educational program for purposes of special education; or who are in the custody of local social service agencies for the purpose of placement (Stroul et. al., 1992, p. 40).

NIC's at-risk population is categorized into one of three classifications: mandated, non-mandated, and other. Mandated children are those young people whom the state is legally obligated to provide services for including those with special education needs or wards of the state. Non-mandated populations are children referred to NIC by a juvenile or domestic court or by Youth and Family Services. The category, other, refers to any additional young people eligible for services under the CSA definition and includes youth with mental illnesses.

While there has been disagreement regarding the CSC target populations and definitions vary between programs

and sites, recent investigations have demonstrated there are many similarities in the actual children being served. Studies conducted in several locations across the United States and in Canada suggested comparable characteristics of CSC clientele regardless of geographical location (Kutash, Duchnowski, Meyers, et al., 1993). Findings from these various sites indicated over two-thirds of these youth are male and less than 20% live in two-parent homes (not necessarily biological parents). Their numbers reflect an over-representation of minority children and low income families. They have average I.Q. scores of 90, yet are an average of one-and-a-half years behind in math and reading. Although the onset of their problems usually began at age six, interventions were not initiated until age eight. Graduation rates for this population are less than 40%.

Regardless of terminology, it is evident from the above characteristics that youth being served in CSCs are "at-risk". It is important to aggressively pursue strategies which will alleviate the obstacles and problems these young people and their families face. Ironically, while CSCs are regarded as the premier way to provide interventions, there is limited empirical data regarding their efficacy (Friedman, 1994; Bickman, 1995).

Despite the limited empirical information, Kagan, et al. (1987) noted there is much about CSCs that has been acknowledged positive. They stated:

> Although the family support movement's contributions are only beginning to be chronicled, it is clear that these programs are

> breaking through traditional service patterns to meet individual needs in new and promising ways. If their benefits were measured in terms of service delivery alone, the contributions would be large. Add to this their value as advocates for social change within institutions, and the contributions of family support efforts escalate in importance. (p. 370)

In a national study to assess the evolution of the concept of comprehensive care systems, Davis, et al. (1994) surveyed all fifty states in regard to several pertinent CSC issues. Their study, "Unclaimed Children Revisited", found that although no new state Child and Adolescent Mental Health (CAMH) Units have been established since 1988, every state now has at least one full time position dedicated to CAMH. Seventy percent of states now have a separate budget to support CAMH and 22 states mandate parental involvement in policy, program, or treatment planning. All but one state has a target population defined in either law or policy and 92 percent of these definitions include young people with functional disabilities (related to behavior and emotional duress). While there is unanimous consensus among the states regarding support for community-based care, every one of these fifty entities still has at least one out-of-state youth placement. The average out-of-state placements reported is 20. Minors are still found on adult psychiatric wards in 20 states.

While the above survey documented much improvement from Knitzer's initial Unclaimed Children study (1982), there are challenges and issues which must be addressed to ensure the continued growth and support of the CSC movement

and values. According to Kagan, et al. (1987), these challenges include additional research in all arenas of CSC operations and outcomes; the need for a national training center with training in areas such as community dynamics, organizational development, and ethnic childrearing patterns; developing strategies to lessen potential family dependence on CSCs; the need for greater public awareness and broader support expressed through advocacy at the state and national level; committed funding sources to ensure organizational stability; and a clarification of the government's role, establishing both direct and indirect support for CSCs.

Friedman (1995) noted other specific challenges for CSCs are the number of at-risk children needing service and the societal context in which these children are served. Friedman contended that CSCs were established on the assumption that the amount of children needing their specialized services would be small and their problems well-defined, readily treatable in a system of integrated services. In contrast to expectations, there are a "magnitude" (Friedman, p.7) of youth requiring CSC assistance and the problems facing this large number of youth are extremely complex. The societal context has been a challenge because it is difficult to connect children and families with their community when the crime in many neighborhood environments has isolated families, making them fearful and insecure (Friedman).

While the lengthy number of challenges demonstrate the

ongoing development of these service integration models, proponents maintain their potential for assisting at-risk children and parents (NRC, 1993; Friedman, 1995). As support for continued implementation of this service integration model has been cited as a national goal, the future of families, as well as our country's, may be dependent upon the success of their continued evolvement and ability to meet the challenges confronting them. This paper will continue to examine the concept of CSCs by focusing on the components of its philosophy and the importance of these core values.

Families: The Critical Element of CSCs

> The capacity of families to realize the developmental potential of their children is, in a very direct sense, the capacity of the nation to realize its potential. In other words, factors influencing the abilities of parents to rear their children well are significant to the national well-being (Hobbs, 1984, p. 29).

Bronfenbrenner (1987) reiterated the importance Hobbs ascribed to families by noting that evolving patterns identified in family-related research suggested that the family, greater than any other context, affected the "capacity of individuals at all ages to learn and to succeed in other settings--in preschool and school, in the peer group, in higher education, and in the workplace, the community, and the nation as a whole" (p.xiii). Marshall (1991) further stated that, "Family relationships constitute the most basic, early, and essential learning

experience in one's life. Within the family, most of us learn how to deal with other people and with the hazards and opportunities of the outside world" (p. 68). In addition, research from the field of education has generated much empirical information which indicates parent involvement in their children's education enhances the child's academic achievement (Marshall, 1991; NRC, 1993; Nuckolls, 1991; Rosow, 1991; University of Wisconsin, 1989).

The above references are a mere sampling of the acknowledgements, from professionals in various fields of study, which demonstrate the significance of the family. From birth to school to the workplace, evidence suggests that families can greatly affect their children's ability to be successful. This significance has been recognized by leaders in the CSC movement and is part of the core values of these organizations.

Considering the profound influence parents can elicit, it is alarming that families appear to be in a state of increasing jeopardy. Hobbs (1984) remarked that while "families have always been under pressure ... the specific pressure on families over the last decades have taken new forms [and] have particular relevance for families' abilities to rear children well" (p.29). Moynihan (1986) added that the stresses which were once unique to minority and low-income families now affect the general population.

One factor which has prompted greater strain on families is the change in family structure and family

organization. Marshall (1991) reported these changes included greater heterogeneity in family units (there has been an increase in all household types but nuclear); increased divorce rates; an increased proportion of single parent households; a decline in fertility rates and a corresponding smaller number of households with children under 18; and an increase in women in the labor force. Of these changes, the increase of women in the workplace, especially those with young children, has been noted as one of the most significant family-altering events (Kagan, et al, 1987; Marshall). Working mothers are regarded as particularly pivotal because families have not adapted well to this structural and organizational alteration. Women in the workplace, as well as other modifications in the family configuration, are crucial because family structure is an important predictor of socioeconomic status (Marshall).

Socioeconomic status is a second factor attributing to increased familial stress. Census data tabulated at the beginning of this decade revealed that poverty rates in the United States have increased since 1979 and this increase has had the greatest impacted children. Marshall (1991) revealed that in 1988, 20% of all children under 18 were considered poor, up from 14% in 1969. Among the poverty population in this country, 40% are children. Nearly half of all black children and 40% of Hispanic children lived in poverty in 1988. Marshall also stated that American children are more likely to be poor than children in any other industrialized country.

The effects of poverty on children and families can be severe. In 1993, the NRC, reported that children in poor homes have a greater chance of being exposed to health risks or events that can harm their health. Their families are engaged less in health-promoting activities and have less healthy lifestyles. Furthermore, parents in poor families have greater difficulty providing what their children need for wholesome childhood development. In addition, studies show that the highest incidence of child neglect and the most severe injuries from abuse and neglect occur in poverty-stricken families (Feldman, 1990, NRC, 1993).

This abuse and neglect may be reflective of the numerous limitations poorer Americans face. Their economic conditions are related to opportunities for housing, social interactions, education, health care, and quality of health care (NRC, 1993). The lack of control over important elements of their lives leads to feelings of "hopelessness and helplessness ... and places a highly significant proportion of American children at high risk for physical, mental, and developmental disabilities that will influence the remainder of their lives" (NRC, 1993, p. 17).

The detrimental effects of poverty can be most acute in urban settings where large segments of poor people are concentrated. Dryfoos (1990) stated highest risk youth are more likely to live in cities than in suburban or rural areas and suggested there may be as many as seven million young people living in disadvantaged inner city

neighborhoods.

In an investigation of how poverty may affect children in the future, the NRC (1993) suggested that a family's socioeconomic status is the strongest predictor of the child's own socioeconomic attainment, regardless of family structure. NRC findings indicated that children who are poor are three times as likely to be poor adults than children who have never been poor.

Although the social problems related to poverty currently have created additional funding needs for remediation, correction, and protection, Marshall (1991) predicted the negative repercussions for our country will increase in the future. In State of the Families, 3, he noted that in 2010, when baby boomers begin to retire, the proportion of nonworkers to workers will change significantly. In addition, longer life expectancies will increase the number of people over the age of 85 from 2.7 million to 6.6 million. Our country will be faced with the challenge of providing social security and Medicare to a much larger group of senior citizens. These changes "could greatly burden American economic resources" (p. 17). To survive economically in the future, our country must be concerned now with the wellness of its families and those young people who could be part of our future work force. Multi-generational poverty cycles need to be addressed as part of this concern.

A third element contributing to the stress on today's families is concern regarding parents' ability to rear

their children effectively . Kenniston and the Carnegie Council on Children (1977) noted that American parents are unsure of their ability to rear their children appropriately. While they wish to spend adequate time with their offspring, they may be resentful of their children's needs. In addition, parents have an ongoing pessimism regarding their success in parenting, yet cannot access the assistance they need. Bronfenbrenner (1979) noted that parents' perception regarding their child-rearing ability is related to external factors such as job flexibility, adequacy of child care, friends and neighbors who are accessible in emergencies, "quality of health and social services, and neighborhood safety" (p.7).

Hartman and Laird (1983) described two factors which may have contributed inadvertently to this parental pessimism and lack of confidence in child-rearing. The first factor was the transition from training children at home to educating them in institutions. As science and technology in the early 1900s improved the understanding of child development, parents increasing turned to sources outside the home for information and assistance. Publications, such as those from the Federal Children's Bureau, became the standard for child rearing (Weissbourd, 1987). The post-war trauma after WWII again encouraged families to seek help and the government's social interventions in the 1960s further acknowledged and affirmed the need for outside support in child and family issues (Kagan, 1987).

Kagan and Shelley (1987) noted that the transfer of child care and education from families to institutions in the twentieth century "diminished family control and some, argue, family self-esteem" (p.7). The knowledge base and experiences of parents, which had once been sufficient, was no longer adequate. Families now needed the guidance of outside experts to be successful (Kagan and Shelley).

Practices in the field of social work are the second component which may have contributed to the lack of parental confidence in child-rearing. Hartman and Laird (1983) contend that social work acts as a "family surrogate" (p.73). Professionals in this arena perform many of the services which were once performed by families or other extended support networks. Dunst, et al. (1989) cautioned that human service personnel must be careful in assisting families with needs. They asserted that "well intentioned professionals and other social groups have a tendency to rush in and try to 'fix' these families by filling in missing resources" (p. 123). The methods they use may only reinforce the family's negative image of themselves. To address parents' perceived or actual lack of ability to rear their children, human service personnel must utilize methods of intervention which respect the role of the parent and are empowering to the family.

While stress-inducing factors, such as changes in family structure, poverty, and parents' ability to rear their children, are universal, the U.S. has experienced the greatest increases in two of these factors. This country

has had a higher rate of divorces, teen pregnancies, single-parent households, women in the labor force (except for Sweden and Denmark), poverty, and unequal distribution of income than all other industrialized countries (Marshall, 1991). Because the U.S. contends with a higher number of potentially negative familial circumstances and because these circumstances may have detrimental effects on our nation, Kagan and Shelley (1987) determined that in this country, "all families face stresses for which they may need assistance" (p.6).

While the need for family support may be global, a 1989 survey found that parents whose children have behavioral, emotional, physical, or chronic medical problems face even greater stresses and demands than homes without at-risk children (Knoll, 1989). According to this study, accommodating the needs of at-risk children created major changes in family lifestyles, impacted siblings, and influenced where the family lived. It also caused economic strain and affected job decisions due to parents' limited ability to further their education, move, change insurance, or working hours.

Although the parents of at-risk children face more acute challenges, research has indicated positive outcomes for families who are involved with a family-oriented system of care. Knoll (1992) found that families who had experienced support through a CSC had a greater commitment to continuing care of children at home, had a reduced overall stress level, improved their capacity to keep up

with daily demands or seek employment, increased their coping skills, and had an improved overall quality of life. Kagan (1987) indicated these parents also had an increase in self-worth and employability and their children have academic gains, improved student attendance, and reductions in disciplinary suspensions. Further studies, conducted by Schultz, et al., (1987), noted that participation in family-oriented CSCs reduced parental tension, stress, and physical strain and provided satisfaction with life, hopefulness about the future, and greater coping ability.

Effective programs, such as those cited above, have intensive, well-planned intervention strategies. They provide not only clinical and medical care, but financial support, respite care, counseling, and introduction into extended networks and support systems. These programs guard against family dependency and are culturally sensitive. While they require a significant commitment of time, vision, and financial resources from both the public and private sectors, these programs help families and children cope with critical, life-changing issues. "Because competent families and support communities are indispensable elements of any effort to realize the full potential for human development in our society", (Hobbs, et al., 1984, p.), our country must continue to investigate the potential of utilizing the family as part of the solution for the problems of at-risk youth.

While there is widespread recognition of the significance of parents in a child's intervention plan,

there also is a growing acknowledgement that the extended family or community support network can be impact treatment. The next section of this chapter will delineate the contributions and advantages a positive community social system can extend to its members, at-risk families, and society in general.

Communities: The Extended Family Network

In the last thirty years, providing treatments and interventions for at-risk children in the community setting is a concept which has been promoted and advocated. In 1979, at the Center on Human Policy at Syracuse University, a group of faculty and students wrote and signed an document called "The Community Imperative". A portion of that work reads as follows:

> In the domain of educational programming and human service: All people, as human beings, are inherently valuable. All people can grow and develop. All people are entitled to conditions which foster their development. Such conditions are optimally provided in community settings (p. 2, cited in Biklen & Knoll, 1987).

The above statement is very reflective of current philosophy regarding treatment and service delivery for children with emotional, social, mental, or physical disabilities. Researchers and practitioners alike have affirmed the importance of community-based services for at-risk youth and their families (Biklen and Knoll, 1987; Eamon; 1994a; Friedman, 1994; Minton, 1995; National Research Council, 1993).

In addition, all three theoretical perspectives

investigated in this study, Bronfenbrenner's Ecological Theory, Structural Family Therapy, and General Systems Theory, recognized the extended family and larger social networks or systems as influential components of a child's ecological context. Research suggests that being part of a larger social network or system "buffers the impact of stressful life events" and provides an overall positive effect to the family (Cleary, 1988, p.196).

While psychological research established the community as an appropriate place to keep troubled youth in the 1950s, it was not highly feasible due to the lack of services and limited interventions available. Treatments for troubled youth, prior to the 1980s, consisted primarily of either "office-based 'talking' psychotherapy" or residential placement (Kutash, Duchnowski, Meyers, et. al., 1993, p. 3). There was no continuum of care or alternative treatments.

With the inception of a more child and family centered approach, alternative community-based interventions such as clinical outpatient services, in-home crisis programs, day hospital treatments, therapeutic foster homes, and specialized community schools were established. Studies comparing services in these natural environments with treatment in residential care support the statement that, "There is increasing evidence of the ability of community settings to handle a whole constellation of problems which at one time were used to justify the need for some individuals to remain in more restrictive settings" (Willer

and Intagliata, 1982, p. 12).

One example of this comparative research was a comprehensive literature search of all studies which randomly had assigned patients to either residential or alternative community services. This investigation concluded that community services are at least as effective and usually more effective than institutional care (Feldman, 1992).

Eamon (1994a) corroborated these findings and further asserted that not only are residential placements often less effective, they can be harmful. She stated that institutional care can foster dependency, lead to the loss of social and vocational competency, restrict civil liberties, invade privacy, and isolate the patient from relationships with family and friends. This isolation is particularly consequential to young people.

Furthermore, youth who are placed in residential care are often the victims of labeling. Being termed "mentally ill" affects their self-perception and may confirm their own concept that they are undesirable and outcasts from both family and friends (Eamon, 1994a; Feldman, 1992).

Another negative aspect of providing clinical treatment in an environment isolated from the patients' natural setting is that it does not prepare them for effective reintegration. Studies suggest that relapse is often instigated by elements present in the patient's external environment (Feldman, 1992). If treatment is given only in isolation, the patient is not equipped to deal with

the dynamic psychosocial interactions they face upon return to the home or community.

Partial residential placements, such as day hospitals, are preferable to residential care. Partial placements have been shown to be as effective as residential placements and the sustained interaction with family and friends "enhances social functioning" (Feldman, p. 233). Medical professionals who work with inpatient children have begun incorporating parents and social networks into treatment plans to make the residential placement less detached from the child's natural environment (Eamon, 1994a). This effort can be negated, however, when the hospital is not located in the families' community.

Communities not only impact the treatment of at-risk children, they have also been ascribed with affecting a parent's ability to successfully rear their children. In a survey of 231 parents, 73% of low income respondents and 79% of high income respondents believed that all families need help nurturing children. Respondents indicated that they solicited help most often from other parents, friends, neighbors, and churches (Kagan, 1987). These interactions with others effect the families' response to their children's treatment plans (Crocker and Walker, 1987). As parents request, receive, and react to assistance from others, Hobbs, et.al. (1984) noted that the quality of this extended support network may impact how well a family raises their offspring.

Considering the influence community systems can have,

one of the goals of CSCs is to establish positive linkages between at-risk youth and families and neighborhood resources. This linkage is particularly important for high risk families. Parents who abuse their children are often isolated from other social networks. Connections to diverse social groups can help facilitate improved individual social behaviors for these alienated parents (Garbarino, 1987, p. 104).

Utilizing communities in the delivery of treatments to at-risk youth provides other benefits. According to the Florida Mental Health Institute (1991), the limited geographical location promotes physical proximity and ready access to local services and assistance. The smaller area and finite number of people also make it easier to promote and create natural support systems with norms that promote positive family values.

Continued research regarding the value of the community will provide additional information on the specific ways in which these extended networks can benefit at-risk youth. The Annie B. Casey Foundation is currently involved in a large community-based study in several U.S. urban neighborhoods. These pilot programs are based on the belief that treatments which focus solely on the child do little to address the root issues which created and will continue to affect the child's disorders. These privately-funded programs seek to promote the mental and emotional health of all families, not just the prevention and treatment of the problems of at-risk children.

Endorsement of the community concept can be readily identified in the NIC Program Model (see Figure 2.1). This organization's primary goals include returning residents to the community, preventing unnecessary out-of-home placements, and helping the family function effectively in the community. One of the facets of this evaluation will be to examine NIC's effectiveness at providing interventions in a family or community setting.

In conclusion, the extended social system called community has demonstrated that it can be a meaningful force in the lives of children and families. The positive interactions which occur within this support network are best expressed in the following description from Hobb's Strengthening Families (1984):

> Community is an immediate social group that promotes human development ... In communities, individuals experience a sense of membership, influence members of the group, and are themselves in turn influenced by others, have personal needs fulfilled, and share a psychologically and personally satisfying connection with other people. Community basically involves the coming together of people around shared values and the pursuit of common cause (Hobbs, et. al., 1984, p. 41).

The Cost of Comprehensive Systems of Care

One of the primary reasons CSCs gained immediate, widespread support, particularly among policy-makers, was because the concept of a community-based continuum of care was believed to be cost-efficient in both short and long term measures (Friedman, 1995; Knoll, et. al.,1992). Although initial programs were successful at reducing both

out-of-home placements and costs (Yuan & Rivest, 1990), recent findings have challenged the cost-savings theory. A national study, conducted at a CSC Demonstration Project in Fort Bragg, North Carolina, found costs at the Demonstration Project significantly higher than at a comparison location which utilized traditional care. Foster, Summerfelt, and Saunders (1996) reported that costs at the Demonstration Project were greater than the Comparison site even when controlling for differences in system-level costs, increased access, severity of clients, and cost-sharing. Higher costs at the Demonstration Site were attributed to longer treatment duration, increased volume of services, heavy use of intermediate services, and higher per unit costs (Summerfelt, Foster, & Saunders, 1996).

While the Fort Bragg study is one of the first scientific investigations comparing costs between CSC and non-CSC sites, it is but one study. Furthermore, it should be noted that this assessment did not examine the costs of CSC interventions in terms of social perspectives or in cost-savings elsewhere in society. It is unknown if community-based treatment alternatives decrease costs related to the at-risk child, such as the use of fewer resources at school, less requirements from protective or rehabilitative systems, lowered property damages, or costs of reduced parent work time (i.e., days missed, lowered productivity due to child demands).

In addition, assessment efforts related to the effects

of CSCs must be cognizant of cost-containment in both short and long-term measures. Eamon (1994a) stated that if at-risk youth do not receive appropriate treatment when they are young, they will require more costly treatment as adults. Feldman (1992) noted that several studies of patients with mental and emotional disorders or substance abuse, who are not treated or treated insufficiently, "consume an inordinate volume of general medical services" (p. 225). Knitzer (1982) reiterated both of the above authors by stating, "Many of the seriously troubled children and adolescents needing mental health services will cost the states money, if not in one way, then in another ... The public policy choice is not whether to spend money, but how" (p.x). Exorbitant adult treatment costs can be prevented or considerably reduced if appropriate treatment is received at a younger age (Eamon; Feldman)

Another long-term economic consideration regarding at-risk youth involves the future work force of the US. Marshall (1991) noted that in 2010, when baby boomers begin to retire, the proportion of nonworkers to workers will change significantly. In addition, longer life expectancies will increase the number of people over the age of 85 from 2.7 million to 6.6 million. This nation will be faced with the challenge of providing social security and Medicare to a much larger group of senior citizens. These changes "could greatly burden American economic resources" (p. 17). To survive economically in the future, the United States

must be concerned now with the wellness of its families and those young people who could be part of our future work force.

In a reflection of the potential long-term effects discussed above, it is important for CSC evaluators to assess not only the short-term economic impact, but questions such as: a) Which service delivery treatments provide longer-lasting effects or stabilize the child's independence? b) Which service delivery methods assist the young person in becoming an integrated, productive member of his community? While CSC interventions may be of greater initial expense, the long-term benefits of family and community integration must be considered. The time and resources required to effectively treat at-risk youth at a young age are a national investment.

This chapter has examined comprehensive systems of care by researching their evolution, the history of the children they serve, the rationale for inclusion of family and community as integral CSC components, and economic considerations of this system of intervention. In concluding this literature review, the final section will explore the assessment process utilized to appraise systems of care--social program evaluation. The author will explore the historical context of program evaluation, focusing primarily on the challenges and benefits of employing this assessment process with CSCs.

CSCs: The Evaluation Process

While social program evaluation has manifested itself as a fundamental characteristic of contemporary society, this assessment process is not an entirely recent phenomenon. Commitments to systematic program evaluation had become commonplace prior to World War I. These early efforts focused on the assessment of social programs aimed at literacy, occupational training, and public health initiatives (Rossi and Freeman, 1989).

During the 1930s, interest in evaluative research began to accelerate as government began to play an increasing role in the lives of citizens. The Great Depression gave rise to President Roosevelt's New Deal social programs and these programs gave rise to an expanded need for adequate evaluation. Increased numbers of social scientists called for rigid social research methods to be applied in the assessment of the numerous community action programs that existed at the time. In response to this call, evaluations were implemented more frequently (Rossi and Freeman, 1989).

After World War II and into the 1950s, the government continued to launch new social initiatives. Rossi and Freeman explained:

> The period immediately following World War II saw the beginning of large-scale programs designed to meet needs for urban development and housing, technological and cultural education, occupational training, and preventive health activities ... Expenditures were very large and consequently were accompanied by demands for 'knowledge of results'.

> By the end of the 1950s, large-scale evaluation programs were commonplace ... Such studies were undertaken not only in the United States, Europe, and other industrialized countries, but also in less developed nations (p.23).

As the call for more evaluations increased, it became clear that the need exceeded the supply of available evaluators. This is not surprising considering that in the 1960s there were no professional organizations dedicated to the field of evaluation research, no specific journals, inadequate training programs, and a dearth of publishing papers in the field (Madaus, Scriven, and Stufflebeam, 1983).

This challenge and the need to address it, lead to what Madaus, et.al. (1983) called the "Age of Professionalization". Beginning in the early 1970s, evaluation research in general, and social program evaluation in particular made great gains. Numerous journals and other literature related to the field, professional organizations, and the emergence of university programs leading to degrees in evaluation came into existence. This decade also saw the creation of evaluability assessment, a process used to examine ways to "bring program rhetoric and reality together through a series of quick evaluations" (p. 13). This process, viewed as a precursor to outcome evaluations, gives program staff and evaluators the mechanisms to develop meaningful program evaluations.

The 1980s found evaluation a respected and competent

element in program implementation, maintenance, and assessment and the field has become much more methodical and scientific. Nevertheless, many troublesome technical hurdles remain, particularly to evaluators seeking to assess comprehensive systems of care. Knapp (1995) revealed five issues which confront CSC assessments. They are:

1. Engaging Divergent Perspectives: Systems of care are composed of various human service agencies, including organizations from social work, criminal justice, education, public health, and mental health clinics. The diversity of these agencies and their unique perspectives regarding the young people they serve may impact collaborative research efforts. Each discipline represented has a unique terminology, focus, and priority. These differences must be understood, reconciled, and integrated in inter-agency evaluation planning.

2. Identifying the Independent Variable: Interventions in comprehensive systems of care are comprised of multiple, separate components, given at different times, at varying sites, by diverse providers. Given the complexity of this individualized treatment, Knapp (1995) stated that "the notion of the independent variable [IV] itself ceases to be a fixed treatment ... and becomes instead a menu of possibilities" (p. 7). Because of the numerous variables which interact in this process, it is difficult to describe the IV or distinguish its "conceptual boundaries" (p. 8).

3. Selection of a Dependent Variable (DV): Given the complex structure of CSCs, choosing what measurements will

accurately reflect the affects of these delivery models is difficult. Researchers must consider their options from a copious list of possible outcomes, they must contend with interdependence among these outcomes, and determine the "range of abstraction from discrete, modest outcomes to those that are more global and complex" (Knapp, 1995, p. 9).

4. Causality: Given the ambiguity regarding the definitions of both the IV and DV in systems of care, attributing results to a particular influence becomes a formidable task.

5. Intrusion: In a CSC approach, there are many private interactions which occur between patients, their families, case managers, and service providers which are not readily accessible to program investigators. While it may be inappropriate or implausible to study these interactions, they may be pivotal connections which make a difference in outcomes. The lack of information regarding the confidential relationships between the people in a CSC process may also confound assessment.

Although program evaluators must be cognizant of these challenges and adapt assessment strategies to minimize concerns, Powell (1987) noted that the potential usefulness of research on CSCs outweighs its problematic character. Evaluations which produce valid, relevant information enable program leaders to focus on accomplishing their goals through measurable outcomes. In a National Center for Service Integration (NCSI) publication, Young, Gardner, and

Coley (1995) asserted that when organizations emphasize the attainment of outcomes, they are more likely to ensure their institution's efforts and activities are actually focused on changing the lives of their clients. Furthermore, Osborne and Gaebler (1993) noted that often, "What gets measured gets done" (p.146).

Organizations which subscribe to a results-based accountability, according to Schorr (1994), have less need for micro-management and realize greater collaboration due to the shared accomplishments. These agencies can identify and eliminate marginal activities more readily, leaving more time and resources to modify and to improve productive endeavors. In a goals-oriented environment, Schorr stated that the public and funding sources are more assured their monies are being productive. Lastly, when outcomes are monitored consistently, it is easier to discern if adequate funds have been allotted to meet program goals.

Considering the many benefits derived from the use of effective program monitoring, it is incumbent upon human service organizations, such as CSCs, to employ evaluation research. As previously discussed, CSCs have been assigned the profound responsibility of addressing the needs of millions of at-risk youth in our country. Assessment efforts which enhance their ability to meet this challenge effectively should not be neglected.

Summary

This chapter provided an overview of the historical

treatment of at-risk youth and the development of CSCs as an ecologically acceptable context for service delivery. While this ecological stance is supported by several theoretical perspectives (Bronfenbrenner, 1979; Minuchin, 1974), little empirical evidence exists which suggest it is a more effective way to obtain improved outcomes for at-risk youth and their families. To address this lack of evidence, the researcher will examine one CSC whose treatment methodology emphasizes an ecological approach, the Norfolk Interagency Consortium (NIC).

The next chapter of this investigation will discuss the assessment process used with this CSC. This will include information regarding the research design, sampling methods, and the statistical analysis which will be used in the NIC Evaluation Model.

CHAPTER III

Research Design

Introduction

The primary purpose of this dissertation was to design and to implement a comprehensive evaluation model for the Norfolk Interagency Consortium (NIC). This model was conceptualized and formulated collaboratively utilizing input and feedback solicited from members of all levels of the NIC organization, state and local stakeholders, state and national research centers, and experienced program evaluators. The comments, questions, and concerns obtained from interactions with these various sources were categorized into four areas of study: program clarification, process, outcomes, and cost factors. The areas of investigation and the NIC Evaluation Model are aligned closely to a five-tiered evaluation model designed by Jacobs (1988). The research questions are:

Program Clarification

PC1. To what extent is the Norfolk Interagency Consortium operating as designed?

PC2. What is the program's theory?

PC3. What components of NIC can be assessed?

PC4. What are the characteristics of the target population served by the NIC?

Processes and Activities

PA1. How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services?

Related null hypothesis. There is no significant difference in the assessment of availability and accessibility of services with respect to NIC organizational level or gender.

PA2. How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There is no significant difference in the assessment of coordination of activities and information with respect to NIC organizational level or gender.

PA3. What are the major accomplishments NIC has achieved in regard to services for at-risk youth and their families?

PA4. What are challenges of NIC in regard to services for at-risk youth and their families?

Outcomes

OC1. Has the NIC process affected the overall Restrictiveness of Living Environment Scale (ROLES) of its clients? If so, are some CATs more effective at maintaining or lowering the ROLES scores of NIC youth?

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES of NIC youth.

OC2. What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and the criterion variable of ROLES.

OC3. What is the community impact of NIC with regard to the implementation of new services and the creation of a continuum of care?

OC4. What is the community impact of NIC with regard to agency integration?

Cost

CO1. What is the relationship between the restrictiveness of living environment scores (ROLES) and the distribution of the Comprehensive Services Act (CSA) funding?

Related null hypothesis. There is no significant relationship between the ROLES and the distribution of CSA funding.

CO2. What management practices have been utilized by NIC to ensure the most judicious use of funding?

Related null hypothesis. There is no significant difference in the assessment of fiscal management practices with respect to NIC Organizational Level or Gender.

Methodology

Sampling Procedure

Four groups of individuals were utilized in this

research. The first group, those who participated in survey research, was the entire population of NIC personnel. This included all members of NIC's three organizational structures, as well as case managers from four of NIC's six agencies. The three organizational structures are the Norfolk Interagency Consortium Board, the Recommendation Review Board (RRB), and Community Assessment Teams (CATs). The four case manager agencies were the Norfolk Public Schools (NPS), Norfolk Department of Social Services (NDSS), Community Service Board (CSB), and Norfolk Juvenile Court Services Unit (NJSCU). The remaining two NIC agencies, the Norfolk Public Health Department and the Norfolk Juvenile Services Board, do not currently have any case managers involved in this CSC process.

NIC Board members are appointed by the Norfolk City Council and include the director of each of the six NIC agencies as well as the Director of Human Services, Director of Parks and Recreation, Chief of Police, a Private Provider Representative, and two Parent Representatives (one consumer, one advocate). The RRB and CAT are also staffed by representatives from each of the participating NIC agencies. RRB personnel are senior agency representatives appointed by their Agency Director. CAT members are middle level representatives who have decision-making responsibility for their agency. In addition, NIC policy requires that the RRB and CATs have a private provider representative and a parent on their teams. While all groups have representation by private providers, only three of the eleven CATS have a

parent member.

Case managers are employees from the various NIC agencies. They work with at-risk children within their own organization and may be the person who initiates NIC referral for their clients. Once in the NIC process, they serve as brokers, contacting service providers, contracting for treatment or service, and monitoring the child and his family's progress according to the individual intervention plan established by the CAT.

All levels of NIC were incorporated in the survey research to provide a broad perspective regarding services to at-risk children and the NIC process. The number of survey instruments distributed was as follows: NIC Board, 8; RRB, 9; CAT, 7-8 per team depending on parent membership; NPS case managers, 14; NDSS case managers, 42; CSB case managers, 1; and NJSCU case managers, 42. Survey participants who served at more than one level were encouraged to complete a form for their highest level of NIC service.

The second group of individuals included in this study were selected from the youth who entered the NIC from July 1, 1993 to June 30, 1994 (FY94). Although the NIC process had been in place for three years, FY94 was chosen because it was the first year of the NIC's operation under Virginia's Comprehensive Services Act (CSA). Utilizing NIC's fiscal year was also important because components of client data were triangulated with NIC fiscal records. This group of young people were selected to provide information

regarding the characteristics of the target population being served by NIC (Question PC4).

To obtain an accurate list of all the youth entering NIC in FY94, the researcher examined CAT planning calendars, identifying those clients marked as "new". These names were triangulated with actual CAT agendas to ensure a meeting had been held and the child was in the NIC process. This procedure elicited 260 names. Further validation was conducted by examining the files of these young people to ensure the FY94 meeting was their first time in the NIC process (cases which had been reopened were often marked on the calendars as new). Thirty-six of the 260 names had been prior NIC clients and were removed from the list. An additional six files were missing, leaving the total eligible FY94 NIC population at 218.

According to research literature (Borg and Gall, 1989; McMillan and Schumacher, 1984) the characteristics of a population can be inferred from a small random sample of the group. McMillan (1996) suggested this random sample could be as low as five percent, but not less than 30 people. Considering these suggestions, it was determined that 30 percent of the 218 youth would be randomly selected. A 30 percent sample provided 65 subjects, comfortably exceeding the minimum. The records of these young people, referred to as the Target Sample, were examined and the following attributes were extrapolated: previous out-of-home placement (POOH), gender, race, age, family structure, agency referral, parent involvement, and the date of NIC entry. A

random number chart was used in the selection process.

The third group used for this research was selected to investigate the characteristics of at-risk youth within each of the NIC categories. To ensure each category was proportionally represented, these youth were chosen using a stratified, random sample of the FY94 youth who had been in the NIC process for a minimum of six months. The six month requirement was incorporated to ensure that the child's categorical placement had been designated. Youth entering the NIC are not placed automatically in a category until CSA funds are required or their needs are delineated clearly. Determining the characteristics of a child's situation which impact placement can be difficult as all pertinent information may not be readily available at intake.

Another consideration which affected selection of a six month time frame was that a subgroup of this stratified sample would be used to investigate NIC's progress in maintaining or reducing overall restrictiveness of living environments (ROLES). Six months is a sufficient period of time to ensure the client had been exposed to NIC services long enough to have impacted the youth's overall ROLES scores (Bickman, 1996).

The stratas used for this sampling were the three NIC categories: mandated, non-mandated/targeted, and other. Mandated children are those young people whom the state is legally obligated to provide services. This includes those with special education needs, handicapped children with placement needs, or youth who are wards of the state. Non-

mandated populations are children who are referred to NIC by a juvenile or domestic court or by Youth and Family Services. The category, other, refers to any additional young people eligible for services under the CSA definition and includes youth with mental illnesses. There is a high degree of homogeneity within these categories because membership is based on a set of specific criteria.

Approximately half of the FY94 young people (n=105) met the six month criteria. Thirty-five of this number were mandated; 56 were targeted; and 14 were in the other category. The characteristics of youth within each of these stratas were identified and compared with the characteristics of the other categories.

The size of the stratified sample was determined by considering the numbers available and the ROLES subgroup which would be formed from this set of young people. Variables related to the subgroup were to be used in a regression equation and it was essential that a sufficient number of cases would meet subgroup criteria. Tabachnick and Fidell (1989) stated that the ratio of cases to predictor variables must be substantial, and a bare minimum requirement is to have five times more subjects than predictor variables. Using this criterion, the bare minimum of subjects needed for this analysis was 15. Based on the small numbers in each category and the ratio of subgroup characteristics, it was determined that approximately 70 percent of the six month eligible youth would be needed to exceed the recommended bare minimum by a comfortable margin

(n=40). Using this guideline, 70% of the young people were randomly selected from each strata of the FY94 six months or more population (see Table 2). This sample will be referred to as the FY94 Six Month Sample.

Within this stratified sample those young people who had a ROLES index and had exited the NIC process were incorporated into a subgroup. This subgroup, referred to as the FY94 ROLES Sample, was used in regression analysis to determine if client characteristics could be used to predict future ROLES outcomes. Using only those youth who had exited the NIC process ensured that the child had not reentered the NIC or was not in an on-going treatment plan.

Table 2

FY94 Stratified Six Month and ROLES Sample

Strata	NIC Eligible	Six Month Sample	ROLES
Mandated	36	27	6
Targeted	55	39	33
Other	13	9	1
Totals	92	70	40

A fourth group of young people were selected to use for cross-validation of regression statistics. These youth were a stratified, random sample of FY95 NIC clients. Selection procedures were the same as the FY94 Six Month Sample

previously described. A subgroup of the FY95 young people was formed using the same criteria as the ROLES group (see Table 3). This group will be referred to respectively as the FY95 Six Month Sample and the FY95 ROLES Sample.

Table 3

FY95 Stratified Six Month and ROLES Sample

Strata	NIC Eligible	Six Month Sample	ROLES
Mandated	50	35	6
Targeted	73	51	31
Other	18	13	9
Totals	141	99	46

Instrumentation

There were three instruments used in this study. The first was an adaptation of the survey, "Assessing Local Service Systems for Chronically Mentally Ill Persons" (Morrissey, Ridgely, Goldman, & Bartko, 1994). This instrument (see Appendix B) was created to assess the performance of adult CSCs in programs within the Robert Wood Johnson Foundation. It also has been adapted and utilized in examining systems of care in children's mental health services. The adaptation formulated for this study was referred to as The NIC Survey. The five sub scales which were used in this investigation were: Adequacy of Services, Quality of Services, Availability of Services, Coordination

of Services, and Fiscal Authority.

Each sub scale has an established internal consistency coefficient (Cronbach's Alpha). Reliability was determined using parallel testing in nine cities. Multiple data sources, including interviews and records analysis, were conducted at each of the nine locations to further affirm survey results. The range of reliability established among the sites were: Adequacy of Services, .69-.91; Quality of Services, .78-.92; Availability of Services, .80-.94; Coordination of Services, .84-.95; and Fiscal Issues, .70-.87.

The NIC survey allowed participants to provide both quantitative and qualitative information regarding NIC and services to at-risk youth in Norfolk. There were 43 quantitative questions on the survey which were answered using a Likert scale from one to five with a "don't know" option. A rating of one indicated the lowest performance and five indicated the highest performance. A response of don't know was given no score. There were two qualitative questions which requested data regarding NIC's greatest accomplishments and their greatest challenges. Participant characteristics, including gender, ethnicity, and length of time working with at-risk youth also were collected. Permission was obtained from the survey's primary author to use and to adapt this questionnaire for the NIC evaluation.

The second instrument incorporated in this study was the Restrictiveness of Living Environments Scale (ROLES) developed by Hawkins, Almeida, Fabry, and Reitz (1992).

ROLES (see Appendix C) is an interval scale which assigns a mean restrictiveness value to children's living environments. This scale was developed by surveying experts in the state of Pennsylvania who had experience working with at-risk young people. These experts were asked to rank order a list of 25 living environments from one (least restrictive) to ten (most restrictive). Validation for the ROLES index was obtained through a test-retest procedure conducted in Pennsylvania and West Virginia.

The ROLES scale will be used in this study to test the efficacy of NIC's ability to provide interventions in the least restrictive environment, preferably the family or community setting. It also will be used as a criterion variable to examine the characteristics which make the best predictors for lowered ROLES scores.

The researcher made numerous visits to the NIC offices in Norfolk in the Fall of 1995 to observe the various levels of this organization in operation. These observations included eight Community Assessment Teams, two RRB meetings, and two NIC Board meetings. A focus group was conducted with various members of the Juvenile Court Services Unit (JCSU) personnel who were active in the NIC process. The focus group included members who worked in all four levels of the NIC.

Unstructured interviews were held with the Chairperson of the NIC Board, the directors of the NIC agencies, members of the RRB, several case managers, and NIC administrators. Semi-structured interviews were held with three agency

directors to collect information regarding agency integration. Information was clarified and extended through follow-up visits and telephone conversations.

Data Collection

Comprehensive systems of care (CSCs) are challenging to evaluate. These challenges included the difficulty in identifying variables which are reflective of the effects of the model and which can be defined clearly. Irvin (1989) noted that to reduce the measurement error in CSC evaluation, multiple measures from different sources are necessary. To increase the accuracy of this evaluation, the researcher sought to collect multiple sources of data whenever possible and use research techniques from both qualitative and quantitative methodology. The sources and techniques for data collection are described in the following section.

Qualitative Methodology

Data collection techniques from the qualitative paradigm were included in this study to establish additional sources of triangulation, to enable the researcher to consider other perspectives regarding CSCs, and to extend the scope and breadth of the research. Additionally, information from qualitative sources helped to identify variables and formulate the basis for several quantitative research questions.

Various data sources were used to investigate the qualitative questions incorporated in this research. These

included interviews, open-ended questionnaires, and an examination of program documentation. The goal in each research question was to collect and analyze data systematically in an effort to gain a more accurate description of the variable being examined.

Program Clarification (PC).

Question PC1. To what extent is the Norfolk Interagency Consortium (NIC) operating as designed?

Question PC2. What is the program's theory?

Question PC3. What components of NIC can be assessed?

Data for these three questions was gathered through an evaluability assessment (EA). An EA is a process which engages the stakeholders in the evaluative process and is a set of practices which define and clarify program theory, program goals, and "judge whether or not they can be evaluated" (Berk & Rossi, 1990, p. 15).

This process began with an examination of all program documentation, numerous on-site visits, and an observation of all levels of the NIC process. The information collected will be synthesized to create a Documents Model, a graphic depiction of the researcher's perception of the NIC's organizational structure. This model will be used in interviews with program managers and in a focus group with NIC Board members to confirm program components, discuss the theoretical basis of NIC, and assess the relevance of current goals. The input gained from the focus groups and interviews will be used to modify the Document Model and create a second organizational representation called the

Program Manager's Model. The Program Manager's Model is a graphic depiction of the NIC process which has been validated by both documentation and by program leaders.

The third and final phase of the EA included an examination of the Program Manager's Model to determine which program components could be evaluated in this study. Components were deemed evaluable if they met the following preconditions: (a) They had been created and implemented as described in program literature; (b) The goals and effects were specified clearly; and (c) Measurable data was available.

The components which met these preconditions will be delineated in a third model referred to as the Evaluable Model. All components which can be assessed will be depicted in a box with no broken lines. Boxes with broken lines indicate elements which did not meet preconditions and could not be evaluated in this investigation.

The EA process served as the first stage of the evaluation research. Identifying NIC goals and components which could not be evaluated narrowed the scope of the research and focused the investigation on formulating inquiries regarding the evaluable elements.

Processes and Activities (PA).

Question PA3. What are the major accomplishments NIC has achieved in regard to services for at-risk youth and their families?

Question PA4. What are the challenges of NIC in regard to services for at-risk youth and their families?

Data was collected for both of these questions in Section Four of the NIC Survey. In this section, participants were asked to name two or three accomplishments and two or three challenges of NIC with regard to services to at-risk youth and their families. The inquiries were open-ended and provided the opportunity for participants to discuss any characteristics of NIC they deemed important. This survey was distributed to all personnel involved in the NIC process including the NIC Board, RRB, CATs, and case managers. As this was a self-reporting instrument, there is no assurance the data gathered on each of these variables is without error. It is an assumption of this study that subjects responded honestly to the questions on this questionnaire.

The survey was distributed and collected in cooperation with the various agencies involved in this CSC process. NIC Administrators gave surveys to RRB and CAT members who were allotted time during their regularly scheduled monthly meeting to complete the survey. Completed surveys were placed in a sealed envelope and returned to the researcher. NIC Board member questionnaires were mailed to each respective member's business address. These surveys were returned to the investigator in person at the February, 1996 Board Meeting or by mail.

As case managers' work is located primarily within their own organization, agency supervisors in the Juvenile Court Services Unit, the Community Service Board, and the Department of Social Services distributed surveys to their

case managers in department meetings. This personal contact gave supervisors the opportunity to explain the purpose of the survey, answer questions, and helped ensure a high rate of return. Personal telephone contact was made by the researcher with Norfolk Public Schools case managers to provide explanation and elicit participation prior to mailing their instruments. All case manager surveys were returned to the investigator in sealed envelopes to ensure confidentiality. The survey research was approved through Old Dominion University's Human Subjects Review.

Outcomes (OC)

Question OC3. What is the community impact of NIC with regard to the implementation of new services and the creation of a continuum of care?

Data which addressed this question was obtained through the following sources:

1. The Norfolk Office on Youth and the Norfolk Youth Services Citizen Advisory Board's 1994 study on the gaps of services available to the NIC. This study provided information regarding the services needed in 1994 to provide a continuum of care for at-risk youth.

2. NIC Records were examined to determine the types of services solicited and chosen during each year of a three year period (FY94 - FY96). This provided information regarding NIC's requests for additional services and vendor response to these requests.

3. Data was also solicited from the NIC Survey regarding the types of services available and the quality of

current service options.

Question OC4. What is the community impact of NIC with regard to agency integration?

This research was addressed primarily through information collected from semi-structured interviews with three NIC agency directors. The three directors interviewed were the directors of the Juvenile Court Services Unit, the Department of Social Services, and the Community Services Board. These people were asked to describe and discuss collaborative efforts which had been initiated recently involving more than one NIC agency. Follow-up interviews were conducted and program documentation examined to clarify and extend the data collected. Additional information regarding agency integration was secured from Section Four of the NIC Survey.

Quantitative Methodology

Program Clarification.

Question PC4. What are the characteristics of the population served by NIC?

This data was collected through a records analysis of one-third of NIC's client files, randomly selected from FY94 youth. Information retrieved from the files of this Target Population included: the CAT who handled the case, the referring agency, gender, race, and entry age. Data also was gathered on the child's NIC entry date, previous out-of-home placements (POOH), and family structure. This descriptive research was conducted to provide a factual and accurate overview of the characteristics of the NIC population.

Identification of the population being served is important for use in planning program resources and predicting trends of service needs.

Processes and Activities (PA).

Question PA1. How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services?

Related null hypothesis. There is no significant difference in the assessment of availability and accessibility of services with respect to NIC organizational level or gender.

This research utilized a questionnaire and was causal-comparative because the opinions being assessed had already been formulated. The questionnaire was distributed to all personnel involved in the NIC process. The design implemented was factorial because it included two independent variables (IVs): sex (two levels: male and female); and NIC organization (four levels: NIC Board, RRB, CATs, and case managers).

The eight dependent variables (DVs) were: avoiding excessive waiting or delays, keeping bureaucratic procedures to a minimum, providing necessary transportation, providing services in accessible locations, offering extended hours for services, making clients feel welcome, establishing adequate grievance mechanisms, and training staff to work caringly with at-risk youth.

The availability and assessability section of the questionnaire allowed participants to rank the performance

of each of the eight DVs using a Likert Scale. The Likert Scale ranged from one to five with a don't know option. A ranking of one indicated the variable was performed very well; a ranking of five indicated the variable was performed very poorly.

Question PA2. How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There is no significant difference in the assessment of coordination of activities and information with respect to NIC organizational level or gender.

This data set was also causal-comparative and contained the same two independent variables of sex and NIC organization as Question PA1. The seven dependent variables in this group were: using a common intake form, sharing information between agencies, understanding the "big picture" of the NIC service system, providing interagency access to client records, minimizing conflicting rules and procedures, ensuring meaningful discharge between state and community facilities, and developing computerized client information systems. The coordination of services section of the questionnaire allowed participants to rank the seven activities using the same Likert Scale as in Research Question PA1.

Outcomes.

OC1. Has the NIC process affected the overall Restrictiveness of Living Environment Scale (ROLES) of its

clients? If so, are some CATs more effective at maintaining or lowering the ROLES scores of NIC youth? What are the client characteristics of the Six Month Sample?

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES of NIC youth.

To accomplish the research goals, data was needed which would indicate if clients in the NIC process were able to achieve a lowered ROLES. Data was collected on a stratified sample of NIC youth who had been in the NIC for six months or more and had been terminated from the NIC process.

The living environments for these young person were identified from the CAT and RRB records in their files. A hand-written narrative about the child is completed at these meetings each time a case is reviewed. The information in this narrative includes what has happened to the child and his family since the last meeting, what services have/have not been delivered, and any outcomes. As these narratives were not written in a prescribed, systematic manner, data was triangulated between CAT and RRB descriptions, the child's intake form, vendor reports, and fiscal records to increase accuracy.

The placements identified for each child were listed chronologically and assigned a ROLES value based on a ranked scale of one to ten (see Appendix C). ROLES values are higher for more restrictive placements such as jails or psychiatric hospitals and lower for home or family-oriented placements such as foster homes or supervised independent

living. Placements were gathered for the subjects from July 1, 1993 to June 30, 1996.

The assigned ROLES values were used in a restrictiveness equation which subtracts the value of each successive placement from the value of the prior placement (i.e., Placement One - Placement Two; Placement Two - Placement Three ...). The subtracted values from all placements are combined to calculate an overall restrictiveness adjustment (Thomlison and Krysik, 1992). Positive adjustment numbers indicate a move toward a less restrictive environment, negative adjustment numbers indicate the child placements are becoming more restrictive, and a score of zero indicates the child's original placement level was maintained. Descriptive statistics such as frequency counts and percentages were calculated for this information for the group as a whole and by stratas.

The data collected also was used to compare the differences in CATs and the ROLES outcomes of their respective clients. Only those children who had been in one CAT during their NIC tenure were used in this analysis. ROLES scores from each of the ten CATS were examined to determine if any CAT had been more successful at lowering or maintaining the restrictiveness of living environment of its clients.

Research Question OC2. What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant

relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and the criterion variable of ROLES.

Multiple regression was used to indicate the variables which could predict a lowered ROLES scores (criterion variable) based on a set of predictor variables. The predictor variables were previous out-of-home placement, parent involvement, and age. Previous out-of-home placement was defined as being placed in a living environment separate from biological parents or a legal guardian prior to NIC entry. This data was collected from NIC intake forms. Parent involvement was defined as participation in the NIC process. Measures on parent involvement were obtained from CAT records. Age was the actual chronological age of subjects when entering the NIC. All predictor variables were selected on the basis of theoretical considerations. The FY94 ROLES sample was used for this research.

Selection and measurement of predictors

The three predictor variables of parent involvement, age, and previous out-of-home placement were chosen on the basis of theoretical considerations. This section of this research will examine each variable and the basis for its inclusion in this investigation.

Parent Involvement. Weissbourd (1987) noted that since the 1970's, there has been widespread acknowledgement of the importance of including parents in the process of interventions for at-risk youth. Parents have the most information about their child and should be involved in

collaborative decision-making with professionals regarding the resources and treatments their children need (Warren and Warren, 1989).

Bronfenbrenner (1987) noted that the family, greater than any other context, affected the "capacity of the individuals at all ages to learn and to succeed in other settings--in preschool and school, in the peer group, in higher education, and in the workplace, the community, and the nation as a whole" (p. xiii). The concept of family involvement is not only supported by Bronfenbrenner's Ecological Perspective, but by Structural Family Therapy (Dym, 1988; Minuchin, 1974) and General Systems Theory (Hartman & Laird, 1983; van Gigch, 1974).

Age. Evidence has indicated that early identification and intervention can reverse negative patterns of behavior and prevent problems from escalating for some children (Stroul & Friedman, 1986). These outcomes would be beneficial not only in human terms, but in economic savings. Because of the increasing confirmation of the efficacy of early identification, Stroul and Friedman noted that early intervention should be emphasized "to enhance the likelihood of positive outcomes" (p. xxiv). The inferences of these authors are supported by Knitzer (1982) and The Joint Commission on Mental Health of Children (1969). Age was included as a predictor variable in this study to determine if the time of NIC interventions were related to a positive ROLES scores.

Previous out-of-home placements. This variable was

chosen because there is much substantiation of the negative effects of out-of-home (OOH) placements on intervention success. Eamon (1994) noted that OOH interventions may produce a dependence on foster care, create a loss of contact with parents, relatives, and others who are important to the adolescent, and promote 'labeling' which affects a child's self-perception. The National Research Council (1993) reiterated these comments by stating that the "very act of separating a child from his or her family is traumatic and may itself cause disturbance" (p.4). Because of the significance attributed to OOH placements, the variable of previous out-of-home placement was included as a predictor for changes in ROLES scores. Data for all predictors was collected from the files of the 40 subjects included in the ROLES regression analysis.

Cost (CO).

Question CO1. What is the relationship between the ROLES scores and the distribution of Comprehensive Services Act (CSA) funds?

The ROLES scores used for this investigation were collected from the FY94 ROLES Sample. An overall restrictiveness of living index was calculated for each child in the sample based on information retrieved from CAT and RRB records, intake forms, vendor reports, and fiscal records. The information regarding the distribution of CSA funds was collected from the Norfolk Department of Social Services (NDSS) records. The NDSS serves as the fiscal agent for NIC and prints an annual report citing expenditures by

month and by vendor for each child. Expenditures for each individual youth in the FY94 ROLES Sample were examined over a three year period, FY94, FY95, and FY96. The amount of CSA funds which were spent each year was added to determine the total CSA funds distributed per ROLES child over the three year period.

Data Analysis

Qualitative

Analysis for all qualitative questions posed in this research were analyzed through the following processes:

1. Coding refers to the analytical processes by which the data is broken down, examined, compared, and reconceptualized (Strauss & Corbin, 1990). The researcher studies the data, identifying discrete ideas, and recurring thoughts or themes. These ideas and themes are characterized by their attributes and grouped into categories with titles or descriptors. These categories serve as classification systems which enable the researcher to tabulate responses.

2. Empirical assertions, a method of qualitative analysis developed by Erickson (1986) was used also in this study. This process begins with repeated reviews of the data, identifying patterns of thought, behaviors, or attitudes which suggest an inference. Inferences which have been generated inductively are proffered as tenable statements or assertions. Once an assertion has been proposed, "evidentiary warrant" must be identified to establish its validity (Erickson, p. 146). This warrant is

found by reviewing all data sets to specify alternative sources of documentation which substantiate or support the assertion. These alternative sources of documentation are called key linkages. Key linkages connect different sources of data to the same assertion. The confidence level of an assertion's validity is strongest when several key linkages have been established.

3. Other qualitative analysis was conducted by comparing and contrasting multiple sources of data through a process known as triangulation. Triangulation enables the researcher "to verify information, to produce logically consistent data, and to provide confidence in the data" (Hecht, 1992, p. 116).

Quantitative

Target Population.

Research Question PC4. What are the characteristics of the population served by NIC?

The data collected concerning the target population, Question PC4, was analyzed using descriptive statistics. Frequency counts and percentages were generated for previous out-of-home placements, referring agencies, sex, race, age, and family structure. Mean scores were calculated for age and NIC entry lag. Entry lag was defined as the time differential between receipt of a referral and the first scheduled CAT meeting. Client characteristics were used to provide a description of the type of population NIC served in FY94. The data regarding entry lag was used as a comparison for information gleaned in the NIC Survey

regarding system service evaluation.

The NIC Survey.

The following three research questions and their related hypotheses were investigated using data collected through The NIC Survey. Because the data for these questions was examined using the same statistical methodology, the following analysis will serve as a collective descriptor for all three questions. It should be noted that all parametric statistics in this study had an alpha level set at .05.

Research Question PA1. How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services.

Related null hypothesis. There will be no significant differences in the assessment of availability and accessibility of services with respect to NIC Organizational Level or Gender.

Research Question PA2. How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There will be no significant difference in attitudes regarding the assessment of coordination of activities and information with respect to NIC Organizational Level or Gender.

Research Question CO2. What management practices have been utilized by NIC to ensure the most judicious use of funding?

Related null hypothesis. There will be no significant difference in the assessment of fiscal management practices

with respect to NIC Organizational Level or Gender.

Each of the questions listed above contain several specific organizational activities which participants were asked to rate on a Likert Scale. The interval scale ratings were from one to five with one being the highest rating and five, the lowest rating. A factorial analysis of variance (ANOVA) was used to analyze each of these practices. An ANOVA was chosen because the investigation was a hypothesis of difference and there is one dependent variable (interval data on each activity) and two independent variables (both nominal data). The IVs were: gender (two levels: male and female); and NIC organization (four levels: NIC Board, RRB, CATs, and case managers).

An ANOVA yields an F score which indicates a magnitude of differences in the main effects and in the interactions. The main effects refer to the two IVs (gender and NIC organization). The interaction refers to whether the level of one of these IVs affects one or more of the levels of the second IV in reference to each of the specific organizational activities. If a significant F score is obtained for either main effects or interaction, post hoc tests will be conducted to determine which levels and/or which interactions of the IVs are significant.

The following ANOVA assumptions were made: (a) all dependent variables were measured on an interval level; (b) the dependent variables were distributed normally in all groups; and (c) the groups had approximately equal variances on the dependent variables. Cochran's C was used to test

homogeneity of variance. The null hypothesis for this test is that all population cell variances were equal.

Although a fourth ANOVA assumption is that cell sizes should be approximately equal, the varying numbers of people involved in each level of the NIC process prohibited the use of equal sample sizes. To compensate for the different cell sizes, a general linear ANOVA model was used which statistically makes adjustments for unequal cell numbers (Norusis, 1994; Tabachnick & Fidell, 1989).

In Research Question PA1 regarding availability and accessibility of services, the eight ANOVAs conducted examined one each of the following DVs: avoid excessive waiting or delays, keeping bureaucratic procedures to a minimum, providing necessary transportation, providing services in accessible locations, offering extended hours for services, making clients feel welcome, establishing adequate grievance mechanisms, and training staff to work caringly with at-risk youth.

In Research Question PA2 regarding coordination of services and information, the seven ANOVAs conducted examined one each of the following DVs: use of a common intake form, mechanisms for sharing information between agencies, understanding the "big picture" of the NIC service system, providing interagency access to client records, minimizing conflicting rules and procedures, ensuring meaningful discharge between state and community facilities, and developing computerized client information systems.

In Research Question CO1 regarding fiscal management

practices, the six ANOVAs conducted examined scores on each of the following DVs: securing funds from multiple sources, efficient use of resources, assurance of stable and predictable resources, financial structure which incorporates incentives for service providers, system-wide fiscal planning, and capacity to shift resources among agencies to meet the need of at-risk youth.

As self-report instruments were used to measure the variables examined, there are no assurances that the variables were measured without error. An assumption of this study is that subjects responded honestly to the questions on the questionnaire.

ROLES.

Research Question OC1. Has the NIC process decreased the Restrictiveness of Living Environment Scale (ROLES) of its clients? If so, are some CATs more effective at maintaining or lowering ROLES scores of NIC youth?

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES scores of NIC youth.

A composite ROLES adjustment score was calculated for each subject in the ROLES sample who had been in the NIC process at least six months and had been terminated from the NIC process, or had been out of NIC for six months. ROLES scores were obtained by listing a child's living environments in sequential order. The placements were then assigned a ROLES value based on a ranked scale of one to ten (see Appendix C).

The assigned ROLES values were used then in a restrictiveness equation which subtracts the value of each successive placement from the value of the prior placement (i.e., Placement One - Placement Two; Placement Two - Placement Three ...). The subtracted values from all placements were combined to calculate an overall restrictiveness scale. Positive numbers indicate a move toward a less restrictive environment, negative adjustment numbers indicate the child placements are becoming more restrictive, and a score of zero is indicative of maintenance of the child's original placement level. Descriptive statistics such as frequency counts and percentages were calculated for the sample as a whole and for the stratas within the sample.

The second part of this question was analyzed using an analysis of variance (ANOVA). An ANOVA was incorporated in this analysis because the hypothesis tested was a hypothesis of difference, there was one dependent variable (ROLES scores) and one independent variable (CATs) with ten levels. Each level of the IV represented one of the ten CATs examined in this study. The results of this test were of interest in order to obtain evidence regarding the relative efficacy of the individual CATs in obtaining positive ROLES scores for their clients.

CAT Nine, the Juvenile Court CAT, meets twice a month and handles a larger client case load. To compensate for the differences in the number of clients per CAT, a general linear model was utilized (Norusis,1994; Tabachnick and

Fidell, 1989). The assumptions for this analysis were the same as for the ANOVAs previously discussed (Research Question PA1). Youth whose case had been handled by more than one CAT were not included in this study.

Research Question OC2. What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and a lowered ROLES score.

Multiple regression was used to determine the relationship between ROLES scores and the predictor variables of previous out-of-home placement (POOH), age, and parent involvement. Regression was chosen because the hypothesis being tested was a hypothesis of relationship and multiple predictors were being used to determine the value on a criterion variable (ROLES).

Stepwise multiple regression analysis with backward deletion was the regression model performed. Stepwise regression was used to develop a subset of predictor variables to predict ROLES scores, and to eliminate those variables that did not provide significant additional prediction. Using this model, all predictor variables were entered into the regression analysis in the first step.

The regression analysis first establishes an index of the relationship between the predictors and the criterion through the calculation of a multiple correlation

coefficient (R), the square of the multiple correlation coefficient (R^2), and the adjusted R^2 for all variables in the analysis. The variables were then removed one at a time based on removal criteria. To be removed, a variable must have a probability of F of .05 or greater. When no further variables could be deleted based on the removal criteria, the analysis was terminated. The regression analysis also calculated unstandardized B weights and standardized ß weights.

Beta weights (ß) standardize the scores of predictors by calculating the same standard deviation and means. They are similar to partial correlation coefficients which examine the relationship between two variables while statistically removing the effects of other variables in the analysis. The use of beta weights and backwards deletion helped protect again multicollinearity and resulted in the rank ordering of predictor variables and the creation of a regression equation (Kachigan, 1986).

The utility of the regression equation was tested through cross-validation, which involves applying the obtained equation to a new sample. The regression equation created using the FY94 ROLES subjects will be used to predict the ROLES score for subjects in the FY95 ROLES group.

The correlation between the observed FY95 criterion scores and the predicted scores was examined using a Pearson's Product-Moment Correlation. A Pearson's was used because the hypothesis was a hypothesis of relationship

between two variables and the variables were interval data. This analysis yielded a Pearson's correlation coefficient, r, which is an index of the degree of linear relationship between the two variables (observed and predicted scores). The range of possible values are -1.00 for a perfect negative correlation to +1.00 for a perfect positive correlation.

Research Question CO1. What is the relationship between the restrictiveness of living environment scores (ROLES) and the distribution of the Comprehensive Services Act (CSA) funding?

Related null hypothesis. There is no significant relationship between the ROLES scores and the distribution of CSA funding.

The relationship between ROLES scores and the distribution of CSA funds was examined using a Pearson's Product-Moment Correlation. A Pearson's was used because the hypothesis was a hypothesis of relationship between two variables and the variables were interval/ratio data. This analysis yielded a Pearson's correlation coefficient, r, which is an index of the degree of linear relationship between the two variables (observed and predicted scores). The range of possible values are -1.00 for a perfect negative correlation to +1.00 for a perfect positive correlation.

Summary

This chapter presented the research design for the

program evaluation of the Norfolk Interagency Consortium. The next chapter delineates the research process and describes the results of the study's data analysis.

CHAPTER IV

Data Analysis

Introduction

In Chapter One the challenges of services to at-risk youth were presented. The concept of comprehensive systems of care (CSCs) was introduced as a model for addressing the needs of these young people and the theoretical philosophy which currently guides services to at-risk youth was discussed. Chapter Two further examined the CSC concept by investigating the historical treatment of at-risk youth and the evolution of community-based treatments. As the first two chapters provided foundational information regarding CSCs and their need for evaluation, Chapter Three specified the assessment methodology utilized to research a local CSC, the Norfolk Interagency Consortium (NIC). This chapter will extend Chapter Three's descriptions of the research processes as well as report the research findings.

The research questions and related hypotheses in this study were categorized into four areas of investigation: program clarification, processes and activities, outcomes, and cost. The investigations were analyzed using both qualitative and quantitative methods. The analysis of data will be presented by the type of research methodology. As recommended by Borg and Gall (1989) an alpha of .05 was established for all quantitative assessments.

Qualitative Research

Research Question PC1

To what extent is the Norfolk Interagency Consortium (NIC) operating as designed?

Data collected to examine this question was analyzed by synthesizing the information through a process known as an evaluability assessment or EA (Smith, 1989). The EA served as the initial phase of the evaluation process and the data generated from this process was utilized in planning and formulating the remaining areas of this investigation.

The first step in the EA included a review of all program documentation related to the organizational structure of the NIC. Descriptions of the program were triangulated with on-site observations to create a flow model which graphically depicted the NIC Process. Program components which directly impacted NIC's at-risk youth and were expected to affect the program's goals were included in this model. This flow illlustration was referred to as the Documents Model (see Figure 1) and was a visual representation of the program's formally stated components and goals and their linkages.

The second step of an EA was to review The Document Model with program leaders. This review was conducted to: (a) identify program components which were not included in the model; (b) clarify the operation of program components; (c) identify goals and effects which may not have been included in the flow representation; (d) define the goals and articulate appropriate measures; and (e) confirm the

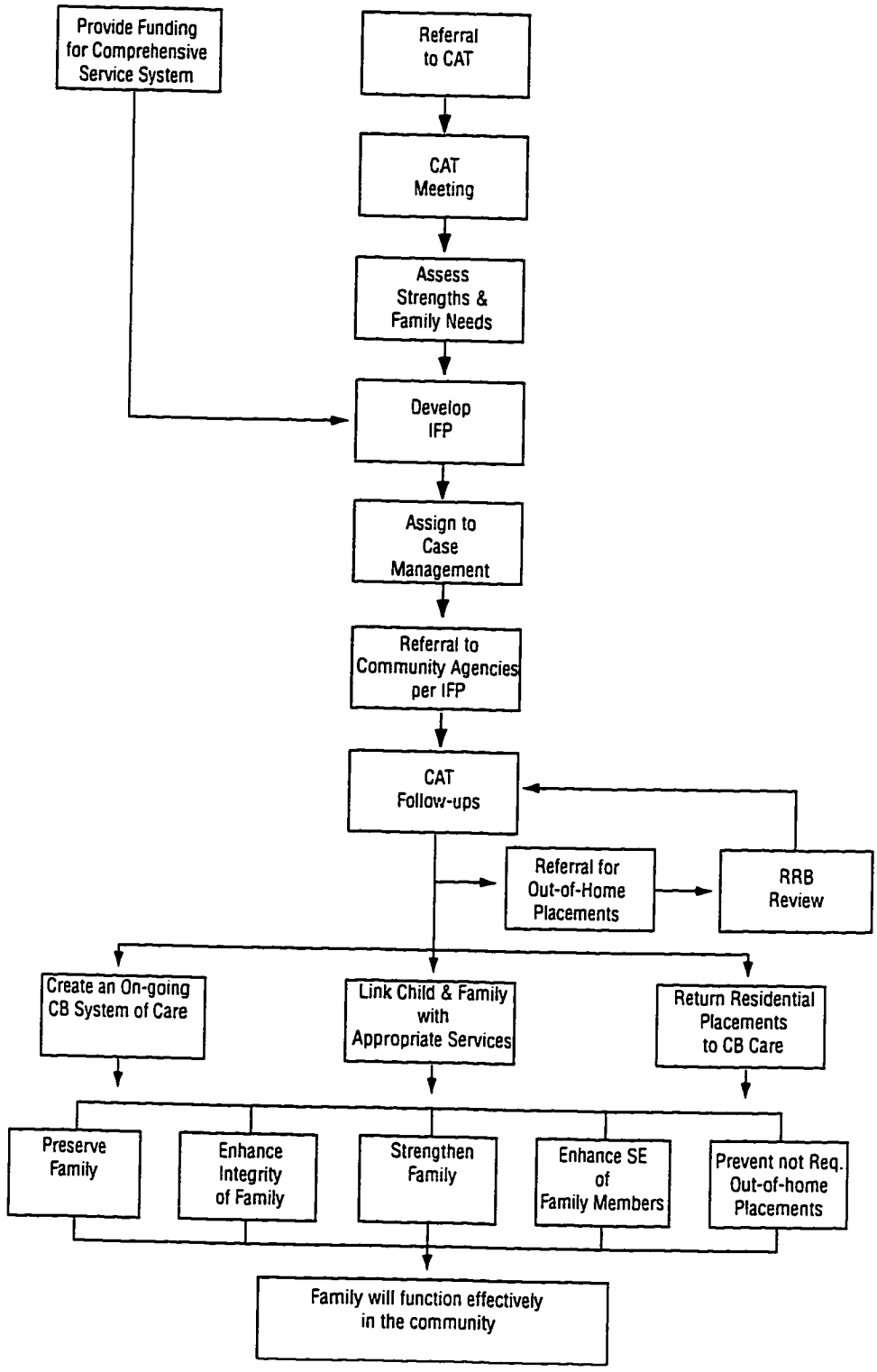

Figure 1. NIC Document Model.

linkages specified between program components and goals. The Document Model was presented and discussed in interviews with program managers and in a focus group with NIC Board members.

NIC administrators and board members decided assignment to case management, referral to community agencies per IFP, and Community Assessment Team (CAT) follow-ups, would be more accurately depicted in a more linear fashion. NIC Board Members also discussed the validity of including two additional elements to The Documents Model.

The first element discussed was the admission/selection process which is required for entry into the NIC. Each agency must conduct its own review of a young person to determine eligibility for the NIC prior to submission of entry forms. While this "in-house" screening is held at each agency's offices and is not part of the actual NIC process, it is a requisite part of accessing NIC services and board members agreed it should be represented in the program's model.

The second element considered for inclusion in the model was direct access children, youth in foster care who receive Comprehensive Services Act (CSA) funds, but do not enter the NIC process. Due to combined funding strands money for these children is included as part of the CSA funds the NIC receives. Board members and program leaders decided that a component should be included which would portray these children and the shared funding arrangement. These three modifications were used in forming a second organizational

representation, referred to as The Program Manager's Model (see Figure 2). The third phase of the EA included the investigation and identification of the program's theory.

Research Question PC2

What is the program's theory?

According to Bickman (1987), program theory is "a plausible and sensible model of how a program is supposed to work" (p.5). A program's theory provides links which connect the program's components and the desired outcomes. Discussion was held with the NIC administration and board members and a documents analysis was conducted regarding the program's theory. The expected outcomes graphically demonstrated by The Program Manager's Model were reviewed, as well as the program components which connect to expedite those ends. The guiding questions used in this process were, "What does NIC want to accomplish?" and "How is this interagency effort accomplishing that?"

These discussions with NIC leaders, the review of the second model, and an examination of the current literature regarding CSCs guided the researcher in advancing a theory for this organization. The theory is that a multidisciplinary, comprehensive continuum of care creates a synergy and a facilitative structure which enables NIC personnel to maintain or lower the restrictiveness of living environment (ROLES) of their at-risk clients. It is presumed, as ecological theories suggest, that a lowered ROLES would have positive impacts not only on the youth, but on the family in general (Bronfenbrenner,1979; Minuchin,

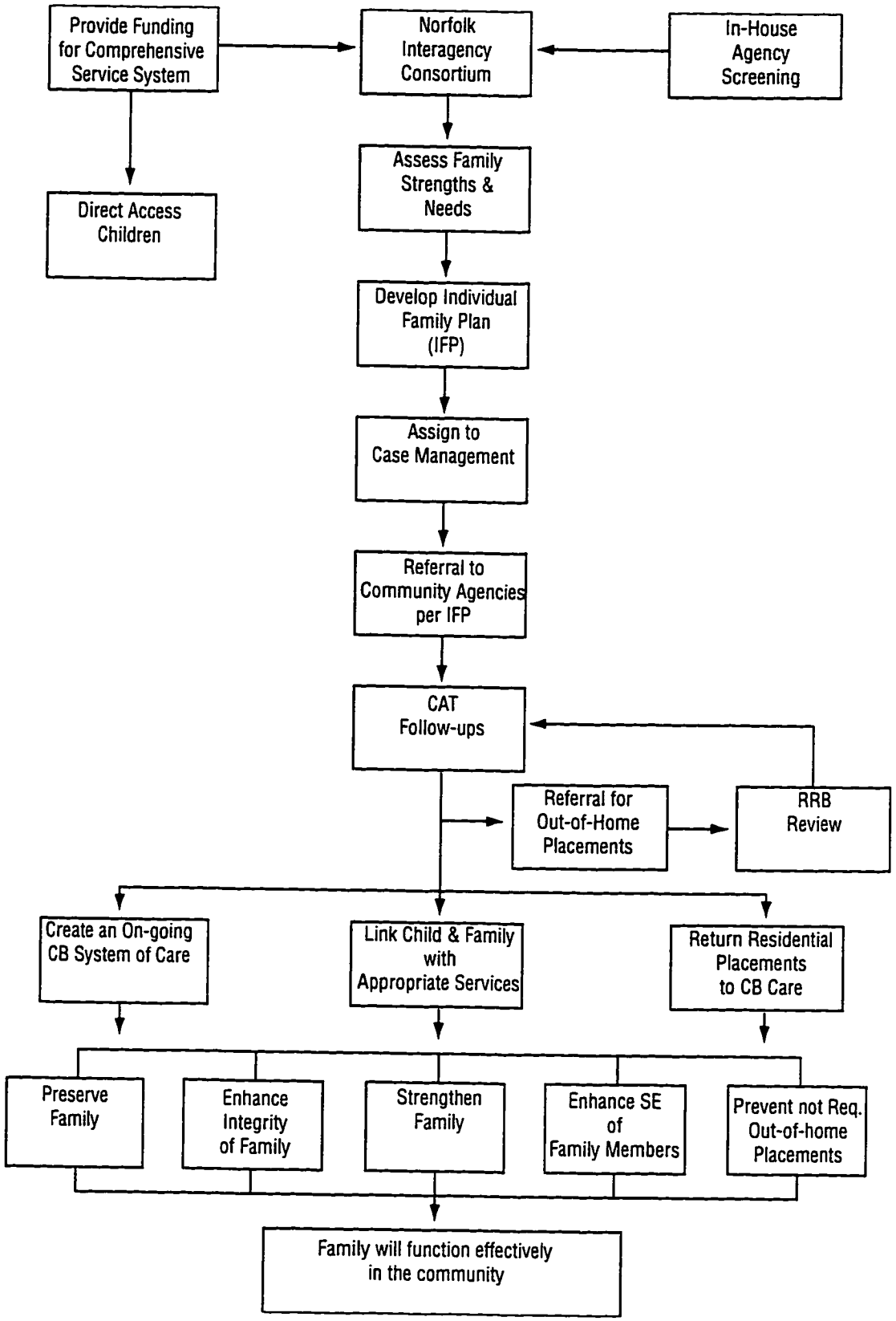

Figure 2. NIC Program Manager's Model.

1974). This theory operated on the assumption that the ecological perspective provides the most appropriate and effective treatment option. The final segment of the EA was determining which components portrayed in The Program Manager's Model were ready to be evaluated.

Research Question PC3

What components of NIC can be assessed?

The process for determining program activities or outcomes which could be evaluated began with identifying assessment criteria. For the purposes of this investigation, the components of the Program Manager's Model were deemed evaluable if they met the following preconditions: (a) They had been created and implemented as described in program literature; (b) The goals and effects could be clearly delineated; (c) Linkages between components and goals were tenable; and (d) Measurable data was available or could be collected (Rutman, 1980).

The Program Manager's Model depicted three intermediate (IM) goals: (a) create an on-going community-based system of care, (b) link child and family with appropriate services, and (c) return residential placements to community based care. The first IM goal, a system of care, had been established as operating as planned by The Documents Model. The effects delineated for this goal were efficient organizational processes and activities. While measurable data was not available, a survey instrument designed specifically for comprehensive systems of care (Morrissey, Ridgely, Goldman, & Bartko, 1994), was obtained to assess

the program's processes and activities (see Appendix B).

The remaining two intermediate goals, linking child and family with appropriate services and returning residential placements to community-based care, were directly related to the ultimate goal of preventing unnecessary placements. As data existed on each child's treatments and the resulting placement, these goals were measured by examining the NIC's ability to provide interventions in a community or family environment. This ability to provide ecological therapy was examined through the use of a Restrictiveness of Living Scale (ROLES) developed by Hawkins, Almeida, Fabry, and Reitz (1992)(see Appendix C).

The remaining ultimate goals, preserving the family, enhancing the integrity of the family, strengthening the family, enhancing the self-esteem of family members, and enabling a family to function effectively in the community, were objectives which had not been clearly defined or operationalized. Accordingly, no data existed to provide indicators regarding the success or failure of NIC with regard to these program impacts. Because these goals failed to meet evaluability criteria, they were not included in this investigation.

To distinguish NIC goals and effects which met the evaluation preconditions from those goals and effects which did not, a third graphic model was created, called the Evaluable Model (see Figure 3). This figure delineated all goals and effects which could be assessed in a rectangular shape with no broken lines. Rectangular shapes with broken

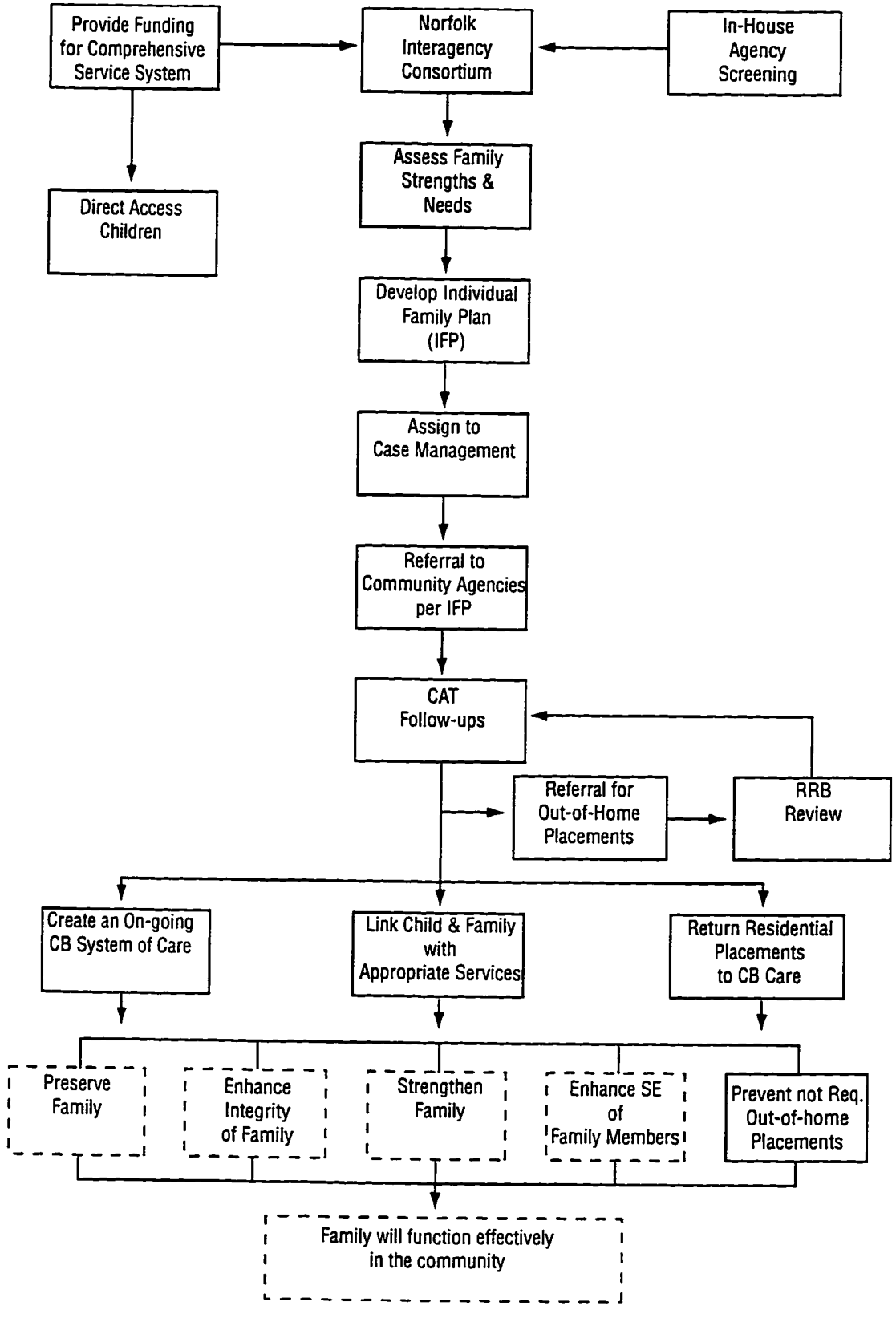

Figure 3. NIC Evaluable Model.

lines indicated elements which did not meet preconditions and could not be evaluated in this investigation.

Research Questions PA3 and PA4

What are the major accomplishments NIC has achieved in regard to services for at-risk youth and their families?

What are challenges of NIC in regard to services for at-risk youth and their families?

These research questions were part of Section Four of The NIC Survey. Over 70 percent of the 149 survey participants responded to these open-ended inquiries (n=105). Response by NIC level was as follows: NIC Board, 88%; RRB, 78%; CATs, 84%; and Case managers, 56%. Table 4 displays the responses by categories and NIC levels.

Table 4

Survey Comments by Category and NIC Level

NIC Level	Accomplishments	Challenges
NIC Board	19	14
RRB	17	21
CATs	122	100
Case Managers	82	84

Results. The perceptions offered regarding NIC's accomplishments and challenges were categorized by NIC levels through a process known as coding. Coding is a qualitative process whereby data is examined for patterns, characterized by attributes, and categorized with titles or

descriptors (Strauss & Corbin, 1990). All comments given were reviewed for patterns. These patterns included the repeated use of specific NIC terminology, phrases, or references to discrete processes or activities. The categories which emerged from the coding process were: NIC services, the interagency structure, the NIC Model, and funding.

As these categories have areas which could overlap, the specific attributes of each was defined in the coding process to clearly delineate the scope of their representation. NIC services included all comments related to the service/treatment aspect of NIC. This included references to case managers, actual services, service delivery, service monitoring, and vendors. Interagency structure comments were those remarks specific to the interaction of the various NIC agencies in the NIC process or the resulting outcomes of this interaction. Key words included agency, team, collaborative, or multi-disciplinary. The NIC Model observations were statements related to the actual NIC processes, including organizational activities, procedures, or operations. The Funding category were those comments which were directly related to CSA funds. Key words included cost, money, budget, and funding.

Within each category, assertions were made using a model of analysis developed by Erickson (1986). An assertion is an inference which is inductively generated based on a repeated review of the data. These statements of assertion are validated by locating alternative sources of data which

corroborate their supposition. Assertions which can only be supported from one data source, regardless of their frequency, are considered the least reliable (Erickson).

In this study, only inferences which could be supported by two or more NIC levels were considered as possible assertions. The use of two or more levels was established because an acknowledgement of an accomplishment or challenge by only one level might simply represent a complaint or attribute associated with that level. Comments reiterated by more than one level are more indicative of a pattern of activities or organizational behaviors, signifying a more valid inference. In addition, the validity of assertions was established by identifying multiple sources of data. Only those assertions which could be supported by more than one data source were included in these findings.

NIC Services.

The area which received the most comments from all NIC levels was Services (n=92). Three of the four levels responded most frequently about this aspect of NIC. Comments regarding this category represented 47% of the RRB's total remarks and 40% of the CATs' remarks. Comments were distributed nearly evenly in these groups between accomplishments and challenges.

The first assertion regarding services is that NIC has been instrumental in the expansion of new services and in the identification of service options. All four levels articulated this assertion regarding new services with multiple comments. Some of these comments included:

1. "(NIC has) assisted in the development of a range of community based services for children."

2. "City employees working together ...often find 'free' programs in the community that will assist the family in need."

3. "(NIC has) gotten vendors to come up with creative means of serving Norfolk's youth."

Specific services which were noted by respondents were preventative foster care, home-based services, intensive probation, and community sex offender therapy.

The assertion of expanded services was supported by interviews with the executive director of NIC. NIC administrators have frequent communication with local vendors regarding specific needs and deficiencies in the current continuum of care. This interaction allows vendors to be aware of service needs and expand their programs accordingly.

Evidence of this service expansion is observable readily through an examination of NIC fiscal records. In FY94, CSA funds were used for services/service vendors in only eight different treatment arenas. In FY95, the kinds of services for which funds were spent increased to 14 and in FY96, the number had grown to 22. Many of these new services are ecological in nature and reflect NIC's requests for expanded wrap-around/community-based options.

Other validation for this assertion emerged from interviews with NIC's agency directors. Working collaboratively, these directors have been awarded several

grants and/or have designated some of their own budgets to create several new programs. These programs reflect the comprehensive requirements of Norfolk's at-risk youth, are ecological in design, and provide CATs and case managers with additional service options. Furthermore, a review of NIC files indicated the NIC process has identified at least 39 community or other agency programs which have been incorporated into intervention plans for their clients.

Other survey comments which were related to this assertion included the following:

1. "All levels of the NIC acknowledged the use of expanded wrap-around services and the promotion of community-based interventions as an accomplishment." Comments such as "more client centered planning" and "reuniting children with their families whenever possible" were offered as accomplishments.

2. Having services "all in one place at one time" was also noted as an achievement by two or more levels. References to sharing information between agencies and the elimination of service duplication were viewed as positive.

While numerous accomplishments were cited in the area of services, nearly as many comments were given describing challenges or shortcomings which NIC faces in this area (n=81). Based on a review of the comments, a second assertion was made. The assertion made is that the NIC faces the challenge of inadequate services. While there has been an expansion of services/service option, all four levels noted the quantity of offerings does not meet the needs of

Norfolk's at-risk youth. Specific services noted as lacking were in the areas of substance abuse, mental health, alternative living, juvenile sex offenders, and foster homes for adolescents with complex or multiple problems. Three of the four levels also stated that additional services should be made available to non-mandated young people.

This assertion is supported by a state report regarding comprehensive systems of care (CSCs) in the CSA pooled funding stream. This report revealed that in FY94, the Norfolk CSC served 350 young people. In FY95, that number had more than doubled to 840. While services have been expanded, their growth has not matched the increase in the numbers of NIC clients.

Other substantiation for this assertion is found in the files of NIC clients. At each CAT and RRB meeting, narratives are written regarding each child. In these narratives, case managers indicated services have not been provided or have been delayed because a provider cannot be found or a waiting list exists with an appropriate vendor. These narratives also revealed the lack of specific service needs such as step-down or transitional living environments for youth with complex or multiple problems. There are notations regarding 'create-a-placement' teams which are established to find an appropriate less restrictive environment for NIC clients. Interviews with NIC administrators, personnel from the RRB, CATs, and case managers have also validated this assertion.

Another warrant for this assertion was the data

obtained through another section of The NIC Survey. All levels of the NIC were asked to respond to the question, 'How many at-risk youth in Norfolk who need this service are getting it?' The services referred to were eleven options currently available to at-risk youth in Norfolk. Ratings were based on a Likert scale with the following responses: all, most, some, few, none. The mean rating of all services was approximately a three which indicated 'some' youth were getting the service. The mean ratings of case managers were consistently lower than other NIC levels indicating they believed services in Norfolk were less adequate.

A third assertion regarding services is that NIC has the need for greater quality control to ensure treatment fidelity. Three of the four levels noted the need for greater monitoring of client services. Comments included:

1. "No control over 'quality' of services or assessing the length needed."

2. "(We need) better tracking of hours people are actually working with these families."

This assertion was authenticated further by interviews with NIC administrators. These program directors are cognizant that vendors have been paid with limited accountability for services delivered to clients. Prior to August, 1996, service vendors were not required to address a specific intervention objective and there was a lack of focus on explicit, measurable outcomes. The current NIC process requires vendors who are contracted to provide services specific to the objective-driven intervention plan.

While this will likely encourage more accountability, the rapid expansion of service vendors will necessitate on-going monitoring.

Evidence which corroborated this assertion also was found in the NIC files. In some of the narratives written at each CAT and RRB meeting, case managers reported discrepancies in time or erroneous interpretations of service delivery by local vendors. Interviews with case managers indicated they contract with vendors whose work they are familiar with whenever feasible. Case managers are often faced with monitoring vendors to ensure the time and services requested are delivered professionally and as contracted.

This assertion was substantiated also by findings from The NIC Survey. All levels of the organization were asked to rate the quality of eleven service elements currently available to NIC youth. The mean rating for all eleven services was approximately three which indicated "adequate". It should be noted that case managers rated services consistently lower than the other levels of the NIC. Their mean ratings indicated an evaluation of less than adequate on six of the 11 services.

Funding.

Comments regarding finances were classified in a second category. Three NIC levels gave challenge remarks for funding three times or more than remarks for accomplishments. Two levels of the organization offered no positive observations related to funding. While there were

several challenge statements, the first assertion offered for funding is an accomplishment. The assertion is that NIC's pooled resources have helped more families.

This assertion is supported not only in the survey by two or more levels of the NIC, but by the actual numbers of clients served. As previously mentioned, between the first and second year of CSA operation, the number of at-risk youth served more than doubled. In addition, several of the programs initiated by NIC agencies serve families who are not part of the NIC process. Their efforts divert children into other ecological, community-based interventions expanding the number of families impacted to an even greater magnitude.

Another confirmation for this assertion is the use of NIC funds for innovative community-based treatment options. Because NIC's ecological emphasis is not bound by a specific treatment protocol, it can consider a wide array of potential interventions based on the needs of each family. This approach has provided funds for services previously not accessible to many at-risk youth. Fifty-seven percent of all accomplishment remarks alluded to the ability to purchase these services. The purchased service most frequently noted was home-based interventions. Data regarding the use of NIC funds was secured from fiscal records and from client files.

A second assertion made regarding funding is NIC faces the challenge of providing services without sufficient resources. Seventy-nine percent of the challenge comments from all four levels noted insufficient funds as a

difficulty. Participants' responses included:

1. "Money!! MORE MONEY!!"

2. "A major challenge is to continue to be consistent and effective in giving the families the appropriate services when there are so many budget cuts."

Specific services mentioned as having inadequate funding included long term care/residential, vocational training, early intervention, substance abuse, and family assistance when the child is out of the home. Three NIC levels also noted pending budgetary legislation as a concern.

This assertion is supported by a report from the state of Virginia regarding CSCs within the CSA funding pool. It stated that in FY94, $3,520,871 was spent on 350 children. In FY95, while the number of youth served more than doubled, funding increased by only 27%. Additional confirmation of this assertion can be found in the NIC files. Narrative records indicate references to the lack of money or the expiration of funds.

NIC Interagency Structure.

A third categorical area of comments were related to NIC's interagency structure. While funding comments were offered more as challenges, 91% of the total remarks given regarding the interagency (IA) concept were noted as accomplishments (n=75). An assertion made regarding IA structure is that the NIC has facilitated the development of an effective interagency relationship. All four levels reported improved IA collaboration, cooperation, and

communication as an achievement. An observation offered was:

1. "There appears to be more of a friendship between agencies who work together rather than agencies feeling they are separate from other agencies."

Another IA outcome which was mentioned by all four levels as an achievement was the involvement of the various disciplines represented by NIC agencies. Statements included:

1. "Maximizing resources by bringing all disciplines to the table and planning for these complex multi-problem youth."

2. "You don't have to make phone calls all over the city to find out how certain agencies can help. Generally the teams (CAT) have those representatives and input."

Additional confirmation for this assertion was found in interviews with agency directors. Most directors interviewed were explicit in their affirmation that their agencies not only see the need to work together, but are actively engaged in the process. In referring to budgetary money, one director stated that allocated funds were no longer viewed as "my money" but "the community's money". Agency directors also indicated that working with each other has provided a different perspective with which to view the at-risk children they work with and the "process results in a better product".

Other evidence warranting this assertion was demonstrated in the actual programs being developed between agencies within the NIC process. Agencies have designated

portions of their budget to purchase personnel or services from each other and provide office space for staff from their partner agencies. In addition, NIC agencies have written and received collaborative grant money which has enabled them to develop programs which extend the continuum of care for young people in Norfolk.

The NIC Model.

The last category of comments referred to concerned the NIC Model. All levels of NIC remarked that the development of a system of care (CSC) was an accomplishment. Comments included:

1. "(The) concept of NIC is positive."
2. "The idea is good."
3. "Development of the NIC model has been a major accomplishment that is difficult if not impossible to find in other localities."

CATs and case managers repeatedly noted the inclusion of parents in the process as a positive feature. CATs also observed the client review process as an achievement.

While there were various statement made regarding the accomplishments of the NIC model, the only assertion which met study criteria is a statement regarding a challenge to NIC. The assertion is that there are facets of the NIC process which may negatively impact the effectiveness of the organization.

All levels except the NIC Board cited "red tape" as a challenge. These same levels also noted time as a concern for getting clients into the NIC, as well as in clients

receiving services. Time was an issue for survey respondents from all levels because of the various meetings and the time commitment required.

While several challenges regarding this last category were shared across levels, case managers offered specific concerns unique to their positions in the NIC. Case managers from all agencies cited multiple comments which indicated negative interactions with CATs. These included a lack of support, a sense of being "interrogated", lack of consideration for their recommendations, poor communication, and minimizing the importance of the case manager.

These negative interactions represented over one-third of all case managers' responses in this category (n=15). The concern by case managers was reiterated by a CAT member who noted that the "complicated process frustrates case managers and may interfere with case managers pursuing services". It should be noted that despite their process-related concerns, several case managers believe NIC is a good concept and one person commented that CAT members were "extremely helpful and supportive".

Confirmation of this assertion was obtained through data collected from conversations with NIC personnel and a focus group. In these conversations, case managers indicated the NIC process could be frustrating and they dreaded taking their cases into the process.

The challenge of time, specifically in getting into the process and receiving services, is also supported by documentation from client intake forms. Of the 182 FY94 and

FY95 files examined, 100 were stamped with a date of receipt noting the day the form was received by the NIC. Using this date of receipt and the date of the first CAT meeting, a lag time between referral and NIC entry was calculated. The mean length of time between referral and the first meeting was 33 days.

Several general statements were given in the open-ended comment section of the survey. These included:

1. "This is 1996. Families need more income in order to pay the high cost of utilities, groceries, and medical care. All families are not on food stamps or medicaid or ADC. They have some basic needs. After a family pays a rent or mortgage and high utility bills, there is little left. Financial stress in families results in alcoholic parents, spousal abuse, child abuse, etc."

2. "Rather than send children to residential, pay parents that money to take care of their own children. Let them purchase the help they need."

3. "We need to increase foster care payments by providing supplemental funds for foster parents who have teens."

4. "Would like to see more peer groups and counselor facilitators utilized in many instances. Peers are extremely important in this developmental stage and this type of resource may be under utilized."

5. "At-risk children need to be targeted at an earlier age."

6. "At-risk youth have a multiplicity of problems."

7. "The increasing domestic disintegration of families increases the number of dysfunctional youth."

Research Question OC3

What is the community impact of NIC with regard to the implementation of new services and the creation of a continuum of care?

A report completed by the Norfolk Office on Youth and the Norfolk Services Citizen Advisory Board (1994) surveyed all levels of the NIC to determine gaps in services for at-risk youth in Norfolk. This report noted that the limited finances available to the NIC through the Comprehensive Services Act (CSA) prohibit the development of population specific services (i.e, mental health sex offenders, mental health sex offender who is emotionally disturbed, etc.). While specific services are desirable, financial realities will mandate the development of a more generalized continuum of services. The report stated that the following program elements should be created and strengthened to increase NIC's ability to serve its at-risk population more effectively: family therapy, respite care services, therapeutic foster homes, mental health assessment and treatment, and parent support groups. The development of these services will provide a measure of NIC's ability to impact a continuum of care in Norfolk.

An examination of NIC's fiscal records provided data in regard to the impact NIC has had toward the development of these recommended program elements. FY94 records indicated that CSA expenditures were distributed in only eight service

areas: residential, home-based, therapeutic foster care, group homes, specialized foster care, day schools, emergency shelters, and independent living. In FY95, the number of service areas had expanded to fourteen and included therapeutic respite, intensive probation, camps, in-home support, outpatient services, and miscellaneous (transportation and tutoring). By FY96, the number of service areas had increased to 22 and included companion services, mentoring, supported living, teacher assistants, wilderness therapy, and speech.

In addition, several of the agencies within NIC have written collaborative grants which have provided several new service options. These include interagency programs which address substance abuse, mental health issues, juvenile offenders, and prevention education.

While NIC did not commission the creation of these new programs, comprehensive systems of care and their human service agencies are the primary purchasers of services to at-risk youth and their families. Their emphasis on ecological, community-based interventions has invoked a basic supply and demand outcome. As the need for treatment options which keep a child with his family or in the community are increasingly mandated, service providers have responded accordingly.

Research Question OC4

What is the community impact of NIC with regard to agency integration?

In explaining the integrated efforts between agencies,

one director noted that it is, "hard to tell where one thing stops and another begins". Agencies share funds, resources, and personnel in distinctive ways that make organizational lines less defined. An example of these unique structures is an arrangement between the Norfolk Department of Social Services (NDSS) and the Norfolk Juvenile Court Services Unit (NJCSU). Two NDSS social workers work in office space located beside the judges' chambers in the juvenile court building. These social workers have computers which are networked with the NDSS mainframe and their salaries are paid for by social services funds. Office space, including equipment, phones, and other utilities is absorbed by the NJCSU. These social workers are available to work with families who wish to submit guardianship of their children to the courts. They help families locate necessary physical resources and alert them to service options, such as respite care and home-based counseling, which might help maintain the child at home. They also help manage the NIC's Preventative Foster Care Program which can help access services for cases being handled by probation officers and mental health people in the court system.

There are several other programs which have been established collaboratively through interagency efforts between NIC organizations. These programs are community-based and structured to be more comprehensive and integrated in their approach. Examples of these efforts include the following:

1. The Division of Youth and Family Services (DYFS), a

component of the NDSS, has "cashed out" two of their positions for two mental health workers. These workers are hired by the Community Services Board, who maintain training and support, but paid for by the DYFS. These people, who are Master's level clinical psychologists, work at the two DYFS group homes in Norfolk providing screenings and evaluations, crisis intervention, individual, group, and family counseling at no cost to the youth or their families. A similar relationship is planned for the Norfolk Detention Home when the new facility is opened.

2. Alternatives to Incarceration is a collaborative grant effort between the Community Services Board and the Juvenile Court System (JCS). Two Master's level mental health workers provide screening, assessment, and referral for any child who comes into the JCS. This program has revealed that over 50% of the youth who gain access to the courts have a severe mental disorder which has already been diagnosed. Often their medications have not been evaluated, monitored, or taken consistently. These young people and their families are diverted into mental health services who can prescribe and monitor drug therapy. The mental health counselors are also available to accompany their clients to court as part of the Juvenile Court Services Team.

3. Substance Abuse Support Services for Youth (SASSY) is a twelve week intensive outpatient substance abuse program for youth referred by the school or court system. The program meets three evenings a week after school for a total of nine hours. Parents must attend one evening with

their child. Random drug screening is conducted and counseling is provided for individuals and families.

4. Bridges to Recovery is a collaborative grant effort between the DYFS and the Community Services Board (CSB). Bridges is an intensive wrap-around program which provides case management, group counseling, home-based family intervention, and education for young people placed in a Norfolk group home and their families. Other services include random drug screens and drug free family oriented recreation opportunities.

5. The High Risk Youth Program is another collaborative effort between the CSB and the JCSU. This program provides early intervention/prevention education for parents and children. Topics include substance abuse, teen pregnancy, HIV/AIDS, Violence and Gangs, Anger Management, Job Search, and School Skills. At least one random drug screen is administered.

6. Chemical Abuse Prevention through Educational Services (CAPES) is a collaborative effort between the Norfolk Public Schools, the Community Services Board, and the Juvenile Court Services Unit. CAPES is a community-based early intervention program for adolescents who have been referred for alcohol and/or drug related offenses. At-risk youth and their parent/guardian are provided with assessments, referrals, and a life skills curriculum. Participation in the program may allow for the diversion of the youth's criminal charges which are related to alcohol and/or drug offenses. Follow-up services are provided for

one year following the program's completion.

7. The NIC's Court CAT will refer clients and their families to Return to Recovery, a program created for youth with substance abuse problems who require treatment in facilities outside Norfolk. The out of town locations may prohibit families from being involved in the child's intervention process, making a return home difficult. Return to Recovery staff provide family therapy while the youth is away and during the return. This therapy focuses on relapse prevention and family restructuring.

8. Norfolk was the recent recipient of a grant from the Virginia Juvenile Community Crime Control Act (VJCCCA). This grant was to develop an evening reporting system which would supplement traditional group home or detention placements for first time offenders. During this ten week program the youth is transported directly from school to an evening reporting center to do homework and participate in group activities, educational and vocational training, and counseling. Young people report every evening Monday through Friday until 9 PM and all day Saturday. Parents must also be involved in the process. One of the requirements for applying for VJCCCA grants is community planning. One of the directors involved in this grant process noted that the interagency NIC format had expedited the Norfolk Human Services Agencies' ability to work together effectively.

Quantitative Research

Research Question PC4

What are the characteristics of the population served by NIC?

Results. Descriptive statistics were used to analyze the target population data. The sample indicated that FY94 youth were 75% male (n = 48) and 25% female (n = 16).

Eighty-one percent or 43 of the FY94 youth had had previous out-of-home placements. While their ages ranged from one to seventeen, the average NIC client was 13.5. Only eight young people were 10 or younger; 86% were 11 or older (n = 55); 58% were 15 or older (n=37). Table 5 displays family structure and racial distribution by percentage distribution.

Referrals to NIC were divided between four of the participating agencies. The Norfolk Juvenile Court Services Unit (NJCSU) led the referrals with 61% (n = 39), followed by the NDSS with 22% (n = 14); the Norfolk Public Schools, 14% (n = 9); and the Community Services Board, 3% (n = 2).

Processes and Activities

Research Question PA1

How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services?

Related null hypothesis. There is no significant difference in the assessment of availability and accessibility of services with respect to NIC Organizational Level or Gender.

One hundred forty-nine NIC personnel participated in the survey which addressed this question. The number of respondents and percentages by NIC levels were: NIC Board, 8 (100% return); RRB, 8 (89% return); CATs, 61 (82% return); and Case Managers, 72 (73% return). Case manager participation by agency was: Norfolk Public Schools (NPS), 79%; Norfolk Department of Social Services (NDSS), 93%; Community Services Board (CSB), 100%; and Norfolk Juvenile Court Services Unit (NJCSU), 52%.

Table 5

Distribution of Target Population by Race and Family Structure (n = 64)

	Percentage Distribution
Family Structure	
Single Parent Mother	50
Social Services Guardianship	21
Two Parent Home/One Step	12
Two Parent Home/biological	7
Relative	5
Single Parent Father	3
Family friend	2
Racial Distribution	
African-American	60
White	34
Hispanic	2
Other	4

Several demographics were collected from the survey respondents. Racial distribution of the group was 44% African-American (n=64); 43% White (n=62); 1% Asian (n=1); 1% Spanish-American (n=1); 1% Other (n=2); and 10% Undesignated (n=15). Gender distribution was 23% male (n=33); 71% female (n=103); and 6% Undesignated (n=9). While the mean years of experience varied between levels, all four organizational structures had an average of 13 years or more experience with at-risk youth and 11 years or more experience with at-risk youth in Norfolk. Table 6 displays the years of experience by NIC level.

Table 6

Demographics of The NIC Survey Participants: Mean Years of Experience with At-Risk Youth

	Total Yrs	Range	Norfolk Yrs	Range
NIC Board	19	2-33	18	2-33
RRB	24	16-31	16	1-28
CATs	15	.5-30	13	.5-30
Case Managers	13	0-31	11	0-26

The 149 participants in this survey responded to the question, "How well does the current service system for at-risk youth in Norfolk perform in the following activities?" The activities referred to were eight separate services related to the concept of availability and accessibility. Assessment of each service was obtained using a Likert Scale

which ranged from one to five with a don't know option. The rankings of the Likert Scale were as follows: one = very well, two = fairly well, three = adequately, four = fairly poorly, five = very poorly, and six = don't know. Don't know responses had no value and were not part of any statistical analysis.

Results. Mean scores were calculated for each activity pertaining to availability and accessibility of services (Survey questions 2.01-2.08). Means for the total group clustered around the response of three (rating of adequate) except for Question 2.06, making clients feel at ease in service settings. Group means for this activity were 2.36 (performance rating of fairly well).

Mean scores were calculated also for each level of the NIC organization. Scores by level indicated that the higher the level of the organization, the higher the ranking of each activity. NIC Board members tended to rank these practices at or near two while Case Managers' rankings were three or above. Rankings of the two middle NIC tiers consistently averaged means which fell between the other two levels. The only activity which all four levels ranked the same was Question 2.05, regarding offering services on weekends and evenings. All levels ranked this at approximately three. The mean scores for all eight activities by NIC levels is illustrated in Table 7.

Eight 4 x 2 (NIC Level x Gender) ANOVAs were calculated, each using one of the following dependent variables (DVs): (a) avoiding excessive delays, (b)

minimizing "red" tape, (c) transportation, (d) accessible services, (e) evening and weekend services, (f) making clients feel at ease, (g) establish grievance mechanisms, and (h) staff trained for at-risk youth. These DVs were measured by a Likert Scale assessment on The NIC Survey. The four NIC levels were: NIC Board, RRB, CAT, and case managers. Because the cell sizes in this analysis were of unequal size, the general linear ANOVA model was used.

Table 7

Mean Scores of Availability and Accessibility of Services by NIC Level

	NIC Board	RRB	CATs	Case Managers
Avoiding excessive waiting/delays	2.14	2.50	2.64	3.34
Minimizing "red tape	2.14	2.50	2.79	3.51
Transportation	1.68	2.88	2.88	3.36
Services located accessibly	2.43	2.25	2.78	2.98
Evening/weekend service hours	3.00	2.75	2.86	3.24
Making clients feel at ease	1.68	1.75	2.26	2.60
Establish grievance mechanisms	1.80	2.86	2.80	3.05
Staff trained for at-risk youth	1.57	2.75	2.53	2.86

(Norusis, 1994; Tabachnick & Fidell, 1989). Table 8 displays the obtained F scores for main effects.

Because the analyses in Table 8 indicated significant differences between NIC levels, the null hypothesis was rejected. Post hoc analyses, using Bonferonni/Dunn, were performed on these significant F scores to determine which pairs of group means were significantly different from each other. Significant differences were between case managers and the NIC Board in avoiding delays, minimizing "red tape", and having a trained staff to work with at-risk youth. Significant differences were between case managers and CATs in avoiding delays and minimizing "red tape".

Homogeneity of variance tests for significant scores were satisfied by Cochrans C. The null hypothesis of Cochran's C is that all cell variances are equal.

Research Question PA2

How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There is no significant difference in attitudes regarding the assessment of coordination of activities and information with respect to NIC Organizational Level or Gender.

The subjects used in this research question were the 149 NIC personnel utilized for Research Question PA1. Participants responded to the question "To what extent do you agree with the following statements about the NIC?" The statements referred to described six practices related to

Table 8

Factorial Analysis of Variance for Availability and Accessibility of Services in NIC

Source	F		
	Gender[a]	NIC Level[b]	Interaction[c]
Avoiding delays in scheduling	1.26	6.39**	1.03
Minimizing "red tape"	3.67	6.70**	2.59
Transportation	.03	2.41	.15
Services located accessibly	.20	1.37	.93
Evening/weekend service hours	2.24	2.01	1.94
Making clients at ease	.26	4.68	1.01
Use of grievance mechanisms	.52	3.87	1.99
Staff trained for at-risk youth	1.82	3.97*	1.01

Note. [a]df = 1. [b]df = 3. [c]df = 7.
*p < .05. **p < .001.

the concept of fiscal management. Respondents evaluated these activities using a five point Likert Scale as in Question PA1.

Results. Mean scores were calculated for each activity pertaining to coordination of services and information (NIC Survey questions 2.09-2.15). Mean scores computed for levels indicated that NIC Board members' rankings clustered at or near two, Case Managers' rankings were at or near three, and

the remaining two NIC levels' means were in-between. Two exceptions to this numerical order were found in Question 2.12, interagency access to client records; and Question 2.15, the development of computerized client information systems that link with public and private service providers. Group means were approximately 3 (adequately) with exceptions again on Question 2.12 and 2.15. Table 9 illustrated mean scores for the seven activities by NIC level.

Table 9

Mean Scores of Coordination of Services and Information by NIC Level

	NIC Board	RRB	CATs	Case Managers
Common intake form all agencies use	2.00	2.14	2.33	2.98
Interagency sharing of information	2.43	1.71	2.70	3.18
Understanding of CSC model	1.86	2.13	2.56	3.13
Interagency access to client records	1.83	1.88	2.44	2.68
Minimize conflicting rules/procedures	1.67	2.13	2.64	2.98
Discharge planning by state/community	2.00	2.25	2.81	3.14
Computerized client records	4.17	3.68	3.89	3.76

Seven 4 x 2 (NIC Level x Gender) ANOVAs were calculated, each using one of the following dependent variables: (a) common intake form, (b) interagency information sharing, (c) understanding of the NIC model, (d) interagency access to client records, (e) minimizing conflicting rules/procedures, (f) discharge planning by state/community, and (g) computerized client records. These were measured by a 1-5 Likert Scale on The NIC Survey. The four NIC levels were: NIC Board, RRB, CATs, and case managers. A general linear model was used to compensate for the uneven sizes of the NIC levels (Norusis, 1994; Tabachnick & Fidell, 1989). Table 10 shows all obtained *F* scores for Coordination of Services and Information by main effects.

Because the analyses in Table 10 indicated significant differences between NIC levels, the null hypothesis of no difference was rejected. Post hoc analyses using Bonferroni/Dunn were conducted on all significant *F* scores to determine which pairs of group means were significantly different from each other. Significant differences between case managers and the RRB appeared on interagency sharing of information. Differences which were less than .05 also appeared between case managers and CATs and between case managers and the NIC Board in understanding of the NIC model. Homogeneity of variance tests for significant scores were satisfied by Cochrans C. The null hypothesis of Cochran's C that all cell variances were equal was not rejected.

Research Question OC1.

Has the NIC process affected the overall Restrictiveness of Living Environment Scale (ROLES) of its clients? If so, are some CATs more effective at maintaining or lowering the ROLES scores of NIC youth? What are the characteristics of the sample used for this study?

Table 10

Factorial Analyses of Variance for Coordination of Services and Information in NIC

	F		
Source	Gender[a]	NIC Level[b]	Interaction[c]
Common intake form all agencies use	1.81	3.18	2.31
Inter-agency sharing of information	.17	3.81*	.44
Understanding of CSC model	3.35	5.39*	1.40
Inter-agency access to client records	.74	2.23	1.19
Minimize conflicting rules/procedures	3.75	3.41	.58
Discharge planning by state/community	1.06	2.76	1.53
Computerized client records	.42	.34	.52

Note. [a]df = 1. [b]df = 3. [c]df = 7.

*$p < .05$.

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES of NIC youth.

Characteristics of Six Month Sample by Category

Family structure was the only characteristic which was similar among the three categories of NIC youth. Single parents (predominantly mothers) were the most prevalent structure and two parent biological homes the least predominant. Table 11 shows the distribution of family structures in the Six Month Sample.

Racial distribution was similar in the mandated and other categories. Mandated youth were 78% African-American, 19% white, and 4% biracial; others were 78% African-American, 22% white. Non-mandated youth were 62% African-American, 31% white, 5% not labeled, and 3% biracial.

Several other differences were revealed in the three stratas including gender, previous out-of-home placements, age, and ROLES scores. Young people in the mandated category were more likely to be females (56% female, 44% male) while non-mandated and other clients were more proportionally male (non-mandated: 74% male, 26% female; other: 67% male, 33% female). None of the other clients had had a previous out-of-home placement while 93% of mandated children and 74% of non-mandated had been placed out of the home prior to NIC entry.

Clients in the other category had a mean age of < 8.6 while the mean age of mandated youth was > 12 and non-mandated was > 14.5. Other youth were also less likely to

experience an out-of-home placement (OOH) during their tenure in the NIC. Eleven percent of the youth from this category had an OOH while in the process as compared to 89% of the mandated and 87% of the non-mandated. From the OOH placements which occurred while in NIC, ten mandated youth and one non-mandated child were still in the intervention process as of June 30, 1996. The percentage of young people who had exited the process with lowered or maintained ROLES scores were as follows: Mandated, 86% (n = 12); Non-mandated, 73% (n = 24); and other, 0% (only one child with a ROLES of -.4).

Table 11

Distribution of family structure in Six Month Sample of NIC Youth by percentile

	Mandated*	Non-mandated	Other
Single Parent-Mom	41	64	78
Single Parent-Dad	0	5	0
Social Services	52	0	0
Two parent-Bio/step	4	10	0
Other relative	4	13	11
Two parent-Bio	0	8	11

* Not all percentages equal 100% due to rounding.

NIC files suggested that mandated youth are the most labor intensive category with a mean number of CATs >7 and mean number of RRB meetings > 3. The mean number of meetings per non-mandated was CATs, < 5.5; RRBs, < 2.4 and other was

CATs < 5.7 and RRBs = 0. NOTE: The mean numbers of meetings was calculated from July 1, 1993 to June 30, 1996 and does not reflect the continued meetings which will be held on the 11 FY94 youth still in NIC.

Volatility indices were calculated also for each group based on the magnitude of the changes in living environments, as measured by the ROLES index. A ROLES change of three or more indicated a more volatile change (i.e., from home to therapeutic foster care or home to a youth services group home).

For mandated children still in the NIC process, 80% had a ROLES change of three or higher. These young people tended to move up and down the index in jumps, i.e, up three, down three. The mean number of placements for this group, through June 30, 1996, was 5.4. Of the mandated youth out of NIC, 71% had volatile changes in their living environments. While their mean number of placements was 3.2, the median placement was 1.5.

There was only one non-mandated youth still in the NIC process at the conclusion of this investigation. This child had experienced eight placements, had a ROLES index of 0, and had had two volatile living environment changes. For the 33 non-mandated youth who had exited the NIC, the mean number of placements was three. Volatility for this group was high with all but one of the 33 having experienced a living environment change of three or higher. Forty-two percent of this group experienced living environment changes of six or higher. The one other youth who had experienced a

change in living environment had four placements with half those placements considered volatile. A subgroup was formed from this stratified sample which included all those NIC youth who had a ROLES index and had exited the NIC process.

ROLES

Of the 40 FY94 youth examined, 75% (n = 30) had ROLES of 0 or higher (0 indicates living environment restored to original level). Twenty-four of the 33 Non-mandated youth were maintained or lowered (73%); 12 of the 14 Mandated clients were maintained or lowered (86%); and the one Other child had a higher ROLES (-.4). Figure 1 portrays the ROLES Scores for the FY94 Sample.

ANOVA. A general linear 1 x 10 ANOVA (ROLES x CAT teams) was calculated using the dependent variable of ROLES. This analysis yielded $F = .44$, $p > .9$. Homogeneity of variance was satisfied by Cochrans C for ROLES, $F(6,10) = .24$, $p > .05$. The null hypothesis of Cochran's C was that all cell variances are equal.

Research Question OC2

What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and the criterion variable of ROLES.

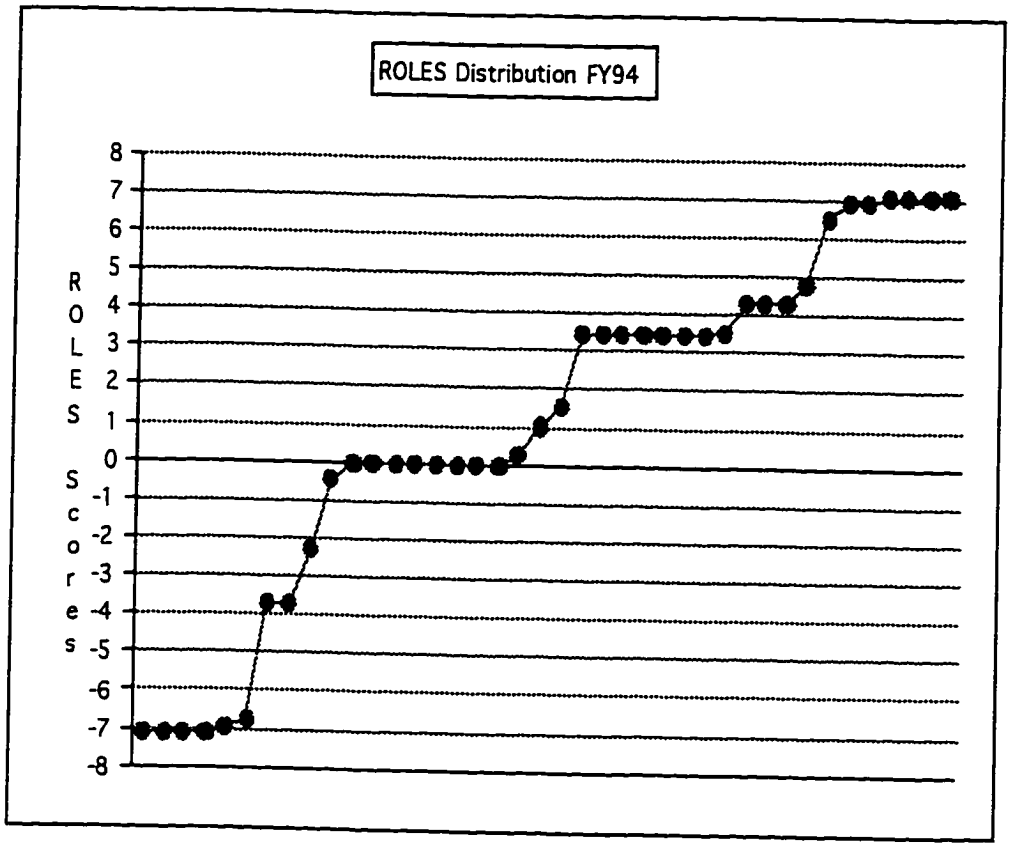

Figure 4. FY94 ROLES Distribution

N = 40

Results. Multiple regression analysis was performed between the criterion variable, ROLES Scores and predictor variables of age, parent involvement, and previous out-of-home placement (POOH). The multiple regression model used was a stepwise method using backward deletion.

The first step performed in a multiple regression equation is the calculation of a correlation matrix for all the variables. The intercorrelations between predictors were examined to see if large relationships existed, as such relationships could affect the results of the regression analysis. Table 12 is a correlation matrix which shows the Pearson r correlations for the criterion variable and all

predictor variables.

Three predictor variables were entered into the initial analysis. They were: age, previous out-of-home placement (POOH), and parent involvement. The backward stepwise analysis resulted in the removal at steps 1 and 2, respectively, of parent involvement (t = .17, p > .05) and age (t = 1.08 , p >.05). At step 3 the remaining predictor did not meet the removal criterion of .05, so the backward deletion stopped. Table 13 demonstrated the unstandardized regression coefficients (B), the standard errors of the predicted values (SE B), the standardized regression coefficients (ß), and the t ratios for each step of the analysis.

Table 12

Correlation Analysis Between Predictor Variables and ROLES Scores

Variables	1	2	3	4
FY94 Roles Sample (n = 40)				
1.ROLES	--	-.51	.05	.11
2.Previous Out-of-Home		--	-.07	.08
3.Parent Involvement			--	-.04
4.Age				--

The R^2 in multiple regression analysis is likely to be an optimistic estimate of how well the equation fits the

population (Kachigan, 1986). To obtain a more accurate reflection of the goodness of fit of the model to the population, an adjusted $\underline{R}^2$ was calculated. For step 1 the adjusted R^2 was .22; for Steps 2 and 3, adjusted R^2 was .24. The multiple regression analysis yielded the following equation:

$$y' = 8.06 - 5.92x$$

where y' is the predicted ROLES Scores and x is POOH. The standard error of the estimate at Step 3 was 3.94.

Table 13

Summary of Stepdown Regression Analysis for Variables Predicting Restrictiveness of Living Environments (N = 40)

Variables	B	SE B	ß	t
Step 1				
Previous Out-of-Home	-6.05	1.67	-.52	-3.63
Parent Involvement	.004	.02	.02	.17
Age	.37	.34	.15	1.07
Step 2				
Previous Out-of-Home	-6.07	1.64	-.52	-3.70
Age	.36	.34	.15	1.08
Step 3				
Previous Out-of-Home	-5.92	1.64	-.51	-3.61

Note. R^2 = .28 for Steps 1 and 2; R^2 = .25 for Step 3

Beta weights calculated at Step 3 of the analysis demonstrated the rank order of the predictor variables in

their relationship to the criterion. The variable most related to ROLES Scores was POOH, ß = -5.92 , followed by age, ß = .15, and parent involvement, ß = .02. The null hypothesis of no relationship was tested using an ANOVA. Table 14 provided a summary of this analysis.

As the data in Table 13 indicated the regression solution is significant, the null hypothesis was rejected. Because the null was rejected, further validation of the equation using cross-validation was conducted.

Cross-Validation. To satisfy the validity requirement, the regression equation developed using the FY94 ROLES Sample was used to predict the restrictiveness of living for the FY95 ROLES Sample. The calculated Pearson *r* between observed ROLES and predicted ROLES revealed a negative relationship, *r* = -.10.

Table 14

Analysis of Variance for the Stepwise Multiple Regression Model Using Backward Deletion

Source	df	F
Regression	1	13.03*
Error	38	(15.52)

Note. The value enclosed in the parentheses is the mean square error.

N = 40.

*p = .0009

Research Question CO1

What is the relationship between the restrictiveness of living environment scores (ROLES) and the distribution of the Comprehensive Services Act (CSA) funding?

Related null hypothesis. There is no significant relationship between the ROLES scores and the distribution of CSA funds.

Results. The correlation between the ROLES Scores and the distribution of CSA funds was calculated using a Pearson's Product-Moment Correlation. This analysis yielded a Pearson's correlation coefficient, r, which is an index of the degree of linear relationship between the two variables. The r for this analysis was .23.

Research Question CO2

What management practices have been utilized by the NIC to ensure the most judicious use of funding?

Related null hypothesis. There is no significant difference in the assessment of fiscal management practices with respect to NIC Organizational Level or Gender.

Results. Group mean scores computed for this data indicated a score of approximately 2 (agree) for able to secure multiple funding sources, efficiently use current resources, and encourage system-wide fiscal planning. The other three fiscal practices, stable funding for vendors, incentives for service providers, and ability to shift funds received group scores of 3 (undecided). Mean scores were also calculated by NIC levels. Table 15 shows the means for all six fiscal practices by NIC levels.

Six 4 x 2 (NIC level x Gender) ANOVAs were computed, each using one of the following dependent variables: (a) securing funds from multiple sources, (b) efficient use of current resources, (c) stable funding for service providers, (d) incentives for service providers, (e) system-wide fiscal planning, or (f) shift resources among agencies. These variables were measured by a Likert Scale on The NIC Survey. The four NIC levels were: NIC Board, RRB, CATs, and case managers). Because the cell sizes of these ANOVAs were unequal, a general linear model was used (Norusis, 1994; Tabachnick & Fidell, 1989). Table 16 shows the obtained F scores for these six variables by main effects.

Table 15

Mean Scores of Fiscal Management Practices by NIC Level

	NIC Board	RRB	CATs	Case Managers
Secure funds from multiple sources	2.14	1.60	2.21	2.84
Efficient use of current resources	1.86	1.88	2.02	2.77
Assure vendors of stable funding	2.00	2.86	2.89	3.00
Incentives for service providers	2.14	2.57	2.48	2.90
System-wide fiscal planning	2.00	2.13	1.96	2.44
Ability to shift funds among agencies to assist clients	2.57	2.71	2.34	2.73

As the data in Table 16 indicated significant differences between NIC levels, the null hypothesis was rejected. Post hoc analysis, using Bonferonni/Dunn, were performed on these significant F scores to determine which pairs of group means were significantly different from each other. Differences which met or exceeded the alpha level (.05) were between the case managers and CATs on securing funds from multiple sources and efficient use of resources.

Table 16

Factorial Analyses of Variances for Fiscal Management Practices in NIC

	F		
Source	Gender[a]	NIC Level[b]	Interaction[c]
Secure funds from multiple sources	.10	3.51**	.07
Efficient use of current resources	.32	5.51**	.33
Assure vendors of stable funding	.21	1.25	1.04
Incentives for service providers	.83	1.72	1.03
System-wide fiscal planning	2.63	1.56	.66
Ability to shift funds among agencies to assist clients	4.12*	1.08	2.70

Note. [a]df = 1. [b]df = 3. [c]df = 7.

*p < .05, **p < .001.

Homogeneity of variance tests for significant scores were satisfied by Cochrans C. The null hypothesis of Cochran's C that all cell variances were equal was not rejected.

Summary

This chapter presented the results of all statistical analyses conducted in the NIC Evaluation. A summary of the research, discussions, contributions to NIC practice, and recommendations for future research will be delineated in Chapter Five.

CHAPTER V

Summary, Discussion, and Recommendations

Introduction

The purpose of this research was to design and to implement an evaluation model for the Norfolk Interagency Consortium (NIC). The NIC is a comprehensive system of care (CSC) which combines the six major child-serving agencies in the city. This interagency structure facilitates services to at-risk youth through a multi-disciplinary, collaborative framework.

The evaluation conducted with the NIC focused on four areas of inquiry. These areas were program clarification, processes and activities, outcomes, and cost factors. This chapter will: (a) briefly summarize and discuss the research and the findings within each of these four areas; (b) present the study's recommendations for NIC practices; (c) discuss the contribution this research makes to the theoretical knowledge base regarding at-risk youth and comprehensive systems of care; and (d) suggest topics which merit consideration for future research. It should be noted that a significance level of .05 was used for all statistical analyses.

Research Summary and Discussion

Program Clarification (PC)

The four questions which addressed the area of program clarification were:

PC1. To what extent is the Norfolk Interagency Consortium operating as designed?

PC2. What is the program's theory?

PC3. What components of the NIC can be assessed?

PC4. What are the characteristics of the target population served by the NIC?

The first three PC questions were investigated using an evaluability assessment (EA). The EA defined and clarified program theory and goals, engaged program managers in the evaluative process, and provided a structure for determining which program components could be evaluated. Data for the EA was collected through on-site visits, observations of all NIC processes, structured and unstructured interviews, focus groups, and document analysis.

The EA was the first stage of this research and the information derived from this process was used in selecting the remaining areas of inquiries and in the development of specific research questions. NIC components and goals, identified in the EA, were considered for assessment if they met the following preconditions: (a) They had been created and implemented as described in program literature; (b) The goals and effects were specified clearly; and (c) Measurable data was available. The components which did not meet study criteria were excluded.

Research Question PC4 was investigated by examining the files of a random selection of thirty percent of the 218 Fiscal Year 94 (FY94) youth. Records of these youth were reviewed and client characteristics were extrapolated. Characteristics collected included: gender, race, previous out-of-home placement (POOH), age, family structure, referring agency, and entry lag (if available). Entry lag was the time differential between the date NIC received a child's referral and the date actually entered the NIC process.

The FY94 sample was 75% male and 25% female. Sixty percent of the young people were African-American, 34% White, 2% Hispanic, 2% Biracial, and 2% had missing information. Eighty-one percent of the total group had had a previous out-of-home placement and the average age was 13.5 years. The home structure represented most frequently was a single mother home, followed respectively by NDSS guardianships and two parent homes. The mean entry lag was 33 days.

Processes and Activities (PA)

Four research questions addressed the processes and activities of the NIC. The questions and their related hypotheses were:

PA1. How well does the current service system for at-risk youth in Norfolk perform in relation to availability and accessibility of services?

Related null hypothesis. There is no significant difference in the assessment of availability and

accessibility of services with respect to NIC organizational level or gender.

PA2. How well does the current service system for at-risk youth in Norfolk perform in relation to coordination of services and information?

Related null hypothesis. There is no significant difference in the assessment of coordination of activities and information with respect to NIC organizational level or gender.

PA3. What are the major accomplishments NIC has achieved in regard to services for at-risk youth and their families?

PA4. What are challenges of NIC in regard to services for at-risk youth and their families?

These four questions were investigated by conducting on-site visits, structured and unstructured interviews, focus groups, document analysis, and survey research. The survey used was an adaptation of the instrument, "Assessing Local Service Systems for Chronically Mentally Ill Persons" (Morrissey, Ridgely, Goldman, & Bartko, 1994). The survey adaptation, referred to as The NIC Survey (see Appendix B), used five of the original instrument's subscales. The subscales used in this study were: Adequacy of Services, Quality of Services, Availability of Services, Coordination of Services, and Fiscal Authority. All subscales except Fiscal Authority were utilized for the processes and activities phase of research.

One hundred forty-nine NIC personnel participated in

the survey research. Participation by NIC level ranged from 73% (case managers) to 100% (NIC Board). To address Research Questions PA1 and PA2, survey respondents were asked to assess eight activities related to availability and accessibility of services and seven activities related to coordination of services and information. These activities were assessed through the use of a Likert Scale which ranged from one to five with a "don't know" option.

The mean response for all participants clustered around a rating of three (adequate) except for making clients feel at ease in service settings, interagency access to client records, and the development of computerized information systems. Making clients feel at ease and interagency access received means of approximately 2 (rating of fairly well) while computerized information systems received a group mean of 4 (rating of fairly poor).

Mean scores also were calculated for each level of the NIC organization. Scores by level indicated that the higher the level of the organization, the higher the ranking of each activity. NIC Board members tended to rank practices at or near two while Case Managers' rankings were three or above. Rankings of the two middle NIC tiers consistently reported means which fell between the other two levels. Exceptions to this numerical order were in sharing up-to-date information between agencies and developing computerized information systems. The RRB rated information-sharing the highest and the NIC Board rated computerized systems the lowest.

A series of factorial analyses of variance (ANOVAs) were used to compare responses between levels. The dependent variable was the Likert Scale assessment of each activity. The independent variables were: gender (two levels: male and female); and NIC organization (four levels: NIC Board, RRB, CATs, and case managers). There were no statistically significant differences between gender or in interactions, but the differences between levels was statistically significant in eight analyses ($p = .05$). In each significant difference, the results occurred between case managers and another NIC level (case managers and CATS, 3 times; case managers and RRB, 1 time; and case managers and NIC Board, 4 times).

Data also was collected in The NIC Survey in an open-ended section which solicited assessment of the NIC's accomplishments and challenges with regard to services for at-risk youth and their families (Questions PA3 and PA4). Over 70 percent of the 149 survey participants responded to these open-ended inquiries (n=105).

This data was analyzed using coding (Strauss & Corbin, 1990) and empirical assertions (Erickson, 1986). Coding refers to the analytical processes by which the data is broken down, examined, compared, and reconceptualized (Strauss & Corbin). Survey data was examined and reconceptualized into categories to classify and tabulate responses. The categories created were NIC services, the interagency structure, the NIC Model, and funding.

These categories of data were reviewed and analyzed for

assertions. Assertions are statements generated inductively through comprehensive data examination. These inferential statements are then validated by identifying other sources of supporting evidence (Erickson, 1986). The greater the number of supporting sources, the more valid an assertion. Only assertions which could be supported by two or more additional data sources were included in this study. The categories and their corresponding assertions were:

NIC Services. The NIC has been instrumental in the expansion of new services and in the identification of service options; the NIC faces the challenge of having an insufficient number of service vendors and inadequate services for specific types of needs exhibited by the at-risk youth and their families; and the NIC has a need for greater quality control of services and service vendors to ensure treatment fidelity.

Funding. The NIC's pooled resources have made it possible to help a greater number of at-risk youth and families and the NIC faces the challenge of continuing to provide services without sufficient resources.

Interagency Structure. The collaborative NIC process has facilitated the development of an effective interagency relationship.

The NIC Model. There are facets of the NIC process which may negatively impact the organization's effectiveness.

The process and activity-related information gathered during this stage of the evaluation suggested that NIC

personnel perceive most of the organization's activities as adequate or better. In addition, data indicated the NIC process had encouraged the quantity and types of services offered, helped a large number of families, and facilitated greater interagency collaboration.

Although areas of concern were noted, recent changes implemented by the NIC have begun to address some of the issues cited in this study as challenges or concerns. The first change is an organizational effort to increase the quality control of services and of service vendors. In September, 1996, Community Assessment Teams (CATs) began utilizing an objective-focused intervention plan (see Appendix G). In this new plan, specific client outcomes are developed during CAT meetings in collaboration with parents, the client, and case managers. This plan is submitted to vendors when services are purchased and the vendors must agree to direct their efforts toward the accomplishment of the CAT's stated goals. Input from service vendors regarding the degree to which the goals are met will be submitted periodically for review.

In addition, the NIC has contracted Sentara Mental Health Management to review the institutions which provide residential placements to their clients. Sentara case managers will conduct on-site chart reviews, interview staff and physicians, and attend treatment staffings to ensure the at-risk youth being treated at these facilities are receiving quality care. These two efforts provide a framework to begin a more active monitoring of the services

NIC secures.

A second NIC change has been in reference to "time" and "red tape" concerns. Time was a concern voiced by NIC personnel because data suggested the average wait necessary to get a child into the CAT process, after a referral was received in the NIC office, was 33 days. Once a child received an intervention plan, there were additional delays because vendors had to be contacted and services secured before treatments were actually initiated. Vendors are not always immediately available causing additional, sometimes, indefinite delays in receiving assistance. This series of events can create a substantial time interval between referral and service delivery.

Additional considerations which affected the interval between referral and receipt of services was NIC's "red tape". Agencies recommending a youth to the NIC are required to hold an in-house meeting prior to referral. Background information and prior treatment efforts are collected during this meeting. There are a number of forms (see Appendix A) which must be completed as part of the pre-referral process, including obtaining parent signatures. Once a meeting is held, CATs may need to seek approval from the RRB if out-of-home placements are indicated. The lag time created by "red tape" and the NIC process could be critical in situations where a child and/or family was in crisis.

Recognition of the need for urgent care led the NIC to establish a protocol for emergency assistance. The procedure allows initiation of NIC services through the agency's RRB

representative. RRB members may request immediate assistance for a child pending formal referral and CAT processing. Additionally, a new policy is being created which will expedite access to NIC funding for non-mandated youth. The Director of Court Services and two Deputy Directors will be authorized to approve immediate access to non-residential services and programs and to other services identified in the Comprehensive Services Act (CSA) Fee Directory up to a maximum of $500 per year per child.

Outcomes (OC): Client

The research questions in the outcomes section focused on two levels of effects, client-oriented and community-oriented. The questions in each level will be presented and discussed separately. The client-oriented questions and their related hypotheses were:

OC1. Has the NIC process affected the overall Restrictiveness of Living Environment Scale (ROLES) of its clients? If so, are some CATs more effective at maintaining or lowering the ROLES scores of NIC youth? What are the characteristics of the youth in this sample?

Related null hypothesis. There is no significant difference in the CATs' ability to maintain or lower the ROLES of NIC youth.

OC2. What variables make the best predictors of a lowered ROLES score for at-risk youth in the NIC process?

Related null hypothesis. There is no significant relationship between the predictor variables of age, parent involvement, and previous out-of-home placement and the

criterion variable of ROLES.

The sample utilized in these questions, the FY94 Six Month Sample, was a stratified random sample of FY94 NIC clients who had been in the NIC process six months or more. The stratas used were the three categories in which Virginia classifies at-risk youth: mandated, non-mandated/targeted, and other. Mandated children are those young people whom the state is legally obligated to provide services, including youth with special education needs, handicapped children with placement needs, or wards of the state. Non-mandated populations are children who are referred to NIC by a juvenile or domestic court or by Youth and Family Services. The category, other, refers to any additional young people eligible for services under the CSA definition and includes youth with mental illnesses. The files of 70 percent of the youth in each category were examined to identify client characteristics per strata.

Comparisons of the youth within the NIC stratas revealed three distinctive sets of young people. While the most common family structure in all three groups was single parent (predominantly mothers) and the least prevalent structure was two parent biological, the categories differed on all other characteristics examined. Variations included racial distribution, gender, age, and previous out-of-home placements (POOH). The most distinctive differences noted were in age, gender, and POOH. Non-mandated youth were the oldest with a mean age of 15, other youth were the youngest with a mean age of 9. Non-mandated and other youth were more

likely to be male while mandated youth were more likely to be females. Mandated youth were the most likely to have experienced a POOH while other youth had had no POOH.

Forty youth from the FY94 Six Month Sample had a ROLES score and had exited the NIC or been out of active status for at least six months. These young people were used to examine NIC's ability to maintain or lower the ROLES scores of their clients. ROLES scores were determined using The Restrictiveness of Living Environment Scale (ROLES) developed by Hawkins, Almeida, Fabry, & Reitz (1992). This scale provided a process for measuring a child's living environment, giving lower ratings to more ecological, family-oriented environments and higher ratings to more restrictive, isolated settings (see Appendix C).

Seventy-five percent of the ROLES Sample (n = 30) had living environment scores of 0 or higher (indicating maintenance or reduction of original ROLES). Maintained or lowered rates for mandated and non-mandated youth were, respectively, 73% and 86%. The one other child had a higher ROLES.

Forty-five percent of the ROLES Sample were in an age range cited by Knitzer (1982) as critical. She noted that older adolescents experience failure after failure in programs. According to her findings, children who are ages 15-17 have negative outcomes and often remain, with little change, in juvenile services until they transition at age 18 to adult facilities. Given the expected outcomes for this age group, NIC's percentage of success in reducing the ROLES

of its clients is positive.

The ROLES scores of these 40 youth were used also in a regression analysis to determine if three of the client characteristics had value as predictors of living environment scores. The predictor variables were previous out-of-home placement, parent involvement, and age. All predictor variables were selected on the basis of theoretical considerations.

The correlation matrix calculated in the regression analysis indicated low correlations between the predictor variables. This low correlation suggested that the predictors were not related to each other, alleviating concerns with multicollinearity. A low relationship, however, was also revealed between the predictors of age and the criterion ROLES and parent involvement and ROLES.

An examination of the data suggested the small relationship between age and ROLES in this study may be due to the fact that most of the youth with out-of-home placements were older. Of the FY94 ROLES Sample, only five children were 12 or under. It should also be noted that the age used in the analysis was the age of the child at their intake in the NIC process. As data was collected over a three year period, the number of young people classified as older has increased.

As the literature is replete with documentation of parent involvement and positive outcomes, the low correlation between parent involvement and ROLES may be a reflection of the measure used to represent a parent's

involvement in the NIC process. The measure used for this study was the number of times the parent had attended CAT meetings. While CAT attendance does represent an effort to participate in the NIC process, this indicator may not be an accurate representation of the level of commitment to the child or NIC's ecological process. Use of CAT attendance as a measure may have been particularly critical in FY94 because NIC administrators noted that in successive years the organization has more consistently emphasized the importance of parent engagement. Parents may have attended meetings in FY94 simply because their case manager emphasized they be present. Parents who did not attend CATs may have been absent due to jobs or transportation problems, not a lack of interest in their child. Additional parent measures should be considered, such as attendance at parent training, the number of positive interactions with their child, the number of times a parent met with home-based counselors, interviews, or attitudinal surveys.

The relationship between the remaining variable, POOH and the criterion ROLES was $r = -.51$. A negative relationship signified an inverse relationship or that high values on one variable were associated with low values on the other variables. An examination of the POOH data revealed the cause of this negative correlation.

The variable, POOH, had two levels. A score of one reflected an out-of-home placement prior to NIC entry while a score of two reflected no POOH. There were six youth with ROLES scores who had not had an out-of-home placement prior

to their participation in the NIC process. Four of these six had a high negative ROLES scores. The negative correlation demonstrated between POOH and ROLES was representative of the fact that as the POOH numerically increased on these four youth (to a two or no POOH), the ROLES index leaped negatively downward. All four of these youth were from the non-mandated category which has the highest volatility rates of the three stratas. In addition, the high negative ROLES reflected a juvenile commitment. Three of the four were committed in their first living environment change after NIC entry which suggested that they may have been at a critical stage at NIC entry.

As might be anticipated by the low relationships between the predictor variables age and parent involvement and the criterion, ROLES, the backward stepwise regression removed these predictors from the regression equation. The remaining variable, previous out-of-home placement (POOH) indicated a significant relationship with the ROLES scores. Although a significant relationship was reported between POOH and the ROLES, the adjusted $\underline{R}^2$ was < .24. Tabichnek and Fidell (1989) stated that while a $\underline{R}^2$ between .20 and .40 indicated a definite relationship, the relationship is small and not dependable.

A cross-validation of the regression equation was conducted with a new sample. A Pearson's $\underline{r}$ between the observed ROLES and predicted ROLES revealed the following relationship, $\underline{r}$ = -.10, which is considered insignificant (Tabichnek & Fidell, 1989). The low correlation between

observed ROLES and predicted ROLES demonstrated that the regression equation developed using the FY94 Roles Sample cannot be reliably used in predicting ROLES based on POOH.

The low r obtained between observed and predicted ROLES may be due to several factors. One is the low variance represented by the predictor, POOH. While POOH's adjusted R^2 was statistically significant, the relative contribution of POOH to the variance in ROLES scores was only .24. There are other variables which affect ROLES that have not been identified and were not part of the equation.

A second reason for the low, negative relationship may be due to variations in the NIC process during the two years included in this analysis (FY94 and FY95). As indicated previously, NIC administrators stated they began emphasizing parent involvement much more consistently in FY95. This is supported by the increased percentages of parents attending CAT meetings in FY95 and may have impacted CAT attendance as a parent involvement measure. In a multiple regression analysis performed on the FY95 ROLES Sample using the predictors and the same measures, parent involvement was the last predictor removed and had a significant relationship with ROLES.

Although the variations between the two populations were slight, they may have also impacted the validation analysis. Twenty-five percent of the FY94 ROLES Sample had negative ROLES compared to 22% for FY95. Of the FY95 negative numbers, there were fewer high negative scores (indicating less volatile changes). Among the FY95 youth who

were maintained or lowered, there were fewer with scores of 0 and a greater number of youth with higher positive scores. The mean age of both groups was 14.5 and there were approximately the same percentage of youth with POOH (81% in FY94 and 85% in FY95).

An analysis of variance (ANOVA) was calculated to analyze the differences in CATs' ability to maintain or lower the ROLES of NIC clients. The dependent variable was the ROLES scores and the independent variable was CAT with ten levels. The ANOVA revealed no significant differences in the ROLES scores by CAT and the hypothesis of no difference was not rejected. These findings suggested a consistency among CATs in intervention planning for at-risk youth. It should be noted that in the fall of 1996, the NIC reduced the number of CATs from 12 to 7. There are now only five regular CATs and two specialty CATs (Juvenile Justice and Education). These changes were made in an effort to be more labor efficient with agency personnel.

Outcomes (OC): Community

Because CSCs are community-based, family-oriented organizations, evaluation research should be conducted at more than just the level of individual clients (Young, Gardner, & Coley, 1995). To accomplish that goal, the NIC Evaluation collected not only individual and group information, but information about NIC's community impact as well. The outcome questions which focused on the community were:

OC3. What is the community impact of NIC with regard to

the implementation of new services and the creation of a continuum of care?

OC4. What is the community impact of NIC with regard to agency integration?

Data which addressed these questions was obtained through The Norfolk Office on Youth and the Norfolk Youth Services Citizen Advisory Board, NIC records, The NIC Survey, semi-structured and unstructured interviews with NIC agency directors and case managers, on-site visits, document analysis, and focus groups.

The information collected was analyzed by comparing and contrasting multiple sources of data through a process known as triangulation. Triangulation enabled the researcher "to verify information, to produce logically consistent data, and to provide confidence in the data" (Hecht, 1992, p. 116).

The data indicated that the NIC and its six human service agencies had influenced the development of new services and an extended continuum of care. In FY94, NIC purchased services in only eight service areas. By 1996, the number of service areas had expanded to 22 and included such wrap-around services as companion services, mentoring, supported living, teacher assistants, and speech therapy.

Data also demonstrated that the NIC has impacted agency integration. The six agencies within the NIC have various collaborative arrangements which enable them to share office space, personnel, and expertise in effective ways. In addition, several grants have been written collaboratively

to establish community-based, ecologically-oriented programs which further extend the continuum of care available to at-risk youth and families in Norfolk. These include Alternatives to Incarceration, a program to support juvenile offenders with mental health issues; Substance Abuse Support Services for Youth (SASSY), a substance abuse program engaging parents and children in a rehabilitative process; and Return to Recovery, established to provide smooth transitions from out-of-community placements to home.

Cost (CO)

The final area of research was cost. Collecting data on cost factors in the CSC process can be complex because the expense of treating young people occurs in three areas. These areas are: the actual cost of treatments, the cost of the NIC operation, and other agency and community programs accessed as part of the intervention plan. Often these expenses are paid for by multiple sources (insurance, Medicaid/Medicare, individuals, and other government entities) and accurate expenditures on a specific child are difficult to identify.

The inclusion of a cost study is important because "omission of resources from the equation results in an unfair measure of the program's effectiveness--because the dosage has no clear relationship to the intended outcomes" (Young, Gardner, and Coley, 1995, p. 9). Determining the relationship between the "dosage" and the "outcomes" is particularly critical for comprehensive systems of care because of the current debate regarding the cost efficiency of community-based care (Foster, Summerfelt, & Saunders, 1996). CSCs

received initial support from some leaders because their ecological interventions were thought to be less costly than residential care (Abbott & Sapsford, 1987).

As the NIC maintains records only on expenditures which involve Comprehensive Services Act (CSA) money, this study focused on the relationship between ROLES and CSA funds. Additional cost investigations were conducted regarding NIC's fiscal management practices. The research questions and their related hypotheses were:

CO1. What is the relationship between the restrictiveness of living environment scores (ROLES) and the distribution of the Comprehensive Services Act (CSA) funding?

Related null hypothesis. There is no significant relationship between the ROLES and the distribution of CSA funding.

CO2. What management practices have been utilized by NIC to ensure the most judicious use of funding?

Related null hypothesis. There is no significant difference in the assessment of fiscal management practices with respect to NIC Organizational Level or Gender.

Data for these questions was collected through NIC Client Records, the Norfolk Department of Social Services (NDSS) Fiscal Reports, and The NIC Survey. The restrictiveness of living scores of the ROLES Sample were obtained from the NIC Records and the distribution of CSA funds were retrieved from NDSS reports (NIC's fiscal agent). The total CSA money spent during the time frame of July 1,

1993 to June 30, 1996 was tabulated for each of the 40 youth in the ROLES sample. A Pearson's Product-Moment Correlation was conducted to determine the relationship between ROLES scores and the distribution of CSA funds. The Pearson's correlation coefficient, r, yielded for this analysis was .23.

The correlation between CSA funding distribution and ROLES scores indicated a small, but significant relationship (Tabichnek & Fidell, 1989). While the relationship is important, the small ROLES variance accounted for by CSA funds suggested there are other factors which affected ROLES as well. These factors might include, but are not limited to, the quality of treatment provided by CSA funds, the length of treatment, the dynamics of the interactions between client and service provider and client and case manager, and the synergy of the multi-disciplinary intervention team approach.

Data regarding the question on fiscal management practices was gathered using The NIC Survey. Means computed for the assessment of NIC's fiscal activities indicated a group mean of approximately 2 (agree) for able to secure multiple funding sources, efficiently use current resources, and encourage system-wide fiscal planning. The other three fiscal practices, stable funding for vendors, incentives for service providers, and ability to shift funds received group means of 3 (undecided).

General linear ANOVAs were performed to determine if any of the differences between the NIC levels or genders was

significant. Differences which met or exceeded the alpha level (.05) were revealed in securing funds from multiple sources and more efficient use of resources. These differences were between CATs and case managers; no significant differences were indicated in gender or interactions.

The activity of system-wide planning was the only fiscal practice which received an "agree" rating from all levels. This indicated that the organization had communicated this concept clearly and all levels were aware of this practice. NIC's recent transition to an objective-based intervention plan and heightened sense of quality control may further increase the confidence personnel appear to have regarding the system's ability to incorporate fiscal planning.

Recommendations for NIC Practice

Computerized information systems

NIC's performance at developing a computerized system was rated by all levels of the organization as "fairly poor". This "fairly poor" system includes three computers which are used for basic office functions including word processing and some database and spreadsheet management. While technical assistance centers for CSCs have affirmed numerous possibilities for improved service through technology, budgetary concerns and limited staff have deterred the NIC from pursuing the idea of expanding their technological capabilities (Hutcheson, 1996).

As comprehensive systems of care are becoming increasingly accountable for their practices, the priority NIC has assigned to expanding technological capabilities should be reconsidered. The first recommendation for NIC practice is the creation of a comprehensive database (DB) of all NIC clients. Although the creation of an inclusive DB would require some technical costs and be labor intensive to initiate, maintaining records would require no more time than is currently required to update and file paper records.

The current paper records can be time consuming to both manage and maintain. If a file is incorrectly alphabetized, it is difficult to retrieve. If a file cannot be located, it may also be because someone else in the organization is using the file. "Seek and find" missions must be conducted to locate pieces of information which are being used by others. In addition, the client's financial information is kept in more than one location, each separate from their NIC records. Keeping records and financial information in several places is a less efficient method of record-keeping and could be replaced by a single DB with all client information in one place, accessible to multiple people at the same time. A computer in the NIC's conference room would enable CAT recorders to update the files as meetings are held.

In addition, a client DB also would facilitate an on-going record of the NIC's target population. This would provide information regarding changes in the number of clients in each category, total numbers of clients,

volatility, gender, etc. Knowing what type of children enter the process may provide insight regarding the programs needed and the kinds of assistance required most frequently for at-risk youth in Norfolk. This information also would be important in forecasting future service needs and in budgetary planning.

Database and spreadsheet technology also could enhance NIC's efforts to maintain quality control. Information could be kept and retrieved regarding the number of client-based objectives any particular vendor had met, which foster care programs are the most successful with maintaining or lowering the ROLES of NIC youth, which clients are successful in which programs, and the average length of treatment in any facility.

The next phase of technological expansion might include networking computer systems of the six agencies within the NIC process. This would provide interagency access to the records of NIC clients and allow personnel at other agencies to input records from their agency's perspective, including juvenile offenses, participation in health clinics, and school attendance records. Periodic updates by individual agency personnel would provide an accurate description of a client's status or progress at any given time.

The suggestions offered in regard to computerized systems would greatly enhance the NIC's efforts to monitor its own programs and their effectiveness. Once established, it is likely a computerized system would quickly pay for itself in reduced time and materials. Additionally, in an

era of increased accountability, being able to quickly and efficiently access client information will become increasingly critical. Organizations that wish to remain viable will have to be able to produce information substantiating their efforts. A computerized system of information will most readily facilitate that ability.

Vertical Collaboration

One of the assertions made in this study was there are facets of the NIC process which may negatively impact the organization's effectiveness. One of these facets is the role of the case manager. Interviews with case managers, a focus group, and survey information indicated that while case managers perceived the NIC Model positively, the assessment of their experience in the process was less favorable. Their comments suggested that they believe there is poor communication between themselves and the NIC, they are not supported in the process, and their recommendations are minimized. In the responses obtained from The NIC Survey, assessment of NIC activities by case managers were consistently lower than other NIC levels (eight of these statistically significant).

The opinions and perceptions of case managers are important because their positions are a critical part of the NIC process. Stroul and Friedman (1986) stated that case managers are "the 'glue' which holds the system together, assuring continuity of services for the child and the family" (p. 145). Their understanding of the client, the community, and the vendors is primary knowledge based on

actual interactions with the people and organizations involved.

In addition, Young, Gardner, and Coley (1995) noted that the technical assistance needed in CSC models must "build on the knowledge of the program staff to delineate the specific assets and needs, goals, activities, and expected outcomes of each program component" (p.11). While NIC's structure facilitates collaboration and experiential sharing across levels (horizontally), it does not provide for interactions and dialogue between levels (vertically). Case managers are an important part of the program staff, but are provided little opportunity to give feedback from their viewpoint.

The importance of the concept of vertical levels of communication was discussed by Cunningham and Gresso (1993). These authors noted that individuals who operate on different levels of an organization may share a common purpose, but have very different perspectives. Only when members of various levels have the opportunity to dialogue with each other will they gain an understanding of the entire organization and respect for all levels of operation. The use of vertical teams can create colleagiality, promote professional development, and establish a supportive, integrated work environment (Cunningham & Gresso, 1993).

Considering the importance of inter-level collaboration, the second recommendation for NIC practice is the creation of a vertical team. This team might include the following membership, based on their proportional

representation in the NIC: one NIC Board member, one RRB member, two CAT members, and three case managers. This vertical team would provide a format for continual review of NIC's processes and activities and also address such issues as clarification of goals and objectives. Since the NIC's decision-making structure is based on state guidelines, this team could serve as a non-voting, advisory unit to the NIC Board.

Socioeconomic considerations

Further consideration should be given to the impact a family's economic status has on the NIC process. Although data regarding income was not available for this study (NIC began collecting in 1996), the importance of this factor is well documented in the literature. Eamon (1994b) noted that low income is related to higher rates of out-of-home placement and is the most "critical variable affecting the decision either to maintain a child in the home with supportive services or to place into foster care" (p. 354).

In addition, Eamon (1994b) noted that children from low income homes have higher levels of behavior problems, conduct disorders, depression, and poor social adaptations. These youth are under greater stress than their higher income peers because of the negative environmental factors associated with poverty. Children of poverty are also over-represented in all areas of the juvenile justice system. Their numbers are so prevalent in the court system that Dryfoos (1990) indicated that most experts agree that low economic status is a predictive factor in delinquency.

To address the serious effects of socioeconomic concerns, a third recommendation for NIC practice is that staff training include an awareness of the dynamics of working with families in poverty. Additionally, CATs may wish to consider the inclusion of concrete services in the intervention plan. While CAT files indicated efforts to provide specific goods for some families, there does not appear to be a consistent focus in this area. In studies of family preservation services, greater provision of concrete services were associated with treatment success (Eamon, 1994b). Meeting the physical needs of families was associated with not only the greatest gains in skills, but with the number of families who remained intact after services were terminated. Eamon noted that unless the poverty issue is addressed, low income children preserved, are preserved in poverty.

Goal clarification

While the EA process initiated a dialogue regarding clarity of goals, it is a fourth recommendation for NIC practice that this goal-related conversation continue. Previously undefined NIC goals should be explicitly delineated and communicated to all six agencies and levels. Gorton and Snowden (1993) stated:

> Groups need operational goals in order to focus efforts, give direction, and provide a basis for evaluation. In the absence of operational goals, a group is likely to flounder and become sidetracked, greatly reducing its potential for productivity (p. 76).

Having well-defined goals is particularly significant for interagency organizations such as the NIC. Schorr (1995)

noted that multi-disciplinary organizations encounter barriers which make cooperative endeavors challenging. These barriers include the various perspectives each agency's discipline brings to the CSC process. Although the processes utilized to bring about a result may be different, these diverse agencies and agency personnel should agree on a common set of goals or outcomes. When consensus regarding the organization's desired affects is gained, collaboration becomes easier and a "community-wide 'culture of responsibility' for children and families is promoted" (Schorr, p. 14).

Another rationale for the establishment of clear goals is the assertion that all organizations conceptualize a vision for their process. According to Irvin (1989), this conceptual vision guides the organization's activities, services, processes, and program, whether the vision is made explicit or not. Unless this guiding purpose is articulated and made explicit to all parts of the system, a consensus regarding outcomes and a unity of effort cannot be created.

While the need for an organization to agree on goals is more widely supported, the need for goal consensus is less obvious in program evaluation. Although many models of program evaluation begin with some concept of the intended outcomes, Scriven has developed a goal-free model of program evaluation (House, 1983). A goal-free evaluation is plannned and conducted with no knowledge of program objectives. The philosophy is that the lack of prior program knowledge reduces the bias of the evaluator and allows him to search

for any and all outcomes. Scriven stated that if a program's results are so subtle an evaluator cannot identify them, the program is a failure (Stake, 1983).

A concern related to goal-free evaluations is the necessity of a critical, alert evaluator who can synthesize observations and determine the organization's intended outcomes (Stake, 1983). If an evaluator does not possess these characteristics, a goal-free evaluation which finds a program weak and ineffective may simply be a reflection of the evaluator's own inabilities. On the other hand, if an alert, critical evaluator begins an evaluation with a known set of objectives and goals, he should still be able to detect goals and efforts which are not explicitly stated.

Although a researcher should be aware of the possibility of implicit outcomes and be sensitive to their existence, the development of well-articulated goals also should enhance the capabilities of evaluation research. Clearly defined goals enable the researcher to characterize the interdependence between other processes, activities and outcomes. Irvin (1989) noted the more explicit the conceptual framework, the better the foundation for evaluation research.

Greater Community Utilization

Among the challenges stated by NIC personnel in the survey research was concern regarding the lack of adequate services and the lack of sufficient resources. Considering the deficit of money and services, the NIC will have to be creative in intervention planning to meet the complex needs of at-risk youth and their families. One of the ways NIC

might consider expanding their service capabilities is to consider integrating the local community more extensively in the treatment process.

The current ecological emphasis of comprehensive systems of care includes not only safely establishing the child within the context of his family, but in the larger context of neighborhoods and communities. Research suggests that being part of a larger social network or system "buffers the impact of stressful life events" and provides an overall positive effect to the family (Cleary, 1988, p.196). Wandesman (1987) also noted that parents who are lonely and isolated benefit the least from parent education.

The National Commission on Children (1969) reiterated the need for community support by stating that the public sector cannot provide all of a family's needs. The commission noted that neighborhoods, communities, and employers must be engaged in the process. Walker and Crocker (1988) noted that relationships established across these extended families, neighborhoods, communities, and religious groups will affect the family's response to a program of treatment intervention. Being a part of a larger social network may provide an overall beneficial impact to the at-risk youth and their family (Weiss, 1988).

Although there is a great deal of substantiation to the positive effects of utilizing community resources, this is a source of assistance that has been largely untapped in the NIC. Human service agencies in Norfolk have begun establishing collaborative arrangements with private

organizations and community people to provide support networks for their clients and families. This support has included calling people on a regular basis and assisting with transportation needs, but could be expanded to meet the needs of NIC's at-risk youth.

A fifth recommendation for NIC practice is the inclusion of community organizations, service groups, and religious institutions. These civic groups can be solicited for parent and teen mentors, training opportunities, scholarships, babysitting, and school tutoring. A list of volunteers and the services they provide could be kept on file in the NIC office and utilized by CATs and case managers when determining an intervention plan for a child and his family.

One of the ways to elicit this local support structure is through community awareness. Holding informational meetings and alerting organizations to the needs of Norfolk's at-risk youth would a way to begin the program. As NIC has limited office staff available to initiate contacts, perhaps the idea could be piloted in one Norfolk neighborhood, with one organization, or with one specific need.

Area universities and colleges also may be a potential source of community assistance. Student interns from the fields of education, medicine, counseling, or social services could provide additional support structures for Norfolk's at-risk children. Although this recommendation for NIC practice would require an initial time investment,

decreased budgetary allocations and increased needs should merit the consideration of including the community in the treatment process.

Theoretical Contributions

Ecological outcomes

One of the core philosophical principles of comprehensive systems of care (CSCs) is the emphasis on ecological interventions. This principle recognizes the importance of maintaining the child in their family or providing treatments in a less restrictive "family-like" environment where a child can be a part of a social group or network. Considering the significance assigned to community and family interventions, Jacobs (1988) noted that outcome measures should "increasingly reflect the ecological focus of programs" (p. 45).

Assuming treatments delivered in a less restrictive, more ecologically-oriented environment is beneficial for at-risk youth, research should measure CSCs ability to maintain or lower the restrictiveness of their clients' living environment. One of the contributions this study makes to the literature regarding CSCs is providing data regarding one system's efforts to keep at-risk youth in the least restrictive environment. This study combined the "Restrictiveness of Living Environment Scale" (Hawkins, Almeida, Fabry, & Reitz, 1992) with a procedure developed by Thomlison and Krysik (1992) to determine an overall restrictiveness index for NIC clients. This overall index

provided indicators regarding the NIC's ability to maintain or lower a child's overall living environment score over a three year period.

Given the average age of the sample examined (mean age of <15) and the negative expectations previously discussed for older children in any child-caring agency (Knitzer,1982), the NIC has demonstrated that CSCs can lower or maintain the treatment setting for even the most at-risk youth. The NIC was able to maintain or lower 75% or more of the FY94 and FY95 Sample.

It should be noted that the samples examined did not include those young people who had entered the NIC during FY94 and FY95 and were still receiving NIC treatments. Of those still in the NIC process from both years, over half had an overall living environment score of 0 or higher at the time of the last measurement (June 30, 1996).

Current literature also admonishes CSC evaluations to provide information about the potential to reduce the level and amount of care. Two hundred eighteen youth entered the NIC process during FY94. At the close of FY96, only 14% of those youth were still in the NIC process. Two hundred forty-two youth entered the NIC during FY95. At the close of FY96, only 6% of those young people were still part of this interagency structure.

Although cases are closed when clients move, runaway from home, are committed, or parents resist assistance, the majority of cases examined in this investigation were closed because the family situation had been stabilized, the child

had been placed successfully in a home environment, or other resolutions had been found. The information from this study suggests that NIC's teams of multi-disciplinary experts are able to provide treatments in an increasingly ecological context and reduce the level and amount of care required by at-risk youth.

In addition to the investigation of individual ecological outcomes, this study examined the influence NIC has had on the larger ecological network, the local community. Questions were created that addressed the impact NIC has had on the development of a continuum of care in Norfolk and on the collaborative arrangements between agencies.

The NIC demonstrated that comprehensive systems of care can impact the community by providing the impetus for expanded service options. Data also indicated that agency integration can be enhanced by participation in a system of care. NIC's six participating agencies have developed several collaborative partnerships in which they share money, space, materials, time, and expertise. Working together in an interagency structure has generated greater respect and understanding of each organization's abilities and knowledge.

Target Population

Studies conducted in several locations across the US and in Canada suggested comparable characteristics of CSC clientele regardless of geographical location (Kutash, Duchnowski, Meyers, et al., 1993). Findings from these

various sites indicated over two-thirds of these youth are male and less than 20% live in two-parent homes (not necessarily biological parents). Their numbers reflect an over-representation of minority children and low income families.

Although information regarding income levels was not available in this study, the remaining characteristics listed as representative of CSCs everywhere are very similar to the description of NIC's target population. NIC's FY94 clientele were 74% male, 64% minority, and only 19% have two parent homes.

Although these international characteristics reflect the general target population of NIC, a closer examination of youth who have been in the CSC process for at least six months revealed groups of young people with more specialized attributes. This study examined NIC clientele, who had been in the system for six months or more, within the three classifications Virginia uses with at-risk children, mandated, non-mandated, and other.

The characteristics of youth in these categories indicated youth within Virginia's three categories had unique characteristics. Other children were the youngest, had the fewest out-of-home placements, and required the least time from the NIC process. Non-mandated youth were the oldest, experienced the most volatile changes in living environment, were less likely to be a minority, and had the highest median number of placements. Mandated youth were the most labor intensive group, were more likely to be females,

and most likely to remain in the NIC process the longest.

One of the reasons the general population of CSCs may appear similar is that when youth enter a system of care, it takes a period of time to develop a comprehensive understanding of the child and their specific situation. Specific categorical characteristics are not easily identified at client intake when demographic data is typically collected.

Additionally, if NIC's populations is representative of other CSCs, 40% or more of the general population are out of the system in the first six months. The remaining 60% are the youth that CSCs spend the most time treating. The 60% who remained in the system reflected more specialized categorical attributes. Additional studies of CSCs in other locations should be conducted to substantiate these findings. Information regarding the types of youth in systems of care will assist in planning interventions and assessing service needs.

Parent involvement

There is much substantiation for ensuring parents are involved in the planning and delivery of CSC interventions. The body of literature regarding inclusion of the family in the treatment process is so extensive, the positive outcomes related to parent engagement are widely regarded as a fact. What is less discernible, however, is what parent engagement actually is and what measures are representative of their involvement.

This study utilized parent attendance at CAT meetings as

a measure of parent involvement. This measure, in FY94, demonstrated a negligible relationship with a lowered ROLES. NIC administrators, however, noted in a review of the data that staff had not consistently emphasized the need for parent involvement until FY95. FY95 data supported this emphasis and revealed an increase in the number of parents attending CATs. In a multiple regression analysis performed on the FY95 ROLES Sample, using parent involvement (as measured by CAT attendance) as a predictor, a significant relationship was indicated between CAT attendance and a lowered ROLES. In addition, FY95 data indicated a lower percentage of NIC youth with high negative ROLES scores (indicating less volatile changes), a greater number of youth with higher positive scores, and fewer young people remained in the NIC process. Although it is not likely parent attendance at CAT meetings was the only factor that affected FY95 ROLES scores, engaging parents in the organization's planning process may be an indicator of meaningful parent involvement in the CSC process.

Numbers of at-risk children

Friedman (1995) noted that CSCs were established on the assumption that the amount of children needing their specialized services would be small and their problems well-defined and readily treatable in a system of integrated services. In contrast to expectations, there are a "magnitude" (Friedman, p.7) of youth requiring CSC assistance and the problems facing this large number of youth are extremely complex. The NIC Evaluation lends additional

substantiation for Friedman's comments. In FY94, the NIC served 350 young people. In FY95, that number had more than doubled to 840. These large, unanticipated numbers have created undue burdens on CSC personnel, budgets, and service providers. Documentation by case managers indicated there are times services cannot be provided or have been delayed because a provider cannot be found or a waiting list exists with an appropriate vendor.

Focusing on the numbers of at-risk youth needing services is critical for a number of reasons. One reason is that funding sources have not increased in relation to the numbers of children requiring services. Lack of funds and large numbers may force CSCs to become more selective in the clientele they accept or deny services, leaving some youth and their families without assistance.

A second reason the number of at-risk children is important is in determining the scope of the needs of the young people in our country. If there are significantly more youth and families in need than has been previously recognized, that finding could impact state and national policy making. The numbers of children in CSCs are important and this information should continue to be monitored.

Operational levels and Case managers

The final contribution this study has made to theory and to the CSC knowledge base is in regard to the role of the case manager and the levels of operation in a CSC. In Virginia, CSCs have an established structural format which divides the organization into operational levels. Although

this structure facilitates and promotes interagency collaboration across levels of the organization, it does not provide for interactions or collaborative work between levels. It is unknown if CSCs in other states are organized in similar fashion, but little has been written regarding the importance of utilizing all levels of systems of care in the collaborative decision-making/planning processes.

In Virginia's structural design, one of the most critical positions, case managers, are most often found in a level of the system which operates more in isolation than in collaboration. Case managers broker services for their clients, serve as the child's advocate, supervise the child's treatment plan, review client progress, coordinate various service providers, and work with the child's family. Although their knowledge base regarding the CSC process, service providers, and client needs is considerable, there is little effort regarding the importance of including these people in the decision-making process. If CSCs should use the knowledge of program staff in decision-making as suggested by Young, Gardner, and Coley (1995), case managers certainly would be included in the process. In addition, the concerns revealed by NIC's case managers should encourage other CSCs to examine the position their case managers hold within the organization. Case managers are recognized as "essential" and "critical" (Stroul & Friedman, 1986, p. xxviii) to the CSC process and utilizing their knowledge to its fullest extent may be a resource that has been overlooked.

Recommendations for future research

Collaboration

Zigler and Freedman (1987a) noted that the most valuable lesson to be learned from a program may not be related to the achievement of outcomes, but how the program functioned. They recommended that salient variables in the functioning of a program be examined as they may "reveal successful elements deserving replication in different contexts and other practices that should be amended or avoided" (Zigler & Freedman, p. 358).

One of the NIC elements which may deserve consideration of replication is the cooperation and collaboration which has developed among many of NIC's constituent agencies. All levels of the NIC repeatedly noted this as an accomplishment on the open-ended section of The NIC Survey.

Interviews with agency directors and state CSA administrators revealed that one of the challenges for agencies within CSC processes is overcoming "turf" issues and the diverse perceptions each discipline holds. While the information collected indicated NIC has not totally eliminated these challenges, data suggested these challenges have been minimized so that the interagency process can work effectively. It is recommended that further studies of the NIC process be conducted to identify factors which have facilitated Norfolk's ability to establish a successful, collaborative process.

Multiple placements

Mandated youth who had exited the NIC had approximately

four fewer placements than those still in the process. The only non-mandated youth who was still in the NIC in FY94 had eight placements as compared to an average of three for non-mandated young people out of the process. This data may suggest that the ability or lack of ability to connect a child with a placement successfully may have continuing effects on the outcomes of the child's intervention.

Considering the potential importance of establishing a child in an ecological context, it is recommended that the NIC focus on those children who are experiencing multiple placements. The greater the number of changes in living environment, the more likely a child was to remain in the NIC process. It may be beneficial to determine what elements are present or absent when the NIC is able to stabilize or maintain a child in each living environment. Identifying those factors which are associated with sustained placements may provide information which can be used in training parents, foster parents, home-based counselors, and other care providers.

Family

Given the importance assigned to parent involvement, further studies should be conducted with at-risk youths' families. Questions which should be investigated include: Is the use of attendance at CAT meetings an accurate measure of parental participation? Which are the characteristics of families most helped by the NIC process? What factors are most associated with the success or lack of success at maintaining a child at home?

More specific information regarding families will help CSCs establish any necessary frameworks for facilitating meaningful involvement. In addition, if certain types of parent engagement are particularly beneficial, requiring participation in these activities might become a critical part of the NIC admission process.

ROLES

While it is assumed that a lowered living environment score is a positive outcome, the ROLES index provides no information regarding the quality of the environment or the long-term affects of interventions focused primarily on lowered ROLES. Although the youth examined in this investigation had been terminated or out of the NIC process for six months, longer follow-up studies should be conducted to determine if the child is still in the home, if the family remains stabilized, if the child is in school or job training, and if the resolutions created by NIC are still effective.

Less than six months clientele

In FY94, 52% of the 218 youth who entered the process were in the NIC for less than six months. In FY95, 42% of the 242 entering youth were six months or less. Studies should be conducted to determine why these children are in the process for such a short period of time. How are they different than clients who are in the process for over six months? Are their problems less severe or are the services they need accessed expediently and effectively?

If there are program attributes which enable these

youth to exit NIC quickly, they should be examined for possible replication and consistent application. If, however, these children do not have serious needs, their requests could be diverted to individual agencies, freeing time and space on the NIC agenda.

Socioeconomic factors

In the fall of 1996, NIC began collecting income data on their clients' families. As previously noted, poverty impacts at-risk youth and their families greatly and may affect the success of an intervention plan. As data soon will be available for all clients regarding socioeconomic levels, consideration should be given to examining the relationships between economic levels and length of stay in the NIC, outcomes such as ROLES and the ability to maintain an intact family, and parent involvement.

Cost

Considering the NIC operates in a time when reallocation of resources and budgetary restraints are ongoing concerns, cost issues are a critical consideration for future research. There is currently a level of accountability in American health care that has not been experienced before (Feldman, 1992). The emphasis being maintained is on improving the quality of care while reducing the cost of service. The NIC must examine ways to accurately monitor the cost of treating their at-risk youth. This should include cost-comparisons and treatment efficacy between service vendors and treatments methods.

Suggestions include utilizing the new objective-based

treatment plans to monitor both quality control and costs. In addition, the NIC should require all service vendors to document and submit the costs of treatment for all NIC's at-risk children whether paid for by CSA funds or not. Only when the NIC Board gets an accurate idea of the total amount of money their intervention system costs will they be able to credibly determine the cost effectiveness of community-based care.

Chapter Summary

The evaluation of the Norfolk Interagency Consortium was a comprehensive assessment of the various components of a local system of care for at-risk youth. Information was collected at four levels of the system including individual client; group, the organization, and the community.

This chapter has reviewed the research questions, discussed their implications, and offered recommendations based on the findings. The data gathered and their analyses should be used by interested persons who wish to become more knowledgeable about specific aspects of what the program is doing and what the program is affecting (Patton, 1978).

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Procedure For Completing CAT - Referral Appropriateness Checklist

Purpose of Referral Appropriateness Checklist

Determining eligibility for CAT assignment.

Who Completes Referral Appropriateness Checklist

Any person considering making a referral to CAT for services/funding.

When to Complete Referral Appropriateness Checklist

The first step in a CAT referral. Complete this form and *attach* to the Person Planning Profile (PPP) and submit to the NIC Office with the PPP if the case is determined to be eligible.

How to Complete Referral Appropriateness Checklist

Answer all questions 1-8 by checking the appropriate blank and adding comments where appropriate.

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CAT - Referral Appropriateness Checklist

A. Personal Information

Name: _____ Today's Date: _____
Date of Birth: _____ Sex: M F
Current Address: _____
_____
SS Number: _____ - _____ - _____
Case Manager: _____ phone no: _____

B. Referral Information (Please check *all* that apply and comment as necessary.)

1. Does the child/youth* that you are referring for CAT intervention have emotional and/or behavioral problems which have persisted over a significant period of time (longer than 6 months)?

   ___ Yes ___ No

   Comments: _____
   _____

2. Are these emotional/behavioral problems of a critical nature requiring intervention applications in multiple settings (i.e., home, school, and/or with peers)?

   ___ Yes ___ No

   Comments: _____
   _____

3. Are the services or resources required currently:

   a) ____unavailable
   b) ____inaccessible (due to waiting list, etc.)
   c) ____beyond normal agency services requiring at least 2 NIC agencies to coordinate services.

* For eligibility purposes, "youth" shall mean a person less than 18 years old and an individual through age 21 who is otherwise eligible for mandated services of the participating agencies including special education and foster care.

4. Is the child/youth at imminent risk of a clinical necessity for purchased residential care?

___ Yes ___ No

Comments: _____

_____

5. Does the child/youth require special education in an approved private school education program?

___ Yes ___ No

Comments: _____

_____

6. Have the emotional and/or behavioral problems caused the child to be entrusted to a local social services agency by either his parents/guardian or a court order?

___ Yes ___ No

Comments: _____

_____

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Procedure For Completing
CAT - Person Planning Profile (PPP)

Purpose of Person Planning Profile:

The *Person Planning Profile* (PPP) provides a framework for compiling all essential data and information and enables the case manager and CAT to develop the most appropriate goals, objectives and service plan for the individual.

Who completes Person Planning Profile?

Case manager or designee.

When to complete Person Planning Profile:

Complete a PPP at the same time as completing a *Referral Appropriateness Checklist*.

How to complete Person Planning Profile:

NOTE: It is recommended that Sections IIC-F and Section III be completed based on an interview with the individual's family.

Section IIC: Please incorporate skills, abilities, characteristics etc. that would be beneficial to include or plan for when designing services (e.g. a good relationship with a sibling, a good sense of humor, can prepare small meals.)

Section IIF: Include current information and historical data. Note past efforts or interventions that have been effective. Include any relationships, past placements or supports that have had a positive impact on the person.

Section IIG: Focus on the aspects of the person's life that need to be incorporated into any service plan that will promote success. Include personal preference regarding schedule (i.e. prefers morning activities), disposition (i.e. needs to be alone in the morning before interacting with others), others (i.e. fear of dogs). A series of focus questions are provided here to facilitate the planning process.

Section III: To be completed by interviewing the individual or family. Use the opportunity to explore desired long term goals and what would constitute success. Allow free expression in order to glean an accurate picture of what assistance, intervention, etc. is desired. Be prepared to assist families in identifying possibilities. Do not discourage family dreams and wishes for the child.

Section V: Please ensure that your description of ideal services encompasses the short term needs and long term vision for this person. Think about transition needs from one service to another. How does the person get from short-term needs to long-term vision? What steps are necessary? Where do you see this person at age 18?

Signature Sheet: All staff who participated in the in-house planning should sign this sheet.

Follow-up to Person Planning Profile:

After completion of all of the sections noted above send to NIC Office along with CAT Pack.

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Date:_____

CAT - Person Planning Profile (PPP)

SECTION I *(Please ensure that information is current and accurate.)*

A. Personal Information

Client Name: _____ SSN _____-_____-_____
Date of Birth: _____ Sex: M F Race*: _____
Current Address: _____
_____

**Race: White, Black/African American, Asian/Pacific Islander, American Indian, Alaskan Native or Hispanic*

B. Referral Information

Referral Agency: _____
Case Manager: _____ phone no: _____
Case number/Referring agency case number: _____
Population type at time of referral:
____ Mandated targeted ____ Other eligible: _____
____ Non-mandated targeted

Was youth court ordered to CAT: ____ Yes ____ No

C. Family Information

Mother's name: _____
address _____
_____
phone no: _____

Father's name: _____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____

Siblings:

name: _____ age:_____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____
name: _____ age:_____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____
name: _____ age:_____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____
name: _____ age:_____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____

Guardian name: _____ relationship : _____
address *(if different from above)* _____
_____
phone no: *(if different from above)* _____

D. School Information
School currently attending: _____
Special Education student: ___ Yes ___ No

SECTION II

A. Reason for referral (check all for which person currently demonstrates need.)
___ In-Home supports
___ Out of home placement (circle one): Short-term Long-term
___ School
___ Other (description required):

B. Current diagnoses (Please be thorough so that all appropriate agency resources needed in planning and service delivery for the individual are identified. Including psychiatric/psychological information (diagnosis), learning disabilities, current IQ and level of functioning. Include any relevant test results, medical information including medication dose and prescribing physician.)

C. Individual strengths (***Interview based:*** Include skills, abilities, talents, and characteristics, family involvement, and significant others)

D. Briefly describe presenting problem and any individual weaknesses the child may have. (***Interview based:*** Please include all accurate information concisely.)

E. Briefly describe the current family situation as it impacts the child's intervention needs. (*Interview based:* Please include if the family is intact. If not, what parameters exist for visits. Are both parents working? How does the family feel about receiving in-home support and services. Indicate its strengths and support capabilities.)

F. List any/all interventions, relationships, and types of service etc., that have been provided in the past. Please note outcomes of those interventions and identify any positive and effective results, note any out-of-home placements with dates and names of providers. *Interview based.*

G. Please list additional ***essentials*** in treatment planning required for success. At a minimum, ensure that responses are provided to the following focus questions. *Interview based*

- Think about what would make you happier than you are today. What you would like to do with your life or in your life and what type of goals you do you want for yourself?
- What about you makes you feel good?
- Is there anything you haven't done yet in your like that you really want to do?
- If I were to ask people who know you really well what is good about you, what would they say?

SECTION III

Based on an interview with the individual and family, what do they communicate as being their long-term goals and desires for the child's future? ***Interview based***

SECTION IV

Please list name and phone number of all members of person's current planning team. (i.e. case manager, teacher, therapist, social worker, etc.)

SECTION V

A. Refer to reason for referral in Section I in responding here. Based on subsequent information gathered in this document, please describe your recommendations for the *ideal* services for this individual. (NB: The services you describe may or may not currently exist. Please focus on what this person needs to be successful).

B. What outcome do you expect at the end of prescribed services? (In completing this section, please incorporate a transition plan for future.)

1) After six months?

2) After one year?

3) After two years?

4) After three years?

CAT - In-House Staffing & Signature Sheet

Recommended Plan:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Date of In-House Staffing: _____

Signatures of In-House Staffing Participants

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

INTRODUCTION

This survey is part of an evaluation of the Norfolk Interagency Consortium. The questionnaire is being distributed to people who are knowledgeable about the current functioning of services for at-risk youth and the extent to which NIC services are provided in a coordinated and comprehensive manner.

Your responses to these questions will be held in strict confidence. The survey should be returned to me in the enclosed self-addressed, stamped envelope as expediently as possible. Responses will be combined with those of other individuals in NIC to develop a composite view of this local service system. Only aggregate data will be used and no individual will ever be identified by name or organization in any evaluation report.

INSTRUCTIONS

This questionnaire takes approximately 12 minutes to complete. Please answer all questions following the instructions at the beginning of each section. You might not be in a position to assess all types of services. There is a "don't know" category for each question; please use this response when you are unable to assess that particular service or function.

If you would like to offer additional observations about NIC, please feel free to write them on the last page or the back of the last page(s).

INFORMED CONSENT

1. You are participating in a study which is a program evaluation of the Norfolk Interagency Consortium. The main benefit of this survey is to gain information relative to the adequacy of services, availability and accessibility of services, coordination of services, and fiscal issues of NIC.
2. Your participation is voluntary. No remuneration will be provided.
3. New information that is obtained during the research will be made available to you.
4. All information obtained from the research will be kept strictly confidential. The aggregate data from this study could be used in reports, presentations, and publications. No individual will be identified in writing unless consent is granted. This data may be subpoenaed by court order or may be inspected by federal regulatory authorities.
5. You may choose not to participate in the study and the investigator reserves the right to withdraw your participation if she observes any contradiction to your continued participation.
6. If you suffer injury as a result of participation in this research project, please contact Melody Wilt at Old Dominion University at 683-3283.

_____ _____

Participant Signature Witness Signature

SECTION 1.A ADEQUACY OF SERVICES

In this section, we would like to obtain your overall assessments of the adequacy of support services currently available for at-risk youth in Norfolk.

How many at-risk youth in Norfolk who need this service are getting it?

Please use the following scale in answering these questions:

	All	Most	Some	Few	None	Don't Know
	1	2	3	4	5	DK
SERVICE ELEMENTS						
1.01 Outreach..... *locating and bringing services to needy clients*	1	2	3	4	5	DK
1.02 Emergency..... *24 hour quick response, crisis assistance for clients and involved family/friends*	1	2	3	4	5	DK
1.03 Mental Health Treatment..... *assessment and provision of inpatient, outpatient, and/or day treatment services*	1	2	3	4	5	DK
1.04 Psychosocial Rehabilitation..... *social and group skills, daily-living and self-care, problem-solving, and coping skills*	1	2	3	4	5	DK
1.05 Case Management..... *single person/team responsible for helping clients obtain entitlements, services, housing*	1	2	3	4	5	DK
1.06 Assistance with Basic Human Needs.. *food, clothing, shelter, safety, income*	1	2	3	4	5	DK
1.07 Prevocational/Vocational..... *employment opportunities, vocational rehab. services, supported/sheltered work*	1	2	3	4	5	DK
1.08 Shelter/Housing..... *residential units within a range of settings, from closely supervised to independent*	1	2	3	4	5	DK
1.09 Medical/Dental..... *assessment, treatment, or referral for medical or dental problems*	1	2	3	4	5	DK
1.10 Substance Abuse Services..... *detoxification, inpatient or outpatient treatment for alcohol or illicit drugs*	1	2	3	4	5	DK
1.11 Other Supportive Services..... *support to family/friends of the at-risk youth as well as peer support/services/programs*	1	2	3	4	5	DK

SECTION 1.B QUALITY OF SERVICES

In this section, we would like to obtain your overall assessment of the quality of support services currently available for At-Risk youth in Norfolk?

How would you rate the quality of care provided to at-risk youth in Norfolk in each of the following services?
(In rating the quality of each service element, consider the technical and the interpersonal aspects of care and its physical setting.)

Please use the following scale in answering these questions:

	Very Good	Fairly Good	Adequate	Fairly Poor	Very Poor	Don't Know
	1	2	3	4	5	DK
SERVICE ELEMENTS						
1.12 Mental Health Treatment..... *assessment and provision of inpatient, outpatient, and/or day treatment services*	1	2	3	4	5	DK
1.13 Substance Abuse Services..... *detoxification, inpatient or outpatient treatment for alcohol or illicit drugs*	1	2	3	4	5	DK
1.14 Case Management..... *single person/team responsible for helping clients obtain entitlements, services, housing*	1	2	3	4	5	DK
1.15 Outreach..... *locating and bringing services to needy clients*	1	2	3	4	5	DK
1.16 Other Supportive Services..... *support to family/friends of the at-risk youth as well as peer support/services/programs*	1	2	3	4	5	DK
1.17 Medical/Dental..... *assessment, treatment, or referral for medical or dental problems*	1	2	3	4	5	DK
1.18 Shelter/Housing..... *residential units within a range of settings, from closely supervised to independent*	1	2	3	4	5	DK
1.19 Assistance with Basic Human Needs.. *food, clothing, shelter, safety, income*	1	2	3	4	5	DK
1.20 Psychosocial Rehabilitation..... *social and group skills, daily-living and self-care, problem-solving, and coping skills*	1	2	3	4	5	DK
1.21 Emergency..... *24 hour quick response, crisis assistance for clients and involved family/friends*	1	2	3	4	5	DK
1.22 Prevocational/Vocational..... *employment opportunities, vocational rehab. services, supported/sheltered work*	1	2	3	4	5	DK

SECTION 2. CURRENT SERVICE SYSTEM PERFORMANCE

In the following section, we are interested in your assessment of the current CSA service system in Norfolk for persons who are at-risk. Here, we would like you to focus on the performance of the overall NIC system.

How well does the current service system for at-risk youth in Norfolk perform in the following activities?

Please use the following scale in answering these questions:

	Very Well	Fairly Well	Adequately	Fairly Poorly	Very Poorly	Don't Know
	1	2	3	4	5	DK

AVAILABILITY AND ACCESSIBILITY OF SERVICES

2.01	Avoiding excessive waiting lists or long delays in scheduling.....	1	2	3	4	5	DK
2.02	Keeping "red tape" to a minimum in enrolling clients into services.....	1	2	3	4	5	DK
2.03	Providing transportation to services/ events when needed.....	1	2	3	4	5	DK
2.04	Placing services in accessible locations.....	1	2	3	4	5	DK
2.05	Offering services during evenings and weekend hours.....	1	2	3	4	5	DK
2.06	Making clients feel welcome and at ease in service settings.....	1	2	3	4	5	DK
2.07	Establishing adequate grievance mechanisms for clients.....	1	2	3	4	5	DK
2.08	Training staff to work caringly and comfortably with at-risk youth.....	1	2	3	4	5	DK

COORDINATION OF SERVICES AND INFORMATION

2.09	Using a common intake form for all agencies.....	1	2	3	4	5	DK
2.10	Developing mechanisms to share clear and up-to-date information on what kinds of assistance agencies offer.....	1	2	3	4	5	DK
2.11	Fostering a "big picture" understanding of the service system and the roles/ responsibilities of the agencies that constitute that system.....	1	2	3	4	5	DK

2.12	Ensuring that other agencies have timely access to client records in ways that do not violate client confidentiality/rights.	1	2	3	4	5	DK
2.13	Trying to minimize or eliminate conflicting rules and requirements between service providers.....	1	2	3	4	5	DK
2.14	Ensuring meaningful discharge planning between state institutions and community facilities.....	1	2	3	4	5	DK
2.15	Developing computerized client record/information systems that link hospitals, other mental health providers, and psychosocial support systems.....	1	2	3	4	5	DK

SECTION 3. FISCAL ISSUES

To what extent do you agree with the following statements about NIC?	*Please use the following scale in answering these questions:*					
	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree	Don't Know
	1	2	3	4	5	DK
3.01 NIC has been successful at securing funds from multiple sources for at-risk youth.....	1	2	3	4	5	DK
3.02 NIC has enforced a more efficient use of current resources.....	1	2	3	4	5	DK
3.03 NIC has been able to assure service providers that there will be public resources for NIC persons at stable and predictable levels.....	1	2	3	4	5	DK
3.04 NIC has been able to develop a financial structure that incorporates incentives for service providers without discouraging clinically sound care.....	1	2	3	4	5	DK
3.05 NIC has encouraged system-wide fiscal planning.....	1	2	3	4	5	DK
3.06 NIC has the capacity to shift resources among agencies to meet the needs of at-risk youth.....	1	2	3	4	5	DK

SECTION 4. OVERALL EVALUATIONS OF NIC

4.01 What do you think are the 2 or 3 major accomplishments of the Norfolk Interagency Consortium to date with regard to services to at-risk youth and their families?

1.

2.

3.

4.02. What do you think are the 2 or 3 major challenges or shortcomings of Norfolk Interagency Consortium to date with regard to services for at-risk youth and their families?

1.

2.

3.

SECTION 5. RESPONDENT INFORMATION

5.01 How long have you been involved with at-risk youth and their families (employment or service-related) in any city?

_____ years

5.02 How long have you been involved with at-risk youth and their families (employment or service-related) in Norfolk?

_____ years

5.03 How do you describe yourself? (Circle one)

1. American Indian
2. Anglo or White
3. Asian
4. Black or African-American
5. Chicano
6. Mexican-American
7. Puerto Rican
8. Spanish-American
9. Other....Please specify

5.04 Are you: 1. Male 2.Female

Additional comments:

APPENDIX C

RESTRICTIVENESS OF LIVING SCALE

JAIL	9.5
YOUTH CORRECTION	9.1
COUNTY DETENTION	8.9
STATE HOSPITAL	8.7
INTENSIVE TREATMENT UNIT	8.1
DRUG REHABILITATION	7.5
WILDERNESS CAMP	6.9
MEDICAL HOSPITAL	6.8
RESIDENTIAL TREATMENT	6.3
GROUP HOME	5.4
THERAPEUTIC FOSTER CARE	5.4
SPECIALIZED FOSTER CARE	4.7
REGULAR FOSTER CARE	3.8
SUPERVISED INDEPENDENT LIVING	3.4
HOMELESS	2.8
ADOPTIVE HOME	2.8
FAMILY FRIEND' HOME	2.4
RELATIVE'S HOME	2.3
PARENTS' HOME (CHILD)	2.0
INDEPENDENT LIVING (FRIEND)	1.6
INDEPENDENT LIVING (SELF)	1.0

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Procedure For Completing

CAT - Recommendations and Summary Sheet

Purpose of Recommendations Summary Sheet

The *Recommendations Summary Sheet* serves as a record of team decisions regarding overall goals and objectives for service planning.

Who Completes Recommendations Summary Sheet

The team captain or designee with signature sheet to signed by all CAT team members present.

When to Complete Recommendations Summary Sheet

At the time of the CAT meeting

How to Complete Recommendations Summary Sheet

1. Establish and document an overall service goal:
   A goal is a long-term outcome or vision for the person; where you ultimately want the person to be when services end (e.g. supported living for an individual.) The goal should be agreed to by the service team.
2. Establish and document objectives needed to reach that goal:
   Objectives are specific actions or steps which contribute to reaching the long-term goal (e.g. rapid stabilization, alternative school program with emphasis on vocational training and supporting a person's current living situation to teach independent living skills.)
3. Identify the person or vendor responsible for each objective:
   The service team should identify person/vendor responsible for attaining each objective. Examples for those listed above might include, a mental health or residential provider; the school; and a vendor who supplies in-home services.

Follow-up to Recommendations Summary Sheet

Once the goal and objectives have been identified and agreed to, the team should set quarterly review dates to evaluate progress toward the goal and on the individual objectives. An Objective Review Worksheet has been developed for use in assessing progress on the objectives and the appropriateness of the goal. A copy of the *Recommendations Summary Sheet* should be sent to any vendor, by the Case Manager, or agencies assigned to carry out aspects of this service plan.

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CAT - Recommendations and Summary Sheet

Individual's name: _____ SS Number: ___ - ___ - ____ DOB: __/__/__

Case manager/designee: _____ Date: __/__/__

Description of long-term goal: _____

_____

Target date for long-term goal: _____

Summary:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Recommendations:

_____

_____

_____

_____

_____

_____

_____

Status of Objectives:

Objective # 1: _____

_____

_____

Vendor/person responsible: _____

Objective # 2: _____

_____

_____

Vendor/person responsible: _____

Objective # 3: _____

_____

_____

Vendor/person responsible: _____

Objective # 4: _____

_____

_____

Vendor/person responsible: _____

Signatures of Participants:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Quarterly Reviews:

1st Quarter Review Date: _____ 3rd Quarter Review Date: _____

2nd Quarter Review Date: _____ Annual Review Date: _____

I, the above signed members of/or participants in the Community Assessment Team Staffing (CATS), hereby agree to preserve the confidentiality of all information discussed at any CAT Staffing.

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Procedure For Completing

CAT - Objective Review Worksheet

Purpose of Objective Review Worksheet:

The *Objective Review Worksheet* will assist the case manager in:

1. monitoring progress on each objective;
2. monitoring person/family's satisfaction with that progress;
3. monitoring vendor performance in reaching the objective or implementing a designated service plan;
4. collecting data to be used in evaluating the overall goal.

Who completes Objective Review Worksheet?

Case manager or designee assigned to follow service implementation.

When to complete Objective Review Worksheet:

Complete one worksheet prior to every scheduled review date.

How to complete Objective Review Worksheet:

Complete all appropriate sections of the worksheet assessing both the status of the person and the performance of the vendor.

Ensure that the date, social security number, objective number, quarter (or other period of time), and vendor/responsible person are indicated on each form.

If the objective is not met or deleted during the review phase, please indicate so and note the date.

In the event that a vendor is not implementing an objective as prescribed, please note what they are doing in its place and your assessment of the new approach and copy to Captain of the CAT.

Follow-up to Objective Review Worksheet

Case manager should review the *Recommendations Summary Sheet* and prior worksheets regularly.

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CAT - Objective Review Worksheet

Individual's name: _____ SS number: _____

Case manager/designee: _____

Objective number: _____ Description: _____

Quarter (circle one): 1st, 2nd, 3rd, 4th Reporting date: _____

Person/Vendor responsible: _____

Target date: _____

Objective met: _____ Date: _____

Objective deleted: _____ Date: _____ (CAT authorized)

Comments:

INDIVIDUAL'S STATUS

1. Individual's participation level.

2. Individual's progress level.

3. What is the individual's/family's satisfaction with this objective.

4. Annual review and recommendations re: this objective.

VENDOR PERFORMANCE

1. Was objective implemented as prescribed? If not, please explain.

2. Have you reviewed documentation of progress and the information that needs to be made available to the team?

3. Please comment on vendor's responsiveness to individual's/family's needs and desires related to this objective.

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CAT - Objective Review Signature Page

Date: _____

Individual's name: _____

NAME	AGENCY

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Procedure For Completing

CAT - Vendor Objective Review Worksheet

Purpose of Vendor Objective Review Worksheet:

The *Vendor Objective Review Worksheet* will assist the case manager in:

1. monitoring progress on each objective ;
2. monitoring person/family's satisfaction with that progress;
3. collecting data to be used in reporting to CAT for the purpose of evaluating the overall goal recommendations.

Who completes Vendor Objective Review Worksheet?

The Case Manager or CAT may request the vendor or agency assigned to complete the Vendor Objective Review Worksheet.

When to complete Vendor Objective Review Worksheet:

Complete one worksheet prior to every scheduled review date.

How to complete Vendor Objective Review Worksheet:

Complete all appropriate sections of the worksheet assessing the status of the person.

Ensure that the date, case number, objective number, quarter (or other period of time), and vendor/responsible person are indicated on each form.

If the objective is not met or deleted during the review phase, please indicate so and note the date.

In the event that you are not implementing an objective as prescribed, please note what you are doing in its place .

Vendor/agency gives the completed worksheet to the case manager to be presented at the CAT.

Follow-up to Vendor Objective Review Worksheet

Vendor/agency should review the *Recommendations Summary Sheet* and prior worksheets regularly and adjust activities based on revisions made by CAT.

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CAT - Vendor Objective Review Report

Individual's name: _____ Case number: _____

Vendor/Agency reporting: _____

Case manager/designee: _____

Objective number: _____ Description: _____

Quarter (circle one): 1st, 2nd, 3rd, 4th Reporting date: _____

Target date: _____
Objective met: _____ Date: _____
Objective deleted: _____ Date: _____
Comments:

1. Was the objective implemented as prescribed? If not please explain why and describe any changes to objective.

2. Please summarize the individual's/family's participation and progress on this objective.

3. Please describe case manager/caseworker involvement.

4. Please indicate any recommendations you have regarding this objective.