

*Assessment of
Service & Training Needs*



Chapter 10

Chapter 10: Assessment of Service and Training Needs

Education and Training of Children's Mental Health Professionals: The Existing and Potential Role of Schools of Public Health

Introduction

In the early 1980s, a landmark national study by Knitzer (1982), conducted on behalf of the Children's Defense Fund, found a widespread failure of states to meet the service delivery needs of children and adolescents with serious emotional disorders. In that study, only 21 states were found to have a child and adolescent mental health unit, and it was estimated that approximately two-thirds of children with serious emotional illnesses were not receiving needed services.

Since the publication of this study, increasing attention has been given in the literature to the conceptualization, development, and implementation of integrated and comprehensive mental health systems of care for children and adolescents (Burns and Friedman, 1990; Friedman and Kutash, 1992; Jordan and Hernandez, 1990; and Stroul and Friedman, 1986). Davis, Yelton, Katz-Leavy, and Lourie (1995) recently reported significant progress in the organization and support of children and adolescent mental health services due, in part, to initiatives by private foundations, the passage of federal legislation, increased interagency collaboration, state legal mandates and court orders, and expansion in the availability of alternative mental health services.

Meanwhile, within the educational systems throughout the United States, research has suggested that educational services for children with emotional and behavioral disabilities have been

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inadequate and have resulted in poor outcomes for children (Knitzer, 1982; Knitzer, Steinberg, & Fleisch, 1990; Knitzer, 1993; and Wagner, D'Amico, Marder, Newman, & Blackorby, 1991). According to the Office of Special Education and Rehabilitative Services (U.S. Department of Education, 1992), these children have lower graduation rates, lower grade point averages, and are less likely to continue in school compared to all students.

Prompted by these findings and in response to the need for improving the outcomes for children/adolescents and their families, a shift in both the conceptualization and practice within an integrated mental health system of care is in progress. The recent national study reported by Davis et al. (1995) found significant progress nationally (since 1982) in the organization, financing, and delivery of mental health services to children and adolescents. Nevertheless, in considering this new children's mental health paradigm of community-based systems of care, Knitzer (1993) and Davis et al. (1995) have maintained that there are presently few well-trained professionals and leaders focusing on collaborative initiatives in children's mental health service delivery. Additionally, Duchnowski and Friedman (1990) have discussed the need for developing improved undergraduate and graduate curriculum to train professionals who will staff, organize, and manage these emerging systems of care. Furthermore, Duchnowski and Kutash (1995) have suggested that training individuals in children's mental health services should ideally be provided within an a multidisciplinary, public health perspective.

It is, of course, not enough to proclaim a new paradigm shift within the mental health system without infusing this re-conceptualization, organization, and delivery of child and adolescent mental health services into a comprehensive education and training agenda. This paper provides

readers with a summary of the existing capacity for and potential to expand education and training opportunities in children's mental health services through a public health perspective.

Method

A national survey was utilized to summarize the existing capacity for and potential to expand education and training opportunities in children's mental health services within schools of public health. A two page, nine item, self-administered questionnaire was developed and sent to all 27 schools of public health in the United States and Puerto Rico which were accredited (as of the fall, 1995) by the Council on Education in Public Health. The survey instrument sought information on the existence, substantive nature, and availability of mental health and substance abuse courses, areas of concentration, as well as degree programs within these colleges of public health. It also contained questions which sought information on how these courses and programs were organized within the schools of public health. Additionally, the survey contained questions which permitted the collection of information regarding child and family health courses which were offered during the 1995-1996 academic year.

Results

Mental Health

All 27 questionnaires were completed and returned, resulting in a 100 percent response rate. Nineteen of the 27 schools of public health offered courses in mental health services, with 12 of these 19 schools offering two or more mental health courses for the 1995-1996 academic year. Eighteen of the 27 schools of public health offered courses in social and behavioral sciences.

A variety of mental health courses was taught in the 19 schools of public health. However, the topics most frequently offered were mental health

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epidemiology (25 courses taught nationally), mental health planning, administration, policy and law (12 courses taught nationally), mental health statistics and research (11 courses taught nationally), children and family mental health services (eight courses taught nationally), and stress (seven courses taught nationally). The courses taught in children and family mental health within schools of public health included: Family and Mental Health (University of California at Los Angeles); Childhood Mental Disorders: Public Health Perspectives (Harvard University); Children's Mental Health (University of Illinois at Chicago); Epidemiology of Children's Psychiatric Disorders (University of Pittsburgh); Mental Health of Children and Adolescents (The University of Texas); An Introduction to Personality and Cognitive Development: Application to Maternal and Child Health (Harvard University); Child Development and Psychopathology (Johns Hopkins University); and Public Health Interventions for Prevalence of Youth Violence and Depression (University of South Florida).

The mental health courses were organized in a variety of departments within the schools of public health. Only Johns Hopkins University organized all of the mental health courses into an independent departmental structure (Department of Mental Hygiene). Nevertheless, 15 schools of public health contained health education, health behavior, and/or social and behavioral sciences departments, while eight schools housed maternal and child health departments.

A total of nine schools of public health offered either master's degree programs, doctoral degree programs, post doctoral degree programs, or areas of concentration in mental health services (Loma Linda University, University of California at Berkeley, Yale University, University of South Florida, University of Illinois at Chicago, Harvard

University, Johns Hopkins University, Columbia University, and University of Pittsburgh). Furthermore, two schools of public health (Johns Hopkins University and University of Minnesota) offered certification programs in mental health. For the 1995-1996 academic year, there was a total of 37 post doctoral fellows in mental health attending seven schools of public health (University of California at Berkeley, Yale University, University of Illinois at Chicago, Harvard University, Johns Hopkins University, Columbia University, and University of Pittsburgh).

Substance Abuse

Substance abuse courses were offered by 14 of the schools of public health. Ten of the 14 schools of public health offered two or more substance abuse courses during the 1995-1996 academic year. Johns Hopkins University and the University of Minnesota offered five substance abuse courses, while both the University of California at Berkeley and Loma Linda University offered four substance abuse courses.

A total of six schools of public health offered areas of concentration, post doctoral programs, and/or certification programs in substance abuse (Loma Linda University, Boston University, Harvard University, Johns Hopkins University, University of Pittsburgh, and University of South Carolina). For the 1995-1996 academic year, there was a total of seven post doctoral fellows in substance abuse attending two schools of public health (Johns Hopkins University and the University of Pittsburgh).

Discussion

Although the first generation of schools of public health was established prior to 1920, almost one half of the total schools of public health were established and accredited after 1960. These interdisciplinary institutions have significantly shorter

histories of producing graduate students, vis-a-vis graduate programs in the core disciplines of mental health services (e.g., psychiatry; psychology; social work; and psychiatric nursing). As interagency and collaborative comprehensive systems of care for children and their families emerge within communities, higher education faces a tremendous series of both challenges and opportunities to participate in the education and training of children's mental health professionals from a multidisciplinary, public health perspective.

Public health, by definition, examines health and disease from multidisciplinary and community perspectives. Prevention and early intervention orientations are basic foundations in public health. When examining systems delivery, a public health framework incorporates an epidemiologic perspective, drawing on theories from medicine, biometry, environmental and occupational health, economics, sociology, business, and many other disciplines. Thus, a public health perspective examines the entire array of problems faced by a specific population. Additionally, many schools of public health have developed cross training and multidisciplinary (joint) degree programs with other graduate/professional programs, including social work (M.P.H./M.S.W. programs), medicine (M.D./M.P.H. programs), and law (J.D./M.P.H. programs). Thus, there inherently exists within schools of public health unique opportunities to utilize their existing capacity to train mental health professionals working with children and their families.

The results of this study indicated that the majority of the schools of public health (70 percent) do not currently have a comprehensive curriculum and/or the expertise available to train practitioners to work with children and youth with emotional disorders. Historically, this lack of multidisciplinary and cross-training of professionals can be attributed to the fragmentation of the children's

mental health delivery systems that currently exists (Duchnowski and Kutash, 1995).

Nevertheless, clearly, schools of public health do have the capacity to develop and create expertise in both the mental health services delivery and the child and family health fields. Currently, nearly three quarters (74 %) of the surveyed schools of public health indicated that they offered degree programs, courses, post-doctoral fellowships, and/or continuing education opportunities to assist mental health professionals in becoming more oriented toward prevention and early intervention paradigms. Additionally, 44 percent of the schools of public health indicated offering both mental health and substance abuse courses.

The authors are currently working with the University of South Florida College of Public Health in developing an area of concentration in mental health and substance abuse services at both the master's and doctorate levels. This area of concentration in mental health and substance abuse would be open to students from any of the four departments within the USF College of Public Health. Furthermore, graduate students enrolled in the Doctoral Studies in Child and Family Policy (based in the USF Department of Special Education and the USF/FMHI Department of Child and Family Studies) would also enroll in these mental health courses, in order to train future professionals in collaborative integrated systems of care for children and adolescents.

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Multicultural Mental Health Training Program: Researcher Projects With Ethnically Diverse Communities

Introduction

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These summaries present the research projects of three graduate students participating in the Multicultural Mental Health Training Program (MMHTP) at the University of South Florida's, Florida Mental Health Institute (FMHI). These students' work involved the development of evaluation or research projects with ethnically diverse minority communities.

The purpose of the MMHTP is to increase the number of ethnic minority mental health professionals in the state. The training program provides students, university and agency staff with practical techniques applicable to mental health service delivery in minority communities (Briscoe, Sedberry, & Henderson, 1996). The National Institute of Mental Health (1991) advised that additional research was needed to support service delivery to minority populations. MMHTP collaborates with the Multicultural Child and Family Project (MCFDP) at the FMHI in developing evaluation, technical assistance and training strategies aimed at improving the effectiveness of innovative community-based neighborhood programs which serve ethnically diverse populations (Briscoe, Wright, & Yang, 1994). Effective interventions with ethnically diverse communities address the cultural values and unique needs of local communities, because ethnic or racial groups differ in their relevant cultural values, norms, expectations, and attitudes (Isaacs & Benjamin, 1991). The MCFDP and MMHTP embrace a neighborhood-based approach to delivery of social services, and conceptualize three theoretical orientations which

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enhance the system of care model's applicability to ethnically diverse populations: (1) neighborhood-driven participation which emphasizes natural support networks within the community and democratic participation; (2) primary prevention to promote the well-being of families and communities; and (3) cultural competence on the part of change agents to incorporate the concerns and values of the local residents into effective programming.

An aim of the following research projects was to develop collaborative ties between ethnically diverse communities and the university to increase the effectiveness of service delivery. The first summary examines the strengthening of linkages between the community and schools. National educational goals recognize the importance of partnerships between schools and the home to the educational achievement of children. How these linkages are perceived, created and maintained in a predominantly African-American community was the focus of this dissertation in Applied Anthropology. The second summary reports the development of a community-based job services program. This project involved the coordination of multiagency family career and job placement services to transition low income community residents into improved employment and self sufficiency. The third summary, from a public health perspective, addressed communicating health information effectively to members of middle income African-American communities. This project involved promoting proper management of household hazardous waste to improve indoor air quality and decrease the prevalence of childhood respiratory ailments.

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Working Together for the Children: School-Community Partnerships in East Tampa

M. Yvette Baber, M.A.

Introduction

This report details the results of a qualitative evaluation of a locally-based effort to increase levels of interaction between schools and parents from East Tampa, FL.

Multicultural Community and Family Development Project. The Multicultural Community & Family Development Project (MCFDP) at FMHI has worked with the East Tampa School-Community Partnership (ETSCP) for the past five years to stimulate the development of a coordinated system of parent-school partnerships among the elementary and secondary schools serving the area. This internship assignment was to provide evaluation and professional support services to the East Tampa School-Community Partnership and to assess the ways in which ETSCP has achieved its stated purpose.

East Tampa School-Community Partnership. In the late 1980s, one problem that was evident to the Lee Davis Neighborhood Service Center (LDNSC) and a parent from an elementary school was the disproportionate level of suspensions and expulsions for children who lived in East Tampa.

The *East Tampa School Children Advocate Committee* was formed in 1990 to provide a network of school and community support to address parents' lack of access to their child's school, misconceptions about the community or the School District, and the high levels of disciplinary actions experienced by the children from East Tampa. In 1992, the name of the organization was changed to the East Tampa School-Community Partnership (ETSCP). Each month since then, principals, teachers, parents, school district staff, and social service staff have met to discuss these issues.

The stated purposes of the ETSCP are: 1) to develop a network of concerned citizens to bridge the communication gap between home and school by identifying obstacles to healthy communication in the arena of education, and 2) to develop strategies to increase home-school communication in the arena of education. As the organization nears its fifth full year of operation, it is beginning to examine how it has reached its goals, with a focus on strengthening the Partnership's infrastructure and increasing local parent involvement in its activities.

Evaluation Methodology

The assessment of ETSCP was conducted using a multi-method approach. First, a review of the literature related to participation and school involvement in African-American communities was completed. Historical documents were reviewed, and a draft evaluation of the ETSCP (MCFDP, 1995) provided critical statistical information on organizational changes. This effort identified key topics which were discussed, initiatives which were undertaken, and those individuals who had consistently attended the meetings of the organization. An intensive review of the partnership's efforts (January - December 1995) identified its accomplishments for this period. This review produced a picture of an organization staffed completely by volunteers that has consistently worked to bring parents and teachers together for the education of East Tampa's children.

The anthropological focus of the evaluations made participant observation a primary research tool. Intense involvement in general membership meetings and board meetings contributed to an understanding of the dynamics of interaction and communication between members of the partnership, the Hillsborough county school system, and the East Tampa community. In addition to these meetings, the author attended the open parent-school events scheduled at the Lee Davis Neighborhood Service Center or involving the ETSCP (Back-to School Kickoff, Parent Enhancement Conference, Christmas Giving Tree). Individuals who belonged to the ETSCP were interviewed about their experiences and perceptions. These individuals were selected based on their membership in the organization and their willingness to be interviewed. They consisted of community residents, school district staff, principals and assistant principals of partner schools, and social services staff from the Service Center.

Evaluation Findings

The review of records indicated that the ETSCP has, in fact, drawn a diverse group of educators, social service staff, residents and parents together. School and agency information was shared at virtually every meeting, and community concerns were addressed consistently over the past six years. From these efforts, vehicles to link schools and community were created. The Back-to-School Kickoff is an annual event where schools come to the community to meet and provide information to parents, and where children are given school supplies. It has grown from serving 200 people in its first year to almost 1,000 people in 1996. Additionally, the Full Service Schools Program in East Tampa was developed and funded as a result of the efforts of ETSCP members and is now an integral source of school-based services.

There are programs and schools that have also maintained a consistent relationship with ETSCP. The public library, the Tampa Police Department, the LDNSC, the Head Start Program, and the Tampa Housing Authority have sent representatives to meetings for the past four or five years. There are some schools that have demonstrated a commitment to linkages and working together for the children through their regular participation and involvement. Nine Hillsborough County Schools have sent representatives to meetings on a regular basis since 1991. These schools, and their staff, have been key players in ETSCP's efforts to increase home-school communication.

The number of parents who attend the monthly meetings has also increased over the years, and 1995 showed the most impressive participation. At the beginning of the year, the number of parents varied from 2-5. From July to the end of the year, the numbers increased, and were in the range of 5 - 16 at each meeting. The Partnership is, indeed, bringing schools and parents together to bridge the gaps of communication and cooperation that had, in the past, plagued the East Tampa community.

The individual interviews revealed that the people who have joined the partnership are convinced that it is a valuable organization and that they are better able to serve the children of East Tampa because of its work. School district personnel expressed concern over low levels of parent involvement in the schools, but they were able to experience parent involvement at the community level through Partnership activities. Parents, teachers, and principals all felt that working together on planning committees and at ETSCP events helped them understand each other better. Parents expressed more confidence in approaching school site staff (teachers, counselors, etc.) and reported that they appreciated the opportunities they were given to meet with these people in their own community.

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One factor that came up consistently in meeting discussions, interviews, and casual conversations was the impact of district-wide bussing on the relationships between schools and parents. Parents said that they could not easily get to some of the schools that their children attended because of a lack of transportation. Social services and school staff talked about the inability to make a personal connection with parents and the way it affected classroom management, resolution of problems, and support for the school programs. All groups acknowledged the importance of parent-school-community linkages but expressed frustration at finding a way to build those linkages. They saw community-based events as one effective tool to draw parents out and emphasized the need to continue to reach out to the “grass roots” in order to build their trust and participation.

Conclusion

The success of ETSCP continues on its upward spiral - drawing more people to its general meeting and working hard to reinforce the developing linkages between schools and the community. The qualitative evaluation of the process of achieving this goal has shown that long-term volunteer efforts *can* succeed with consistent participation and a continuing focus on the purposes of the organization. The Partnership helps close the gap between schools and residents of an inner-city neighborhood—a gap created by forces beyond the control of either the parent or the schools. Parents and school personnel can meet and work together on projects for the children that are community-based. The school personnel gain an understanding of the environmental realities of their students, and the parents gain confidence in their ability to communicate effectively with the people responsible for the schooling of their children. The Partnership has gained district-wide attention for its efforts, and discussion is now underway about how to develop similar partnerships in other neighborhoods in Hillsborough County, Florida.

Community-based Job Services Programs: The First Step Toward Community Economic Revitalization

Tracy Lea McPhail, M.A.

Introduction

This summary describes the use of community-based job development efforts to initiate economic revitalization.

The issue of welfare reform and the need to economically revitalize certain communities in Tampa prompted the community leaders and concerned faculty at the University of South Florida (USF) to address ways to transition low income welfare recipients toward gainful employment and self-sufficiency. The Center to Develop Communities of Tampa (CDC of Tampa), formerly known as the Lee Davis Neighborhood Development Corporation (LDNDC), has been dedicated to developing and sustaining community enhancement programs for many years. Such programs include the Men to Boys program which pairs successful African-American men with African-American boys who are at risk for developing problems in the community. Another successful program is the East Tampa School-Community Partnership which has been instrumental in opening the lines of communication between school administrators and concerned citizens.

A 1993 Needs Assessment of East Tampa Residents revealed that the respondent's top three needs were jobs, day care, and affordable single family housing. The urgency of these needs prompted several partnerships between the university and community organizations. One such partnership was initiated by Florida Community Opportunity Partnership Center (FCOPEC) and Multicultural Child and Family Development Project of the Department of Child and Family Studies at the University of South Florida's, Florida

Mental Health Institute. These projects at the USF united with the LDNDC, the Department of Labor and Employment Security (DLES), and the City of Tampa Private Industry Council (PIC) to create “one stop” community-based job development centers. These facilities would serve as a tangible first step in transitioning the unemployed toward self-sufficiency. One-stop job development centers are designed to provide referrals for jobs, vocational training and education. These centers are comprehensive, in that they also address many barriers to sustaining employment such as day care/elder care and transportation.

East Tampa is one of four sites for job development centers. The Job and Education Placement Center (JEPC) is housed within the Lee Davis Neighborhood Development Corporation (LDNDC). The JEPC is designed to address the needs of the unemployed and underemployed residents in the target area. With the help of the aforementioned entities, the JEPC provides many services to their clients. The DLES has set up several job information services terminals which clients use to electronically search for jobs posted by employers in four Florida counties. For clients who are unsure of their career path, the JEPC provides a computerized vocational assessment tool that prompts the clients to answer questions concerning their skills and interests.

In addition to referring clients to area vocational schools, JEPC also offers two job training programs. Job readiness training provides forty hours of customized instruction and hands-on practice designed according to the employer’s human resource needs. The Florida Aquarium used JEPC’s job readiness training during its initial staffing. The JEPC also offers an employability skills training program. This program consists of weekly courses on issues such as resume writing, interviewing skills, and proper business attire. This training is offered in several locations in East Tampa including the Lee Davis Neighborhood Service Center and

various housing developments. When training participants appear to have low self-esteem, the staff conducts motivational exercises before presenting the traditional employability training material. These exercises help the program participants recognize their worth, while identifying the skills they can offer to prospective employers.

After all job searches and job readiness evaluations are completed, the client may be referred to a job or a vocational training facility. If job or education placement occurs, then the JEPC should monitor their clients’ progress for 90 days. The current staff capacity at JEPC does not allow for comprehensive monitoring of all clients.

Program Evaluation

Within its first month of operation, JEPC had served 90 clients. All the client demographic data was not available, however simply comparing the responses of the needs assessment to JEPC’s client’s in its first month of operation shows that JEPC is truly serving a much needed function in the community.

Five months later, more than 350 people have visited the CDC of Tampa office. Of those people, 74 have been placed in jobs, demonstrating a one out of five placement rate. This placement rate is two placements higher than the larger Job and Benefits Offices. The types of jobs vary from janitorial work to mechanical engineering. The types of organizations that have hired clients include GTE Mobilnet, Ametek, USF, and Creative World Day Care.

Jobs and Community Revitalization

When examining the community economics from a macroeconomic perspective, it is clear that jobs are the first steps toward community economic development. Communities like East Tampa are constantly recruiting businesses to locate in their area. Businesses are attracted to a locale’s amenity

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factors such as tax incentives, skilled workers, quality education, quality transportation, and a low crime rate (Kasarda & Irwin, 1991). East Tampa is fertile ground for economic revitalization. As a federally designated enterprise zone, businesses located within the target area receive tax incentives and other perks.

Community-based job centers are a crucial link in improving the amenity factors that can attract businesses to the area. As businesses use the JEPC to find qualified, responsible employees, the residents acquire income that can be spent within the community. Continued efforts to recruit more businesses in the community will help diversify the local industry mix. The revenue from goods and services consumed (and eventually produced) in East Tampa will contribute to the community's economic expansion. The process all begins with jobs (Hindley, 1981; Kasarda & Irwin, 1991).

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Health Information Effectively to Middle-Income African-American Communities

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Introduction

One of the primary goals of this study was to determine the preferred sources of health information for middle-income African-American families, as well as how health risks are perceived differently among ethnic populations. The health risk example identified for this study was exposure to environmental contaminants, as the condition and quality of one's surrounding environment can have significant influence on physical, mental, and emotional health. The most common exposure to environmental contaminants occurs in our homes with common household products that contain hazardous chemicals. This summary describes this exploratory research's methodological procedures and preliminary implications.

Methods

This study's selected target population, middle-income African Americans, is one of the fastest growing economic sectors in American society. Currently, three out of ten African-American families in the United States have attained middle-income socioeconomic status. Conveying health information effectively to these families should be a primary concern for prevention. To be eligible for this study, participants had to reside in Hillsborough County, live in a single-family dwelling, and have at least one child under the age of ten years old.

This study used direct observations, elite interviews, focus groups, and community surveys to gain information on perceptions and preferred sources of health information, as well as more specific concerns and behaviors related to environmental health. Fifteen direct observations

estimated product preferences, usage levels, and storage methods. Thirty interviews with community leaders provided insight about the target population; quotes from focus groups also were instrumental in designing preliminary health messages using the cultural cues and values from middle-income African-American parents. Results of these qualitative research methods reflected a range of opinions and concerns, and proved beneficial to preliminary development of community surveys. These surveys were distributed to a sample of 250 homes from six selected neighborhoods in Hillsborough County. The selected neighborhoods were comprised of at least 50% African-American residents, based on 1990 Census data. At least 40% of the households had children present, and at least 40% of the households earn more than \$25,000 per year.

So how does this study translate into practical application? Preliminary analysis suggests:

1. With a limited number of ethnic populations utilizing available mental health services, it is imperative to address current health concerns in the marketing of current resources through a focus on the community strengths.
2. Cultural cues and pivotal messages may be slightly more distinct for such a specific demographic population. Thus, quotes from interviews and surveys may serve to peak the interest when describing available programs.
3. Due to this population's typically strong and constant spiritual beliefs, an avenue of joining forces with a particular religion's or denomination's health ministries may be explored further.

Environmental Psychology Implications

On another level, perceptions of the environment or surroundings may yield a reflection of mental health influences. Nature or environmental experiences can help broaden our sense of the

world while deepening our sense of ourselves (Wals, 1994). Qualitative and quantitative findings suggest that those residing in urban ethnic communities, without regard to socioeconomic status, are often exposed to excessive air, water, and soil pollution. A common response is concern for the cumulative impact on their children's health twenty years from now. Door-to-door community surveys revealed shared concerns and emotions that require solution to ensure the stability of future physical and mental health.

Feedback

The community survey data, complemented with qualitative approaches, will provide concrete suggestions and strategies for addressing a distinct ethnic population with multiple community networks throughout the socioeconomic scale within the black community. Feedback to the community is a critical component of any research. In this instance, the community will receive information in the form of data that can be transformed to program ideas, radio talk shows, newspaper articles, and meeting presentations. Based on the information and concerns expressed, an environmental education program can be designed to include topics of most interest to the communities, increasing adults awareness of the impact of environmental contaminants on the family's physical, mental, and psychological health.

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Conclusion

This symposium was intended to highlight the research projects of students participating in the MMHTP in coordination with the MCFDP. These research projects address the overall objective of the MMHTP to improve the quality of services to minority communities through a combination of training, research and treatment services. These minority student researchers are dedicated to understanding and studying the mental health needs of an increasingly ethnically diverse population. Initially, the MMHTP placed students in community sites to offer treatment services and technical assistance. These current students are combining research and evaluation procedures to improve service delivery within communities. Data collected in these projects involved community-based programs or community residents. The data gathered required formal and informal linkages between community residents and the researchers. The roles of these researcher are viewed as collaborators or partners for successful service delivery. The MMHTP will continue to offer minority students the opportunity to develop research projects and collaborative approaches for improving service delivery with ethnically diverse populations.

The Continuum of Care Study: An Assessment of Child/Adolescent Service Needs Within the Public Mental Health System

Introduction

Given the current fiscal environments in which State Mental Health Administrations are operating, there is increasing pressure to develop empirical methods of assessing need and allocating resources. In 1995, the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) conducted a study to evaluate the need for services across the continuum of child/adolescent mental health services. The specific objectives of this study were to: (a) describe the youth receiving services, (b) determine where and to what extent gaps in services exist, (c) determine the reasons why youth do not receive services, (d) empirically classify youth on the basis of "service packages" received (or identified as needed), and (e) identify those sociodemographic, clinical, and treatment history variables that best predict the service packages identified as needed.

Method

Data were gathered through a survey of community-based case managers (or primary clinicians) on a stratified random sample of youth who were receiving public mental health services on December 31, 1994 ($N = 2,059$). This population was divided into two distinct sub-populations, youth with serious emotional disturbance (SED; $N = 1,100$) and non-SED ($N = 959$) to determine whether their service needs differed.

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Respondents to the survey provided (a) descriptive data about the youth, (b) the types and amounts of services received during the last quarter of 1994, (c) the types and amounts of services that would have been needed to most appropriately and effectively serve the youth during the quarter as estimated by the youth's case manager or clinician, and (d) reasons for differences between services received and needed (e.g., service not available, insufficient service capacity, etc.). Gaps in services were determined by calculating the difference between the types and amounts of services provided and the types and amounts of services needed.

Using cluster analysis, "typical" service packages were identified, based on services recommended as needed by the case managers/clinicians. The youth were then classified according to cluster membership and a discriminant function analysis was conducted using sociodemographic, clinical, and treatment history variables to determine which variables best predicted recommended service packages.

Demographic variables that were included in the discriminant function analysis included age, race, gender, educational level, special education enrollment, residence in private household, legal status (voluntary vs. involuntary), annual income, SSDI eligibility, SSI eligibility, and payment source. Clinical variables used in the analysis included number of prior episodes, history of previous psychiatric hospital admissions, SED status, and score on the Global Assessment of Functioning (GAF). Due to the low frequency of some of the diagnostic categories used in the survey, primary and secondary diagnoses were grouped into the following categories: (a) schizophrenia and other psychoses, (b) adjustment disorders, (c) mental retardation or pervasive developmental disorder, (d) attention-deficit or disruptive behavior disorders, (e) anxiety or mood disorder, (f) substance dependence or abuse, and (g) other.

Results

Consumer Profile

The typical youth enrolled for services at a Community Mental Health Center (CMHC) in Virginia was a male (60%), 13 to 17 years of age (50%). African-American youth were over-represented relative to their percentage in the general population (29%). Half of the youth with SED were enrolled in special education. The majority of these youth (83%) came from families with total annual incomes of less than \$20,000. Medicaid was the most common source of payment for CMHC services, although the consumer's family was the direct source of payment for a large percentage (29%) of youth without SED.

Among youth with SED, primary diagnoses of disruptive behavior, attention deficit, anxiety, and mood disorders were most common, accounting for 83% of the youth. By contrast, among consumers without SED, the most common primary diagnosis was adjustment disorder (27%). Disruptive behavior, attention deficit, and mood disorders were also very common, accounting for an additional 44% of youth without SED.

Service Needs

In order to identify gaps in service capacity, the total amount of individual services recommended was compared to the total amount received. The CMHCs were able to meet a substantial amount of estimated need for inpatient and medication management for consumers with SED (greater than 90% and 80%, respectively). For consumers without SED, estimated need for inpatient and highly intensive residential services was most frequently met (greater than 70%). With respect to gaps, the largest gaps for youth with SED were found for in-home supported living, day treatment, and residential support where less than 50% of recommended services were received. For youth without SED, the largest gaps were found for residential support, in-home/supported living,

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rehabilitation, day treatment, and early intervention; less than 30% of the total estimated services needed were provided.

Reasons for Gaps

The reasons for insufficient amounts of services being provided were consistent regardless of SED status. “Lack of capacity” was the reason reported for the greatest percentage of youth not receiving needed services. “Missed/no show” and “consumer/family decision” were also significant factors, particularly for outpatient and medication management services. For this latter service category, “consumer/family decision” was the most frequently occurring reason. Other reasons, cited only rarely, were “consumer behavioral problems,” “insufficient consumer resources,” and “inaccessibility.”

Cluster Analysis

The cluster analysis was limited to consumers who responded to the Virginia Service Assessment Questionnaire and Continuum of Care Consumer Profile. The final data set included 1097 youth with SED and 799 non-SED youth. Because the number of youth with SED were not in proportion to the number of non-SED youth, the non-SED sample was weighted by 1.67. This weight was derived from the percentage of SED cases in the sample weighted by geographic location. This resulted in a total sample for the cluster analysis of 2428 youth.

In order to classify consumers according to the service packages recommended by case managers, a cluster analysis

using the K-means procedure of the Statistical Package for Social Sciences (SPSS) was conducted. Cluster solutions using 3, 4, and 5 clusters were computed in an effort to identify the solution which created clusters with sufficient sample sizes ($N > 30$) to allow for further data analysis and ease in interpretation. Using this criterion, the four cluster solution was chosen as the preferred solution for services recommended.

Using cluster membership as the independent variable and number of service hours per service type as the dependent variable, a one-way analysis of variance (ANOVA) was used to identify those service types that distinguished among the clusters. When the *F*-score for a given service type was found to be statistically significant, the Student-Newman-Keuls procedure was used to differentiate among clusters on that service (see Table 1).

Table 1
Mean Hours per Service Type by Cluster for Services Recommended

Service Type	Cluster Number and Membership			
	1 (N = 32)	2 (N = 2260)	3 (N = 33)	4 (N = 103)
Inpatient	11.25	6.11	1096.39	<u>77.12</u>
Outpatient	12.55*	5.87*	4.34	8.16
Medication Management	1.53	0.44	0.24	0.67
Intensive in-home	16.57	8.53*	16.69	<u>31.62</u>
Case Management	4.28*	2.99*	<u>8.16</u>	<u>11.38</u>
Day Treatment	15.72	12.98	25.42	71.88
Rehabilitation	21.62	7.41*	7.87	<u>30.86</u>
Vocational Services	0.00	0.01	0.00	0.92
MH Residential Treatment	22.49	2.55*	906.05	<u>36.11</u>
Intensive Residential	2050.00	2.58*	9.27*	<u>74.09</u>
Residential Support	0.00	1.36	0.00	2149.51
In-home/Supported Living	0.00*	2.15*	6.24	<u>9.25</u>

Note.
Values in bold type are significantly different from all other groups, $p < .05$.
Underlined values are significantly different from groups indicated by *, $p < .05$.

To interpret the clusters, attention was given to those services shown by the *post-hoc* analysis to most clearly distinguish each cluster from the other clusters. Individuals in Cluster 1, labeled *Residential Services*, needed the most units of intensive residential services and outpatient services. The most characteristic feature of Cluster 2, which described over 90% of the sample, was the low rate of all services recommended. Therefore, this group was labeled *Minimal Services*. Individuals in Cluster 3, labeled *Inpatient Services*, were described as needing the highest rates of inpatient, residential, and case management services. Individuals in Cluster 4 were recommended for the widest variety of services with need for residential support, day treatment, and vocational services exceeding that of the other groups. These services are primarily community based and of moderate intensity, and therefore, this cluster was labeled *Wraparound Services*. The stability of the cluster solution was confirmed by selecting random subsamples and repeating the cluster procedure on the subsamples to test for consistency of the cluster memberships between the full sample and subsamples using the Kappa statistic.

Discriminant Function Analysis

To determine which demographic variables could predict cluster membership, a discriminant function analysis was conducted using the Wilk's lambda method to test for the discriminating power of the variables in the function. Given the absence of a *priori* knowledge about the distribution of group membership, the equal prior probabilities method was used. The variables that predicted cluster group membership based on services needed are presented in Table 2. Classification of cases to clusters based on these variables made 61% fewer errors than would be expected by chance. In order to determine the relationship of these variables with cluster membership, a one-way analysis of variance was conducted using cluster membership as the independent variable and the predictor variables as the dependent variables. All of the predictor variables were significant ($p < .01$). Finally, the Student-Newman-Keuls test ($p < .05$) was used to determine the significance of differences between the group means.

These findings indicate that children perceived as needing Inpatient Services (Cluster 3) are more likely to be in special education, have a thought disorder diagnosis, have a history of previous mental health hospitalization, and have a low GAF score, indicating high impairment. Youth needing Residential Services (Cluster 1) were more likely to have an involuntary referral from the criminal justice system, a diagnosis of substance abuse, and a relatively high GAF score, indicating low impairment. Non-SED children living in a private home were most likely to be perceived as needing Minimal Services (Cluster 2). There were no clear predictors of membership in Cluster 4, Wrap-around Services.

Table 2
Variables Predictive of Cluster Membership
based on Services Needed^a

Variables	Clusters
Special education status	3 > (4 > (1, 2))
Diagnosis of schizophrenia or other psychotic disorder	3 > (1, 2, 4)
History of mental health hospitalization	3 > ((1, 4) > 2)
Axis V - Low GAF score	3 > 4 > (1, 2)
Legal status	1 > ((3, 4) > 2)
Diagnosis if substance abuse	1 > (4 > (3, 2))
Private residence	2 > (4 > (1, 3))
Non-SED	2 > (3, 4, 1)

^a Clusters enclosed in parentheses are not significantly different from each other.

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Discussion

Overall, the results of this study indicate that in Virginia's public mental health system:

- The greatest needs are for increased service capacity for residential and day support services.
- In the opinion of direct service staff, lack of service capacity is the major reason why consumers do not receive the amounts of service needed.
- Youth who are recommended by clinicians/case managers to receive more intensive services fall into three groups based on typical service packages recommended (i.e., inpatient, residential, and wraparound).
- Several demographic and mental health variables can be used to predict which youth will be most likely to use a particular "service package." These variables include score on the GAF, history of mental health hospitalization, diagnosis, SED status, special education status, legal status, and residence in a private home versus other living arrangement.

The results of this study provide documentation of the greatest service needs for child/adolescent consumers of public mental health services within one state system. There appears to be a large unmet need for all types of community-based services, and a need for CMHCs to be able to offer a broader array of services than they currently offer. The results of this study are being used to support and develop a "reinvestment strategy" (i.e., moving funds from inpatient to community-based services) as well as managed care-type initiatives.

The youth typologies and related service packages can provide a useful tool for service systems planning. Knowledge of appropriate service packages for different types of youth will allow planners to "size" the system of care based on the known characteristics of the consumer

population. Since there are differences in the variables that predict service usage between youth and adults, examining these populations separately is likely to result in more accurate estimations of service utilization.

The Individualized Needs for Service Assessment (INSA) for Children with Serious Emotional Disturbances

Background & Significance

This summary reports on efforts underway in New York State to develop the Individualized Needs for Services Assessment (INSA), a set of standardized procedures and data definitions to guide assessment of service needs for children with serious emotional disturbances (SED). The INSA is intended to be used by: (a) service providers and family members who want to develop individualized service plans; (b) planners and policy makers who want to quantify need for services at the community level, and services researchers who want to study factors correlated with service needs; and (c) managed care organizations and purchasers of services who want to balance issues of ensuring access to needed services while reducing provision of unnecessary, ineffective, or overpriced services.

A major challenge confronting the mental health field is to operationalize and quantify the concepts of *need* and *unmet need for services* (Klerman, Olsson, Leon, & Weissman, 1992; Bebbington, 1990). Policymakers, service providers, and advocates for children with emotional disturbances consistently place a high priority on the provision of sufficient services to meet what are perceived to be high unmet needs for services. Methods for detecting and diagnosing emotional disorders in children have improved and become more standardized. However, there are no standardized procedures either for determining which services are needed in individual

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cases or for specifying the community service capacities needed to serve diagnostically defined subpopulations.

Assessment of service needs is complicated by the fact that children with SED frequently are served by multiple provider systems. Needs typically have been defined in terms of organizational settings or *program components*, such as residential treatment facilities, clinics, or day treatment programs (Burns, Angold, & Costello, 1992; Pires, 1990). Yet, a program component approach does not clarify what service items are needed and makes it difficult to measure the extent to which service needs are met by other systems of care that may deliver similar services but use incompatible terminology. It also creates problems in applying findings from one geographic region to another, where services may be organized differently, or for designing new forms of service organization that would be more efficient in meeting needs.

Individualized Service Planning

The federal Child and Adolescent Service System Program (CASSP) initiative identified children with SED as a high priority, given that many of them are underserved and in need of advocacy, while others are treated, often ineffectively, in costly inpatient settings and other out-of-home placements (Stroul & Friedman, 1986). CASSP selected the following as basic parameters for defining the population of children with SED: (a) impaired social functioning in family, school, and neighborhood contexts; (b) in need of a range of services requiring the involvement of multiple agencies including the mental health, health, education, child welfare, juvenile justice sectors, and others; and (c) impairment that has lasted or is expected to last one year or more. CASSP envisioned a child-centered, community-based system, providing a comprehensive array of services includ-

ing mental health, social, educational, health, vocational, recreational, and operational components (Stroul & Friedman, 1986).

Recent literature has placed emphasis on principles that lay a foundation for services that are (a) flexible and accommodate the individual needs of the child and family, (b) family-focused and involve the family in planning, and (c) competent and meet the needs of multi-cultural populations (Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy, Lourie, Stroul, & Zeigler-Dendy, 1992). CASSP envisions the development of *individualized service plans* as a critical aspect of practice within a comprehensive system of care and that should have a strong bearing on what services a child and family ultimately receive (Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy et al., 1992; Rivard, Perry, & Hinkle, 1994). With the growing programmatic emphasis on individualized service approaches — based on the principles of unconditional care, family involvement, multi-cultural competence, delivery in a child's natural environment, and tailoring to the individual needs of the child and family — knowledge about appropriate assessment of individual service needs is sorely needed.

The growing emphasis on managed care to control access to and coordinate services places additional importance on the development of a consensus within the child mental health field of what constitutes service need. Under traditional financing arrangements and multiple, uncoordinated delivery systems, there was little incentive to reduce costly or inappropriate provision of services for children who had access. The broad coverage and capitation financing arrangements envisioned under managed care will provide strong incentives to limit or deny care when services are judged as unnecessary. In the absence of guidelines for what constitutes

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need, the impact of managed care on children with SED may place children at even greater risk for under-provision of services.

MRC Needs for Care Assessment Approach

While the *Medical Research Council (MRC) Needs for Care Assessment Procedure* was developed for adults with psychiatric disabilities (Brewin, Wing, Mangan, Brugha, & MacCarthy, 1987; Mangan & Brewin, 1991; Brewin, 1992), it provides concepts, procedures, and a *logic structure* that we have adapted for assessing the service needs of children with SED. Needs are defined according to an assessment of functioning that includes domains related to psychiatric symptoms and social role performance. Generic service items (defined independent of program components) are listed under each functional domain where they are considered likely to be effective.

For any particular individual, need is defined according to *assessment of functioning*, the *effectiveness* that a particular service item is expected to have for this particular individual, and the *acceptability* of the service item to the individual. The procedure includes a logic structure that leads from judgments in these three areas to categories of need for each domain and each service item. In addition to results ranging from unmet need, partially met need, and met need, the procedure allows for ratings of no meetable need (i.e., when no interventions are judged to be effective and acceptable to address a domain problem for a particular individual) and *overprovision* (i.e., when the frequency or intensity of a service item exceeds what is required to achieve functional outcomes).

Process

The INSA procedure for children with SED is designed to be consistent with principles from CASSP and individualized service planning and applies data standards and a logic structure adapted from the MRC Needs for Care Assessment. The INSA is being further specified and tested in *The SED Study*, an National Institute of Mental Health (NIMH)-funded child mental health services research study being conducted by Columbia University (Christina Hoven, Principal Investigator) in Westchester County as well as in *The FRIENDS Project*, a Center for Mental Health Services (CMHS)-funded comprehensive services demonstration in the Mott Haven section of the Bronx.

Interdisciplinary Teams with Family Participation

In both settings, service needs are being assessed using interdisciplinary teams with the participation of family members. In Mott Haven, for example, once a child is found eligible for FRIENDS (based on criteria for SED), a team is assembled to develop an individualized service plan. Team members include parents or surrogate parents, the child (as appropriate), and representatives from the mental health and education systems. Representatives from child welfare, juvenile justice, alcohol substance abuse, primary health care, recreation, and other relevant programs or community organizations also may be included. Information about providers previously or currently serving the family or expected to serve the family in the future is considered in selecting team members.

The team reviews the thorough clinical and functional assessment conducted as part of the FRIENDS admission process, along with historical records, and gathers any additional information required for the needs assessment. Team members complete INSA forms individually, and then the

team discusses each component of the assessment with the goal of achieving consensus on all phases. The team's INSA results represent what the child needs ideally. This information is then used by the team to develop an individualized service plan that factors in how services can best be delivered given real-world constraints of availability, organization, and financing of existing services. Analyses comparing INSA results with individualized service plans will be conducted to support community planning and funding allocation. For the Westchester study, a similar process is being undertaken, incorporating an expert, multi-disciplinary panel into the research process.

Data Standards and Logic Structure

Functional Domains

Functioning is assessed for the following domains: (1) self-care; (2) family life; (3) social and interpersonal relationships; (4) learning, school performance, vocational development; (5) disruptive behavior; (6) mood symptoms; (7) anxiety symptoms; (8) symptoms of psychosis; (9) attention deficit and/or hyperactivity symptoms; and (10) alcohol and/or other substance abuse. The child's functioning in each domain is rated according to a four-point scale from no problem to severe. Additional instrumentation is in development to support functional ratings responsive to the child's developmental stage.

Service Items

The INSA approach incorporates a taxonomy of over 75 *generic service items* thought to be capable of meeting need. "Generic" refers to service items that are generalizable and comprehensible across different organizational units and systems of care. Examples include:

- psychotherapy, brief or short-term individual, for the child;
- home-based training in parenting skills, child behavior, and symptom management for parent(s) or family members; and
- peer support, self-help, or support group for the child.

For each functional domain, service items thought likely to be effective according to expert judges are listed. Some service items appear under multiple domains. For those functional domains where the child is experiencing problems, team members rate *service provision* according to a scale that takes into account both current and past receipt of the service item.

Anticipated Clinical Effectiveness

The team rates the anticipated *clinical effectiveness* of each service item in addressing problems the child is experiencing in a given domain according to the following scale: (0) *demonstrated ineffective with adequate trial*; (1) *no adequate trial, but judged to be ineffective*; (2) *no adequate trial, but believed to be effective or partly effective*; (3) *partly effective based on adequate trial*; (4) *demonstrated effective based on adequate trial*; (8) *inconclusive, judgment deferred*; (9) *not applicable*. These judgments incorporate knowledge found in the professional literature (e.g., outcome studies, practice guidelines) as well as factors specific to the individual, such as service history.

Child and Family Acceptability of Services

The team rates the level of acceptability of the service item to the child and family according to the following scale: (0) rejection; (1) not likely to be acceptable; (2) likely to be acceptable; (3) demonstrated to be acceptable; (8) uncertain; (9) not applicable. This rating is made considering the family's prior experience with similar approaches,

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cultural appropriateness, and other factors related to individual preferences.

Need Status

Need status is measured according to the following scale: (0) no need, (1) no meetable need; (2) unmet need for assessment/trial; (3) unmet need for provision; (4) met need, maintain current frequency/intensity; (5) met need, increase frequency/intensity; (6) met need, assess overprovision. In addition, a judgment as to the presence or absence of overprovision is made when indicated. A logic structure that considers the ratings made on the above dimensions either determines the rating on need status or narrows the response categories available for any given rating. For example, a service item with an acceptability rating of rejection or a clinical effectiveness rating of ineffective would lead to a need status of no meetable need. A computerized version of the needs assessment, that automates the logic structure, is being planned.

Discussion

The INSA approach offers a standardized set of methods for assessing the service needs of children with SED that may be applied to individualized treatment planning, managed care, services research, and community planning. When aggregated across individuals, need may be studied on at least three levels: (1) global measures of need and unmet need, such as whether any unmet need is present or the number of items with unmet need; (2) functional domains, such as what factors are associated with unmet need for services designed to address disruptive behavior; and (3) individual service items, such as factors associated with need for behavior therapies. Over time, the INSA will be adapted to incorporate new knowledge about service strategies and effectiveness.

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Assessing Need and Planning for a System of Care in a Culturally Diverse Urban Community

Introduction

There is a growing urgency to develop community-based systems of care for children with serious emotional disturbances as the nation moves to provide mental health services in less restrictive and less costly living environments than those provided in institutional settings. In many communities across the country, ethnic minority children represent a significant proportion of the child population. The challenge is to find ways of incorporating these children into service delivery systems that are more culturally sensitive to them.

In response to a call for a framework that would guide the development of community-based systems of care, Stroul and Friedman (1986) proposed that “emotionally disturbed children should have access to a comprehensive array of services” (p. 18) coordinated across human service agencies such as education, social service, health, and juvenile justice. Cross, Bazron, Dennis, and Isaacs (1989) added that “when the system of care functions as an integrated support network” (p. 53), it supports and enhances the delivery of culturally competent services. In an integrated support network, the chances of considering the needs of both ethnic minority and ethnic majority children are likely to be much higher than in a fragmented and duplicative system. Cross et al. (1989) further suggested that those making plans for culturally competent systems of care need to be aware of the resources, available inside and outside communities, which can promote change. Some com-

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munities have a wealth of resources that allow them to develop home-grown, self-sustaining, and culturally competent systems of care, but many communities must rely on outside resources to sustain and enhance their own culturally competent care systems.

Study 1 of this summary provides an assessment of need for children's mental health services in the Mott Haven community of the South Bronx. Such assessment will be used as a baseline of the need for a community-based system of care currently being developed through the Families Reaching in Ever New Directions (FRIENDS) Initiative, a five-year project funded by a grant awarded by the federal Center for Mental Health Services. The assessment will seek to answer the following questions:

- What is a reasonable estimate of need for children's mental health services?
- What is the current utilization of children's mental health services?
- What is a reasonable estimate of the cost of mental health services currently being utilized?

Study 2 describes the cultural, personal, and service utilization characteristics of Mott Haven children who are recipients of existing mental health services through a correlational analysis. Such description is viewed as important to planning for a system of care in a culturally diverse community that is 67% Hispanic, 31% African American, and 2% Caucasian. The analysis will address the question: To what extent are the cultural and personal characteristics of Mott Haven children related to the children's utilization of mental health services?

Method and Results

Study 1

The New York State Office of Mental Health (NYSOMH, 1992) has developed a population-based approach to estimate the need for mental health services for children in specific communities across the state. This methodology resulted in estimates of the number of children needing services during a typical week of the year for each of seven types of mental health programs (acute inpatient and crisis residential, home-based crisis intervention, intermediate inpatient, residential, school-based clinical, intensive case management, and clinical). Low, average, and high need for

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capacity rates per 100,000 children in the population were generated based on geographic differences. The high rate was applied to the child population of Mott Haven because of the presence of the many environmental risk factors that are believed to exacerbate the mental health conditions of the children. The first column of Table 1 shows the estimate of needed capacity for each of the seven types of mental health programs. As indicated, a system of care in Mott Haven would need to serve at least 467 children on a continuous basis. These children represent 1.4% of the population of 32,793 children and youth residing in Mott Haven. This is consistent with Friedman's (1987) estimate that a public system of care should have a capacity to serve between 1 to 2 percent of children at any given time.

Second, the above estimate was compared to the actual utilization of mental health services by Mott Haven children and youth during a one-week period in 1993, as reported in the Patient Characteristics Survey of the NYSOMH. As seen in the second column of Table 1, only 160 children and youth, or 34% of the estimated number of children who need mental health services, utilized those services.

Third, Table 2 reports cost estimates for each of the seven types of mental health services per unit of utilization, for total units utilized, and for an entire year. The figure of \$4,234,932 provides an estimate of the total annual cost of sustaining a comprehensive array of services for children and youth ages 21 and younger in the Mott Haven community.

Table 1
Estimated Need and Current Utilization of
Mental Health Services in Mott Haven

Program Area	Estimated Need ^a	Current Utilization ^b
Acute Inpatient & Crisis Residential	10	11
Home-Based Crisis Intervention	6	0
Intermediate Inpatient Residential	6	0
School-Based Clinical	18	0
Intensive Case Management	146	21
Clinical	34	2
	247	126
Total	467	160

^a Need refers to the unduplicated number of children and youth who need to be served during a typical one-week period.

^b Utilization refers to the duplicated number of Mott Haven children and youth ages 20 and younger seen and surveyed through the Patient Characteristics Survey of the NYSOMH during a one-week period in 1993.

Study 2

Plans to develop a culturally competent system of care are enhanced by information on how cultural and personal characteristics of children with mental health needs relate to the children's utilization of mental health services. Such relationships were explored among a sample of 143 Mott Haven children and youth ages 17 and under who utilized mental health services during a one-week period in 1993. Measures of cultural and personal characteristics included Ethnicity (African American = 1, Hispanic = 2), Primary Language (English = 1, Other language = 2), Age Group, defined as eight age categories between 0 to 17, and Gender. Children's service utilization was measured through Program Type (Outpatient = 1, Inpatient = 2), Clinic Visits, with a 0 to 2 range, Day Treatment Visits, with a 0 to 5 range, and Location (inside or outside Mott Haven). The measures of visits to clinic and day treatment programs were selected because clinic and day treatment were the services to which Mott Haven children had the greatest access.

Table 3 shows Pearson correlations between the measures of cultural and personal characteristics and the measures of children's service utilization. Ethnicity had a relatively strong negative relationship with Location indicating that African American children had a tendency to receive services outside Mott Haven, while Hispanic children tended to be served inside Mott Haven. Primary Language had a moderate negative relationship with Location. Since Spanish was the primary language for many of the children, the finding suggests that these children had better

access to mental health services within Mott Haven rather than outside Mott Haven. Ethnicity and Primary Language were weakly and positively related to Clinic Visits suggesting a tendency for Hispanics and persons speaking Spanish and other languages to visit clinics more often than African Americans. Finally, there was a weak negative relationship between Age Group and Clinic Visits suggesting that younger children are more likely to visit clinics than older children. Among possible explanation is that older children and youth may view visits to a clinic as potentially stigmatizing.

Table 2
Unit Utilization and Estimated Cost of Mental Health Services
for Mott Haven Children and Youth: A Baseline^a

Program Area	Unit Utilization	Cost Estimate		
		Per Unit ^e	Total Units ^f	Annual ^g
Acute Inpatient & Crisis Residential	21 ^b	\$805	\$16,905	\$879,060
Home-Based Crisis Intervention	-	-	-	-
Intermediate Inpatient Residential	35 ^c	\$779	\$27,265	\$1,417,780
School-Based Clinical	99 ^d	\$125	\$12,375	\$643,500
Intensive Case Management Clinical	2 ^d	\$123	\$246	\$12,792
	170 ^d	\$145	\$24,650	\$1,281,800
Total	-	-	-	\$4,234,932

^a Data for this table was obtained from a sample of 166 duplicated Mott Haven children and youth ages 21 and younger in the 1993 Patient Characteristics Survey of the NYSOMH. Missing data occur among types of services that Mott Haven children did not use.

^b Refers to 7 bed-days multiplied by 3 children and youth.

^c Refers to 7 bed-days multiplied by 5 children and youth.

^d Refers to the number of visits made by children and youth during a one-week period.

^e Cost figures represent the best estimate per unit obtained from consultations with financial officers of the NYSOMH.

^f Total Units Cost Estimate = Unit Utilization X Cost Estimate Per Unit.

^g Annual Cost Estimate = Total Units Cost Estimate X 52 weeks.

Discussion

Study 1 in this paper suggested the utility of applying a population-based approach to estimating the need for a comprehensive array of mental health services for children with mental health needs in an urban community such as Mott Haven. The estimate of need for services in Mott Haven was compared to the children's actual use of services showing that there may be a large gap between the need and the use of services. An estimate of the cost of providing mental health services to Mott Haven children in 1993 was possible given the availability of information on the children's use of services. The long term benefit of having a baseline estimate of mental health service costs is that it will make it possible to compare it with an estimate of costs after a new system of care for children has been implemented through the FRIENDS Initiative. At such time, it will also be possible to determine whether a new system of care reduces or increases costs of serving children with mental health needs in an urban community.

The findings in Study 2 provide some support for using personal characteristics and cultural measures to better understand patterns of service utilization in culturally diverse urban communities. It was particularly interesting to see the extent to which children from African American and Hispanic backgrounds appeared to use mental health services differentially inside and outside Mott Haven. Such finding suggests the need to develop a fuller understanding of the cultural factors that mediate the differential use of services by children with mental health needs.

Estimating service needs, determining rates of service utilization, estimating service costs, and understanding personal cultural factors that mediate service use are all important components in planning systems of care for children with mental health needs that are also culturally competent. This study serves as a starting point for describing the relationship between these indices.

Table 3
Correlations Between Cultural and Personal Characteristics
and Service Utilization
(N = 143)

Cultural and Personal Characteristics	Service Utilization			
	Program Type	Clinic Visits	Day Treatment Visits	Location
Ethnicity	-.12	.17*	-.13	-.53**
Primary Language	-.11	.17*	-.16	-.39**
Age Group	.07	-.19*	.10	.03
Gender	.06	.07	-.14	.05

* $p \leq .05$. ** $p \leq .01$.

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