

**Parent/Professional Perceptions of Collaboration When Viewed in the Context of
Virginia's Comprehensive Services Act System of Care**

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(ABSTRACT)

In 1992, Virginia created a system of care that was designed to address the needs of troubled youth and their families. Known as the Comprehensive Services Act, the legislation mandated that family and service system interactions were intended to be child-centered, family-focused, and collaborative in nature. Whether at the assessment, planning, implementation, or evaluation phase of a family's individualized service plan unfolding, strong collaborative linkages between families and professionals were encouraged. The present study focuses on determining perceptions of collaborative experiences from the point of view of parents of emotionally disturbed children who have been served by the system of care's Family Assessment and Planning Team, and the perceptions of experiences of professionals who comprise that team. In addition, the study will attempt to show a relationship between a parent's collaborative experiences and a child's treatment outcome.

Data suggest that differences exist between parents and professionals in their perceptions of collaborative experiences during the FAPT process, and that the group to which one belongs is a determining factor in shaping those perceptions. Secondly, no statistically significant relationship was found between parent perceptions of collaborative experiences and treatment outcomes of their children.

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DEDICATION

This study is dedicated to my parents, Herman and Lorraine Tannenbaum, who valued everything I did;
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I love you more than you'll ever know;
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CHAPTER I

Statement of the Problem

In 1990, the Department of Planning and Budget of the state of Virginia published a document titled Study of Children's Residential Services which concluded that the existing system driving state and local expenditures for residential care was fragmented and fiscally inefficient. Alarmed by statistics that showed that the cost of residential care was increasing at a rate of 22 % annually, then Governor Wilder and the 1991 General Assembly appropriated more than \$2.4 million for FY 91-92 to begin addressing the issues of escalating costs and early intervention with families. Early in 1992, legislation was introduced to the General Assembly and enacted as the Comprehensive Services Act for At-Risk Youth and Families, heretofore referred to as CSA. The Act's intent and purpose states that:

It is the intention of this law to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youth and their families in the Commonwealth. (CSA, 1993 p.VIII)

More specifically, the Act targets children who exhibit emotional and/or behavioral problems that:

- (a) Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted; (b) Are significantly disabling and are present in several community settings, such as at home, in school, and with peers; and (c) Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies (Council on Community Services for Youth & Families, 1991 p. 22); or the child "has emotional and/or behavior problems and is currently in, or is at imminent risk of entering, residential care" (Council on Community Services for Youth & Families, 1991 p. 2).

On a national scale, "nine to 13 percent (3.5 to 4 million) of youth ages 9 to 17 years experience a serious emotional disturbance that can impair daily living and school, family, and community activities" (Action Alliance for Virginia's Children and Youth, 1999 p. 9).

The Context of CSA

The CSA was designed to be a collaborative system of mental health care for troubled youth and their families that acknowledges the relationship between parents and professionals as a central dimension of service provision. Consequently, a mechanism for family involvement in service delivery and management was created.

Family Assessment and Planning Team

Part of the administrative structure developed for implementation purposes included the creation of a local interagency team called the Family Assessment and Planning Team (FAPT). The mission of this team is to "review referrals of youth and families, provide for family participation, develop individualized service plans, make referrals to other agencies, recommend expenditures from local Funds Pool allocation, and designate case management responsibilities" (CSA, 1994 p. 2). CSA requires that the minimum mandatory membership of each team include representatives from the following groups: (a) Community Services Board; (b) Department of Social Services; (c) Health Department; (d) Juvenile Court Services Unit; (e) Local School Division; and (f) a parent representative (CSA, 1994). Other members may be appointed to the FAPT at the discretion of another locally-based team called the Community Policy and Management Team (CPMT). The CPMT is charged with the mission of managing the cooperative efforts within each locality, and maximizing the use of state and community funds.

It is the responsibility of the FAPT to assess the strengths and needs of troubled youths and families while ensuring family participation in all aspects of assessment, planning, and implementation of services (CSA, 1993). The desirability of family/service provider collaboration during the development and implementation of a service plan has been well-documented in the professional literature. For example, Melaville & Blanks (1993) remark that "If the collaborative's efforts are to improve family outcomes and achieve broad-based community support, the people who use services (customers) must help establish its goals and strategies" (p. 26). Indeed, collaboration with families is central to any system of care designed to be family-focused, as is the case in Virginia. And for Virginia families of children with serious emotional disabilities in need of services, FAPTs represent their first formal connection to the collaborative aspects of the locally based comprehensive services system of care.

Individualized Family Service Plan

At the heart of the FAPT's work with families is the evolution of an Individualized Family Service Plan (IFSP). The IFSP is a document that describes a breakdown of appropriate, cost-effective, and least-restrictive services needed by a child and his/her family as developed collaboratively by the family and a multi-agency team of professionals. Once the IFSP is developed, it is FAPT's responsibility to oversee the implementation of each family's service plan through case management. The service plan is viewed as an evolving document in that it is always subject to change as a family's circumstances change. Here again, it is the responsibility of the FAPT to assess changing family circumstances and make necessary IFSP adjustments by relying on evaluation data provided by the family as well as

service providers. This can only take place when the FAPTs develop strong collaborative linkages with all involved parties. In the total scheme of things, then, family and service system collaboration should take place not only in the context of assessment, planning, and implementation of a family's service plan, but also in evaluation of those agreed-upon services as well (CSA 1993).

In summary, the Comprehensive Services Act mandates that family and service system interactions shall be child-centered, family-focused, and collaborative in nature. Whether at the assessment, planning, implementation, or evaluation phase of a family's individualized service plan development, strong collaborative linkages between families and service providers are encouraged.

At the heart of a collaborative relationship between families and service system professionals is the sharing of power and responsibility. This requires that professionals recognize the perspective, knowledge, and resources that families possess, and involve them as partners in decision-making. For some professionals, however, the concept of collaboration presents some dilemmas. More specifically, professionals are now faced with addressing the task of redefining their role from that of one who exercised a great deal of power by virtue of knowledge, expertise, and client acquiescence in decision-making, to a role that now requires professionals to act as a facilitator who empowers clients to help themselves. How willing are professionals to undergo this role transformation? Are their collaborative expectations similar to what families seek in a collaborative relationship? Indeed, collaboration may take on a different meaning when discussing it from the perspective of the family versus the service provider.

Purpose of the Study

Given collaboration's reciprocal notion of shared power and responsibility, the goal of this inquiry is to provide greater understanding of family and professional expectations for collaboration in meeting the intent of the CSA. Specifically, the present study seeks to compare family perceptions of collaborative experiences to the perceptions of professionals. The present study will identify perceptions of collaborative experiences from the point of view of parents of children with emotional and behavioral problems who have been served by a Family Assessment and Planning Team, and the perceptions of collaborative experiences of professionals who comprise that team. In addition, the study will seek to establish a relationship between collaboration and treatment outcomes.

Research Questions

The overall questions guiding this inquiry are these: Do parents whose children have been served by a Family Assessment and Planning Team have different perceptions of collaborative experiences when compared to the perceptions of professionals who serve on the same teams? Moreover, is there a relationship between parental collaborative experiences and a child's treatment outcome? Specific answers will be sought to the following questions: What kind of information does the FAPT gather from the family in the development of the IFSP? How does the FAPT involve the family in decision-making about services? To what degree does the FAPT involve the family in evaluating the child's progress, the services rendered, and the outcomes of these services? Does a relationship exist between collaborative experiences and measurable outcomes?

Survey methodology and archival data in the form of scores from a uniform assessment instrument adopted by the CSA's State Executive Council will be used to address these questions. A questionnaire will be developed that merges a definition of family/professional collaboration into a set of questions framed in the context of the FAPT process. One version of the questionnaire will be mailed to parents who have had a child staffed by a Family Assessment and Planning Team and are still considered part of the active file membership list at the time of the questionnaire's mailing. The other version will target professionals who are members of the local FAPT. Survey items will measure the degree to which characteristics of family/professional collaboration is taking place in the context of the FAPT process. Two Child and Adolescent Functional Assessment Scale (CAFAS) or two Preschool and Early Childhood Functional Assessment Scale (PECFAS) scores for each child will be obtained comparing the initial assessment score to the most recent utilization review score. The CAFAS (to be used for children ages 6 through 17) and the PECFAS (to be used with younger children ages 4 through 7) are both designed to measure how impaired a child is in day-to-day functioning.

Survey instruments will provide data that measure the extent to which parents and professionals perceive having had collaborative experiences in the context of the FAPT process, while the CAFAS baseline and six month interval scores will reveal changes in each child's level of impairment within a period of time deemed sufficient to have realized treatment effects.

Significance of the Study

Meeting the needs of seriously emotionally disturbed children and their families represents the overarching goal of Virginia's Comprehensive Services Act. A new system of care has evolved that underscores the belief that families of emotionally disturbed children should be fully involved in the collaborative planning and delivery of services. The literature supports the notion that when service providers seek to empower families through meaningful involvement in the provision of services, children experience better treatment outcomes. In the context of the CSA, family empowerment pertains to the service system's efforts at helping families, through collaborative family/professional relationships, advocate for themselves, make decisions about the kind of help they need, and locate and utilize services. A critical CSA performance question, however, which has yet to be definitively answered, is whether or not the intended collaborative responsibility on the part of parents and professionals is working, and whether evidence exists that where collaborative experiences are positive, treatment outcomes improve. The intent of the service system calls into question the traditional role of both service provider and client. The present study will attempt to determine the degree to which collaborative strengths and weaknesses exist, where those strengths and weaknesses lie, and highlight collaborative differences among key participant groups. Data from the present study will reveal whether or not professionals and clients have accepted their new respective roles, the implications of which might very well affect how much progress can be made meeting the needs of troubled children.

Limitations

Characteristics of professionals providing services, frequency of contacts, duration of services, types of services, and specific family characteristics have been found to affect what parents believe to be key elements of collaboration (DeChillo, Koren, & Schultze, 1994). These same variables might also affect the degree to which parents identify with having positive collaborative experiences. Moreover, isolating similar family characteristics might reveal hidden biases maintained by professionals related to perceptions of a family's ability to collaborate with a team. The effect of having such biases could shape the flavor of collaborative encounters initiated by professionals. These variables will not be a part of the present study.

Defining Terms

Child and Adolescent Functional Assessment Scale (CAFAS): A clinical instrument designed to measure a child's level of mental health impairment.

Collaboration: Two or more parties working together toward a common goal.

Community Policy and Management Team (CPMT): A team of professionals representing public and private agencies and parents charged with the mission of managing a locality's use of state and community funds.

Comprehensive Services Act (CSA): Virginia legislation creating a system of care for at-risk youth and their families.

Empowerment: To encourage one to act with authority.

Family Assessment and Planning Team (FAPT): A local team of professionals representing public and private agencies and parents whose mission is to develop, implement, and evaluate a child/family service plan.

Family-centered: Focusing mental health services and treatment on the context of a client's permanent living environment.

Individualized Family Service Plan (IFSP): A written document that describes services needed by a child and that child's family.

Locality: A CSA organizational and geographic boundary that mirrors county and city boundaries.

Service Provider: Either a person or entity in the business of providing mental health treatment to individuals and families.

Systems of Care: A comprehensive array of mental health services organized into a coordinated network to meet the needs of at-risk children and their families.

Organization of the Study

The study is organized into five chapters. Chapter two is a review and synthesis of related literature found in databases such as Lycos and Infoseek. Hand searches were completed in relevant journals for the past 10 years resulting in a high percentage of pertinent documents. Major areas of investigation include an historical perspective on building a system of care, a theoretical view that focuses on families, and reviews developments in family-centered research underscoring the role of collaboration between families and professionals as a path to better treatment outcomes. Articles chosen were published in professional journals and written by authors who had been cited repeatedly in research. Studies included in this review of the literature were of sufficient quality that their results could be trusted. A thorough discussion of studies was included, allowing readers to make their own professional judgements regarding the quality of each study's findings. Chapter three describes the methodological approaches taken to gather, analyze, and report data. Findings are reported in chapter four and will assist the reader in answering the research questions. The study will conclude with Chapter five, containing a discussion of implications and recommendations resulting from the findings.

CHAPTER II

Survey of Literature

Families are the epicenter of effective systems of care for children with emotional problems. The following chapter will provide an historical perspective on building a system of care, will offer a theoretical perspective that focuses on families, and lastly, will review developments in family-centered research underscoring the role of collaboration between families and professionals who are part of the service provision process as a path to better treatment outcomes.

Background: Building a System of Care

History shows that services to children in the context of strengthening, preserving and, to a certain degree, empowering families is not a new idea. Among the first agencies to sanction policies that underscored the need for family-oriented services were state and local welfare departments. Mirroring several of the new family-centered service system principles practiced today, early 20th century welfare workers

gave serious attention to the needs - especially the concrete ones such as food and housing - defined by clients, spent enormous amounts of time getting and keeping natural helping networks (relatives, landlords, neighbors) involved, timed visits to meet family needs and respond to crises, and used helping teams (homemakers, visiting nurses) freely. But, most significantly, within the limits of Progressive Era morality and paternalism, these workers held, as we do, the goal of keeping the family together. And so long as the client shared that goal . . . the family was in charge of the help it got. (Stehno, 1986, p. 234)

Other contradictory societal forces at work during this same period sought to remove troubled children from their homes and place them in institutions. Inherent in the institutional approach was the "view that society could be served if children were subjected to their programs away from the negative influence of the environment and more specifically away from their families" (Petr & Spano, 1990, p. 228). Psychoanalytic theory of the time held parents responsible for the problems of their children (Friesen & Koroloff, 1990), and it was not until the 1960s, that alternatives to institutionalization began to materialize. A trend geared toward the closing of state-run mental hospitals and replacing them with locally-based privately-owned for-profit and non-profit therapeutic residential centers then took place, a trend which lasted well into the 1980s (Petr & Spano, 1990), and beyond.

Since the mid-1980's, many states have redefined services for seriously emotionally disturbed children by modeling principles set forth in the Child and Adolescent Service System Program of the National Institute of Mental Health, commonly referred to as CASSP (Macbeth, 1993). "The principles underlying CASSP call for community-based systems of care that are comprehensive and emphasize co-ordination among child-serving agencies, service delivery in the least restrictive environment, full involvement of families, and cultural competence" (Lourie, Howe, & Roebuck, 1996, p. 1).

Building upon the principles underlying CASSP, policymakers sought to create a system of services that would take the form of "a comprehensive spectrum of mental health and other necessary services which are organized to meet the multiple and changing needs of severely emotionally disturbed children and adolescents and their families" (Stroul & Friedman, 1986, p. 4). Since the mid 1980s, the dominant public service delivery goal for severely emotionally disturbed children and their families has been the creation of a single, as opposed to fragmented, system of care that is community-based, child-oriented, and family-focused (Burns & Friedman, 1990). Other authors, including Melaville and Blank (1991), suggested that high quality comprehensive service delivery include the following elements: (a) a wide array of prevention, treatment, and support services; (b) techniques to ensure that children and families receive the services they need; (c) a focus on the whole family, (d) the empowerment of children and families; and (e) mechanisms to measure the impact services have on children and families.

Theoretical Perspective: Families as the Focus of a System of Care

An issue central to this newly emerging system of care has developed, which underscores the notion that families of emotionally disturbed children should be fully involved in the collaborative planning and delivery of services (Collins & Collins, 1990; Stroul & Friedman, 1986). Heflinger (1995) summarizes Bronfenbrenner's systemic analysis by pointing out that the parents facilitate "the interaction between the child and the service system" (p. 7), and, as such, represent the "central dimension" of the system of care.

In an attempt to define family centeredness as the focus of a system of care, both families and professionals at The Beach Center on Families and Disability at the University of Kansas defined the term as "service delivery, across disciplines and settings," that "recognizes the centrality of the family in the lives of individuals. It is guided by fully-informed choices made by the family and focuses on the strengths and capabilities of families" (Petr, 1995, p. 10).

Several human service models have evolved in the recent past that give credibility to this point of view, all of which conclude that "families should play a major role in shaping the direction of resources and supports they receive, and that resources and supports ought to be provided in ways that strengthen the capabilities of families" (Dunst, Johanson, Trivette, & Hamby, 1991 p.124).

Family-Focused Approaches

Family-focused approaches in the provision of services to emotionally disturbed children also have occurred partly as a byproduct of an aggressive consumer rights movement. According to Petrilu (1992), "a relatively new development in the mental health field is the growth of organizations of families and of consumers (or recipients) of mental health services" (p. 101). According to Friesen and Koroloff (1990), "efforts in many states to develop statewide parent advocacy organizations have helped parents gain the information, skills, and access to decision making they need to work on behalf of their own children and other families" (p. 19).

Developments in the field of special education as first evidenced by passage of P.L. 94-142, The Education for All Handicapped Children Act (EAHCA) in 1975, and continuing in its reauthorization as the Individuals with Disabilities Education Act (IDEA),

P.L. 105-17, 1997, have especially recognized the critical role of families in assuring the healthy development of children. Special education owes a portion of its significance to the fact that a public sector entity historically mandated to serving children now recognized and sought to serve the family as the primary service recipient (Krauss, 1990). Allen, Brown, and Finlay (1992), add that "parent involvement is an important component of the federally funded education programs for disadvantaged students and for students with disabilities" (p. 15).

Family-focused approaches to intervention represent a departure from traditional service schemes that viewed the family as either "informant or client" (Collins & Collins, 1990, p. 522). Further, the authors state that these "empowerment-based practice issues are central to efforts to reconceptualize professionals' relationships with parents of emotionally disturbed children and adolescents" (p. 525).

Kalyanpur and Rao (1991) take this idea a step further by concluding that the role of the professional is crucial when cultivating a family's sense of empowerment. According to these authors, empowering relationships materialize "when professionals provide enabling experiences" (Kalyanpur & Rao, 1991, p. 524) that create opportunities for families to learn to utilize both family and community resources, thus leading to active participation in the decision-making process.

Blank and Lombardi (1992) deal with the issue of empowerment by arguing that "people most directly affected must have some control over the types of services provided and the ways they are delivered" (p. 6). Implicit in this notion is the belief that families have the ability to identify their own needs and concerns (Hanson & Carta, 1996), and possess strengths that can contribute to achieving family and child treatment goals (Kuperminc & Cohen, 1995). Hanson and Carta (1996) also make the point that families must also be empowered to gain access to resources and help direct their use. Weick and Saleebey (1995) report that

listening to families over the years has demonstrated that most families, despite turmoil and problems, have resources upon which they can and do draw, and that work with families, regardless of the theory that drives such work, should take into account families' internal strengths and external resources. (p. 144)

Dunst, Trivette, and Deal (1988) take this notion a step further by claiming that their research evidence and clinical experience suggest that when professionals are guided by specific intervention guidelines that promote a family's sense of empowerment, families have been successful in identifying critical needs and mobilizing resources.

Young (1990) also supports a family-focused approach to services suggesting that efforts to help emotionally handicapped children would be more productive if they focused on the child's immediate family (environment), as opposed to solutions that are child-centered. Fleck (1990) adds that "whether one studies normal development or clinical conditions, an exclusive focus on the individual without attention to the context in which such processes occur is inadequate. That context is social and most often is one's family" (p. 51).

According to Schorr (1988), the circumstances of their environment is the single largest factor impacting children. Researchers studying families with children with emotional disabilities have identified a variety of environmental risk factors. Schorr (1988), for example, listed poverty, isolation, inadequate health care, homelessness, crime, and

mental illness as key risk factors. Contemporary thought acknowledges that there are ecological factors at work contributing to behavioral problems exhibited by children, however, parents are now recognized as key partners in the quest to ameliorate those risks.

The Needs of Parents

Young (1990) argues that the mental health needs of children with emotional disabilities are embedded in the needs of their parents. Young adds that to affect modifications in a child's environment "typically requires the coordinated efforts of both formal organizations and natural support networks" (p. 124). Parents, through the family, play a major supporting role in this drama. Mental health service providers now recognize that a child's emotional health is intricately connected to the social, economic, and spiritual health of the immediate family. Embedded in a system of care philosophy that emphasizes a child-centered, family-focused approach to service delivery is the belief that a child's familial environment should be supported and recognized as the primary agent in helping a child achieve their treatment goals.

Case Management

The successful implementation of an integrated and comprehensive service plan for families of children with severe emotional disabilities requires skilled coordination through the work of a designated case manager. Case management, a vital component of service provision, has also been highly influenced by family-focused, collaborative practices.

"Traditional case management models have been based on the assumption that families and children are passive recipients of resources and services" (Swan & Morgan, 1993, p.167). Traditional case management sought to ensure that clients received services that the case manager felt were in the best interests of his or her client. A trend toward a more collaborative client/professional relationship has materialized and was helped in part by the passage of P.L. 99-457 in 1986. This federal act not only focused upon the collaborative aspects of service planning, but sought family involvement as a mandated feature of a child's service plan development (Woody, Woody, & Greenberg, 1991). Specifically, special education, regarding preschool-age children with handicaps, had to plan for and obtain coordination and cooperation among different professionals, agencies, and the family. The act mandated an interdisciplinary approach to addressing problems through the development of an Individualized Family Service Plan (IFSP). According to Friesen and Osher (1996), the act provided "a model for a more holistic approach to children and families, foreshadowing the integrated service approach" (p. 191) central to systems of care. Case management began to exemplify shared client/professional power and responsibility. Where it was once commonplace for children with disabilities and their families to receive fragmented services from multiple providers, case management was now offered in the context of a comprehensive, interagency, and collaborative service system model. As such, case management had now taken on

a boundary-spanning approach in that, instead of providing a specific direct service, it utilizes case managers who link the client to the maze of direct service providers. These case managers are expected to assume ultimate responsibility for seeing that the service delivery system is responsive to all the needs of every client. (Rubin, 1987, p. 212)

Contemporary models of case management emphasize family-centered service coordination. This new approach to case management "views parents and service providers as equal partners in assessment, decision making, and intervention" (Swan & Morgan, 1993, p. 168). The authors add that at the heart of family-centered case management practices "are the concepts of enablement and empowerment" (p. 168). Enablement refers to the ability of a system to create means and opportunities, while empowerment refers to families gaining a sense of control and self-sufficiency. Yet, besides facilitating coordination between service providers and families, the role of case manager ultimately must become that of helping families gain the necessary knowledge and skills to seek and obtain access to resources, and make decisions that are in the best interests of the disabled child and family (Swan & Morgan, 1993).

The Role of Family/Professional Collaboration

Collaboration is often seen as the foundation upon which a family-focused system of care geared to achieve better outcomes for severely emotionally disturbed children and their families is based. There exists, however, some ambiguity surrounding the notion of collaboration in the context of human services (DeChillo & Koren, 1995). The number of proposed characteristics associated with the notion of collaboration, for example, vary widely. Moreover, several definitions exist, depending upon who is collaborating with whom. In the context of collaboration among professionals, Melaville and Blank (1991) describe it as taking place at two distinct levels. At the system level, collaboration can be characterized as "empowered - politically, by virtue of their members' collective 'clout', or legally, by the state or other entity - to negotiate, as well as to advocate for programs and policies leading to more comprehensive service delivery" (p. 17). At the service delivery level, collaboration is defined as follows:

Instead of focusing on their individual agendas, collaborative partnerships establish common goals. In order to address problems that lie beyond any single agency's exclusive purview, but which concern them all, partners agree to pool resources, jointly plan, implement and evaluate new services and procedures, and delegate individual responsibility for the outcomes of their joint efforts (Melaville & Blank, 1991, p. 16).

Collaboration is commonly understood as two or more parties working together in pursuit of a common goal. In children's services, collaborative family involvement is facilitated by service provider professionals. As such, theoretical discussions of the subject of family/professional collaboration were primarily intended to guide professionals in their collaborative efforts with families.

Swan and Morgan (1993) caution that whether between professionals, or parents and professionals, true collaboration cannot be mandated. Even with nurturing and clear goals, the authors add that it is both a process and attitude which takes time to develop. First and foremost, however, collaboration is seen by increasing numbers of professionals and families as central to achieving a family-centered system of care designed to achieve better outcomes for seriously emotionally disturbed children and their families.

Newly emerging family-centered service system collaboration, which has been characterized as promoting close working relationships mutually respectful of knowledge,

skills and experience, trusting, open, and committed to meeting the needs of seriously emotionally disturbed youth and their families (Gaschnig, Vohs, & Weaver, 1995) manifests itself through the provision of services. From the point of view of service providers, families are now being recognized as a valuable partner in the care and treatment of the child. How professionals put into practice elements that reflect this shared power and responsibility between the family and professional becomes the bellwether of the system's collaborative effectiveness. Within the context of the CSA, interaction with families during the evolution of an individualized family service plan represents the vehicle by which our locally-based system of care attempts to collaborate with families.

Linking Collaboration to Outcomes

The recent and rapid growth of systems of care underscore the importance of documenting their effects on the clients served (Stroul, McCormack, & Zaro, 1996). Effects on family involvement, including increased family participation (Stroul, et. al) at all levels of service delivery, have been identified as quality indicators of a system of care. Family/professional collaboration is the principle vehicle by which systems of care impact family involvement. The primary objective of enhanced parent/professional collaboration is to improve outcomes for children and families. While increasing levels of family/professional collaboration is an important objective of systems of care, few studies have been done that routinely and systematically collect data designed to assess progress in this area, or seek to determine whether or not a relationship exists between perceptions of family/professional collaboration and meaningful improvements in a child's clinical status and levels of functioning. Although data are scarce that focus on the notion that including parents in the planning, delivery, and evaluation of services enhances treatment effects for children, some studies give credence to the idea.

A great deal of money, time, and effort has been expended toward systems of care reform efforts. According to Salzer and Brickman (1997) "numerous assumptions underlying the purported effectiveness of systems of care remain unvalidated" (p. 1). An important question is whether or not efforts that have resulted in significant changes in how services are designed to be delivered are also significantly impacting service recipient outcomes.

There was little interest in studying clinical outcomes associated with systems of care until the National Institute of Mental Health issued a research announcement in 1990 (Salzer & Bickman, 1997) calling for studies that examined case management in the context of newly emerging collaborative systems of care. Since that time, a number of studies have been undertaken that examine outcomes associated with systems of care principles. According to Salzer & Bickman, these studies are inherently weak in that by their very nature they represent global concerns which reflect distal connections to outcomes. As such, the authors add, the studies impede validating causal relationships. It is difficult to establish a causal connection, for example, between improved clinical outcomes and a system of care principle such as coordinated service delivery. What is needed according to (Salzer & Bickman, 1997) are studies that explore the relationship between outcomes and certain variables that are more proximate to the service recipient. One such proximate variable that can be linked to outcomes revolves around the critical issue of parent/professional collaboration.

Data from the field of psychiatric medicine support the positive relationship between

parental collaboration and treatment outcomes. For example, in a state-operated inpatient unit providing acute, intermediate, and long-term care to approximately 60 seriously mentally ill adolescents per year, parent/professional collaboration is recognized as the centerpiece of the program's treatment philosophy. According to Byalin (1990), providing parents with genuine and authentic opportunities to create and implement treatment strategies in consultation with staff, has resulted in reducing inpatient stays from an average of more than one year to less than four months.

Education is another field where emerging conclusions support the notion that increasing parent participation can lead to improved outcomes for children. Here again, while existing evidence is slim and relies heavily on anecdotal data and best-practices assumptions, evidence suggests, for example, that parent involvement in the decision-making process affecting the educational placement of their children can lead to improved outcomes (Duchnowski, Berg, & Kutash, 1995, p. 184). Sheridan and Kratochwill (1992) share anecdotally that eliciting parental input and exchanging information can sustain treatment effects for children with behavioral disorders.

Clearly, a need for studies that further explore the role that family/professional collaboration might play in affecting outcomes for children is called for. While much information is available that supports the theoretical constructs underlying system of care approaches to service delivery, limited amounts of research have been undertaken that explore how certain approaches to service delivery are affecting outcomes. While family/professional collaboration has been identified as an important objective of systems of care, and has, in fact, been utilized as an aspect of service delivery, little is known about this aspect of service delivery's contribution to treatment outcomes.

Family-Centered Research

The following review of five studies that explore linkages between family/professional collaboration and outcomes provides a summary of family-centered research. The studies were found by searching electronic databases such as ERIC, PSYCHINFO, YAHOO, ALTAVISTA, LYCOS, and INFOSEEK. Search terms frequently used included: mental health, children and adolescent, systems of care, collaboration, case management, reform, clinical studies, families, service provision, and outcomes. Studies selected for review came primarily from books and articles in professional journals that contributed to an understanding of system of care reform, particularly in the area of family/professional collaboration. Information that traced the historical development of family/professional collaboration as policy and practice within the mental health, social services, and education fields were of particular importance. Articles that engaged the reader in a theoretical discussion of family-centered practice and studies that explored the benefits derived from such practices were used.

Collaborative Case Management Practices and Family Outcomes

While the concept of family-centered, collaborative service coordination has gained some acceptance among the service provider community, and is likely to result in improved consumer satisfaction (Grella & Grusky, 1989), little research exists that empirically explores whether or not service recipients derive benefits from such case management practices. In an investigation of case manager help-giving practices and associated family

functioning consequences, better family outcomes were found to be related to case manager helping styles that were consistent with enhancing a family's decision-making power regarding the services they receive (Dunst, Trivette, Gordon, & Starnes, 1993).

Dunst et al. (1993) utilized a case study methodology as a means of assessing whether or not aspects of program practices would have differential effects on family outcomes. Measures of interactions between 22 families participating in human service programs, and 11 case managers who worked with the families were operationally defined and analyzed. Family-case manager interaction outcomes were "ascertained by examining the family descriptions of the effects they experienced as a result of different case manager and program practices" (Dunst et al., 1993, p. 108). The study characterized family-centered case management as promoting the involvement of families in all aspects of program practices. Positive outcomes were defined as higher levels of family-perceived self-sufficiency and empowerment. Beyond demonstrating a positive relationship between case management practices and client outcomes as defined in the study, the study demonstrated that practices that provide families with the resources to assume greater control over services rendered will lead to improved perceptions of family functioning. The study utilized a service delivery technique that shifted professional practice away from the notion of authority and power to parent/professional partnership, resulting in improved perceptions of family functioning in the context of the family's ability to make decisions about services. Can the benefits of this collaborative technique be extended to include a parent's ability to help their children function while in the home or community at-large?

Family/Professional Collaboration Characteristics

While a survey of literature in the fields of mental health and social work that focused on proposed components of collaborative family/professional relationships revealed a wide range of elements, five family/professional collaboration characteristics were consistently cited:

- (1) a caring, non-blaming attitude toward the family;
- (2) sharing information;
- (3) recognition of the family as a key resource;
- (4) recognition of limits and of the existence of other responsibilities;
- (5) shared responsibility and power in the relationship, including joint decision-making and problem-solving (DeChillo et al., 1994, p. 565).

This study conducted by the Training Center on Family Support and Children's Mental Health, of Portland State University, attempted to bring focus to the notion of collaboration as viewed strictly by family members. The study sought to identify elements of collaboration from the perspective of parents of children with emotional disorders. Analysis of data was based on the responses of 455 parents to a questionnaire. The study revealed a large degree of overlap when comparing collaborative characteristics found to be important to parents with collaborative characteristics intended to guide professionals. The Portland study defined collaboration as seen by parents as being composed of four major characteristics:

(1) the support and understanding shown by professionals in their relationships with family members, e.g., including families in decisions about the child and recognizing that they have responsibilities other than their child with a disorder; (2) the assistance given to families in the practical aspects of getting services for their child, e.g., helping families find, coordinate and pay for services; (3) the clear and open exchange of information between families and professionals; and (4) the flexibility and willingness on the part of professionals to modify or change services based upon parental feedback (DeChillo et al., 1994, p. 572).

After careful review, one can conclude that the collaborative characteristics which should guide the efforts of both professionals and parents are, to a large degree, the same. The usefulness of this notion is clear in that it helps establish a meaningful and mutual collaborative frame of reference for both parents and professionals. It takes a discussion of collaboration beyond the realm of principle or value and attaches characteristics that are applicable to practice and further research.

Family/Professional Collaboration and Outcomes

One study that recognized the relationship between the family and professional as critical in the provision of mental health services was conducted by Vanderbilt University in 1995. Referred to as The Vanderbilt Caregiver Project, this study sought to evaluate a training program that was designed to enhance caregiver empowerment and subsequent involvement in the mental health treatment of their children. It was hypothesized that by using a curriculum that taught empowerment by focusing on knowledge, skills, and mental health services efficacy, caregiver involvement in the treatment of their child would increase which would in turn affect service use and ultimately, the mental health of the child (Brickman, Heflinger, Northrup, Sonnichsen, & Schilling, 1998). Empowerment was defined as enabling parents to become collaborators in their children's mental health treatment. The study's sample population included 250 parents or guardians whose children were receiving mental health services through the Fort Bragg Child and Adolescent Mental Health Demonstration, located in Fayetteville, North Carolina. All caregivers in both the training and comparison groups were asked to complete baseline, and 3 and 12-month follow-up questionnaires. The experimental group received 11 hours of training. Results at both 3 and 12-month intervals demonstrated that the empowerment training was successful in increasing parental measures of knowledge about the mental health service system and perceptions of self-efficacy. No statistically significant data, however, supported the hypothesis that empowerment would lead to more parental involvement, service use, and improved mental health of the child. While enhanced caregiver empowerment as defined by this study did not show an increase in caregiver involvement in the mental health treatment of their children, data results do not diminish the anticipated usefulness of a connection between parent/professional interactions and its importance to outcomes. Increasing a family's knowledge about the mental health service system and perceptions of self-efficacy fall short of what previously cited researchers found to be descriptors of collaborative characteristics. The results of studies whose primary intent is to focus on the treatment ramifications of day-to-day real-life collaborative interactions between professionals and families tend to show more promising results.

DeChillo (1993) conducted a study on an inpatient psychiatric unit that focused on the collaborative interactions between families of patients with severe mental illness and inpatient social workers. The authors assessed the degree to which families and practitioners collaborate, factors that influence collaboration, and the effects of collaboration on clinical outcomes. Social workers and families were surveyed at the time of the patient's discharge. The study sample consisted of 102 families, and fourteen social workers. "Collaboration was defined as the degree to which the family and worker worked together and the degree of perceived reciprocity in the family-social worker relationship" (p. 106). Variables identified as predictors of collaboration were: (a) Social worker's attitude toward family involvement; (b) Family identification of worker skill/attitude/technique; (c) Family and worker identifying mutual goal; (d) Worker identification of family intelligence/psychological awareness; (e) Number of inpatient meetings between family and worker. Findings revealed a relatively high degree of family/worker collaboration. In addition, the social worker's attitude toward family involvement in the patient's treatment was found to be the most important variable related to the degree of collaboration achieved. Lastly, in terms of desired outcomes, higher levels of collaboration were significantly correlated with increased family involvement in discharge planning, and satisfaction with services. According to DeChillo, the most important finding in the study was the relationship between collaboration and greater family involvement in the patient's discharge plan. This finding is significant because "previous research has indicated that family involvement in the discharge planning process results in better patient functioning post-discharge and decreased likelihood of relapse" (DeChillo, 1993, p.113). The study offers further empirical evidence that the benefits derived from a process that encourages a high degree of family/professional collaboration appear to be significant enough to, perhaps, one day be seen as a treatment necessity.

A study was commissioned by the Virginia Office of Comprehensive Services in 1998, less than one year after implementation of a newly-established utilization management initiative. Utilization management was defined as a decision support process guideline designed

to assist localities in providing appropriate, high quality, cost efficient services for children served by the CSA. A decision support process provides pertinent information and guidelines to individuals and organizations interested in designing, implementing, monitoring, and evaluating services on dimensions of appropriateness, quality, and cost effectiveness (Commonwealth Institute for Child and Family Studies, 1999 p. 2).

The study was conducted by the Commonwealth Institute for Child and Family Studies at Virginia Commonwealth University. The study sought to measure the extent to which localities were putting into practice CSA utilization management principles and strategies, stakeholder perceptions of the benefits of utilization management, as well as the impact of the utilization management initiative on service utilization and cost. Data from 9 out of 133 existing localities were collected utilizing: case reviews of children served by the CSA as a measure of utilization management implementation; surveys and focus groups with parents, FAPT and CPMT members, and private providers measuring perceptions of use and benefit of utilization management functions; and analysis of existing data on state-wide service

utilization and cost. While family/professional collaborative linkage was not the central focus of the VCU study, findings did shed some light on collaboration trends. Results of case review audits found that family involvement was low. Discussions with individuals who conducted the case reviews indicated that poor record-keeping may have contributed to this auditing conclusion. In contrast, survey results from FAPTs, CPMTs, and families perceived high levels of family participation in service planning. Stakeholder focus group collaboration perceptions were a mixed bag. Comments within all groups questioned ranged from enthusiasm with efforts made on behalf of collaboration to frustration and anger. Strong collaborative linkages between families and service providers have been identified as a central tenet of Virginia's system of care. The VCU study identified wide differences in collaboration trends attached to the different data collection techniques utilized. Perhaps differences can be partly attributed to the research methodology techniques utilized, or perhaps they reflect an all or nothing collaborative mentality on the part of localities in general.

Discussion

Since the mid 1980's, policy makers across the country have responded to the National Institute for Mental Health's published model outlining principles that underlie the creation of community-based systems of care for youth with emotional problems and their families. Many states have created community-based collaborative systems of care that are child-centered and family-focused. Collaboration with families is central to any system of care designed to be family focused. Families are now recognized as a valuable resource in the care and treatment of a child. The literature suggests that when service providers seek to empower families through meaningful involvement in the provision of services, children experience better outcomes. While family/professional collaboration has been identified as an important objective of systems of care, has it, in fact, been utilized as an aspect of service delivery? Can gains in a child's treatment outcome be related to productive family/professional collaborative relationships?

Virginia implemented a system of care for children with emotional and behavioral problems and their families in 1993 that was intended to be child-centered and family focused. Research that specifically explores the degree to which collaboration with families takes place in the context of service provision planning, implementation, and evaluation is sparse, at best. One Virginia study utilizing a combination of case reviews, surveys, and focus groups that explored the issue of family/professional collaboration, did so in the context of clinically-based service provision decision-making guidelines. Family/professional collaboration was addressed as one of several aspects of decision-making and was not the primary focus of the study. Moreover, research that explores the relationship between family/professional collaborative aspects of Virginia's service system process and a child's treatment outcome is virtually nonexistent.

CHAPTER III

Methodology

The present study sought to compare family perceptions of collaborative experiences to the perceptions of professionals. Survey methodology was used to determine perceptions of collaborative experiences from the point of view of parents of children with emotional and behavioral problems who have been served by a FAPT, and the perceptions of collaborative experiences of professionals who comprise the same team. The study also sought to establish a relationship between collaboration and a child's treatment outcome.

The following chapter describes the research questions, provides background about the construction and design of the survey instrument, and reviews statistical techniques chosen to analyze data.

Research Questions

Do parents whose children have been served by a Family Assessment and Planning Team (FAPT) have different perceptions of collaborative experiences when compared to those of the professionals who serve on the same teams? Moreover, is there a relationship between collaborative experiences on the part of the parent and a child's treatment outcomes?

Background

Two versions of the same questionnaire (one targeting parents whose children have been served by a FAPT, the other targeting professionals who serve on the same team) were developed, which borrow what a past study (DeChillo et al. 1994) described as key components of family/professional collaboration. A survey instrument was developed by DeChillo et al. (1994) to identify elements of collaboration from the perspective of family members of children with serious emotional disorders. Scale item content was based on "concepts from the literature, findings from a telephone survey of family members and professionals who had participated in collaboration training, and suggestions from staff of the Research and Training Center on Family Support and Children's Mental Health" (DeChillo et al., 1994, p. 566) located at Portland State University. Scale items were designed to measure eight key components of family/professional collaboration: "(a) joint decision-making and planning; (b) locating or developing services; (c) funding services; (d) evaluation based on feedback from the family; (e) conveying a caring attitude; (f) sharing information; (g) recognizing the family as a resource; (h) recognizing limits of the family" (DeChillo et al., 1994, p. 566). Results from factor analysis supported construct validity and associated scale items as reliable measures of family/professional collaboration. The questionnaire consisted of 40 family/professional collaboration scale items, each with four response alternatives. A draft of the questionnaire was reviewed by focus groups made up of parents of children with emotional disabilities for issues of readability, clarity, and content of items. The present author constructed collaboration scale items from the DeChillo et al. study organized by reflecting the context of the three phases of the FAPT process as set forth in the CSA Manual. These phases are defined as: (a) the gathering of information for case review; (b) FAPT meetings and decision making about services; and (c) evaluation of

a child's progress, services rendered, and outcomes (CSA Manual, 1998). Each questionnaire version asked the same collaboration items found in the DeChillo et al. instrument, differing only in phraseology designed to reflect the appropriate respondent audience.

Sample

Similar versions of the questionnaire were mailed to 240 parents who had a child staffed by a Family Assessment and Planning Team and are still considered part of the active file membership list maintained by each locality at the time of the questionnaire's mailing, and 58 professionals assigned to FAPTs. Families who returned surveys and noted having children who received services for less than 6 months and/or are older than 21 years of age, were excluded from the sample. In some localities, FAPTs do not operate entirely as described in the CSA implementation manual in that some of the duties that come under the purview of the FAPT process are assumed by agency professionals who are not also members of a FAPT. Therefore, the survey only targeted localities where the unfolding of all phases of the FAPT process are carried out by FAPT members. Targeted parents were those individuals who fit the definition of parent as taken from the federal Individuals With Disabilities Education Act (IDEA). The IDEA defines a parent as a parent, a guardian or a person (close relative) acting as a parent. "The term does not include the State if the child is a ward of the State" (C.F.R. 300, 1999). For purposes of this study, "guardian" refers to private individuals who have been given legal custody by a court of law. When the State or a State agency is the legal guardian, the State will not be considered the parent and will be excluded from the study. The questionnaire surveyed families and professionals within five CSA districts located across the Commonwealth of Virginia. CSA districts selected were based on a locality's data-retrieving capabilities, and a willingness to participate in the study. Localities originally asked to participate represented a sampling of 4 geographic areas: south western Virginia, central Virginia, eastern Virginia, and northern Virginia. Several localities turned down requests to participate, citing data retrieving problems, or simply gave no reason. Those localities that agreed to participate were managed by CSA coordinators or CPMT members familiar with the researcher based upon longstanding business relationships.

Instrument Design

Two questionnaires were developed (one targeting parents, the other professionals), each containing 40 collaboration items taken from the DeChillo et al. (1994) study. Scale items were designed to measure and reflect characteristics of family/professional collaboration. Each item had four response alternatives ranging from "Not at all" (scored as 1) to "Very much" (scored as 4). Each scale item was worded to incorporate family/professional collaboration item stems from the DeChillo et al. (1994) questionnaire while changing terminology to reflect the context of the FAPT process and questionnaire target group. Scale items were grouped by this author to reflect that phase of the FAPT process each question most resembles. A DeChillo et al. collaboration item, for example, that asked a parent the degree to which a professional asked the parent what they thought about their child's problems and needs was worded to ask the same question in the context of their FAPT interactions during the gathering of family information

phase of the FAPT process. The parent questionnaire contained two demographic questions: one asking for the age of the child (children) receiving services, the other asking how long the family has worked with the FAPT. In order to keep the analysis focused on issues relevant to minors, analysis was based on the responses of parents who had an emotionally disabled child age 21 or less. Age 21 was chosen because it represents the oldest age within an age range a child in Virginia is eligible for a Free and Appropriate Public Education (FAPE). Analysis of responses was limited to those reporting no less than six months of contact with the FAPT. Anything less might not be sufficient to have a reasonable impression of collaborative practice.

Two CAFAS or PECFAS scores were obtained comparing an initial assessment score to the most recent score obtained. The CAFAS/PECFAS is an instrument designed to measure how impaired a youth is in day-to-day functioning. More specifically, each instrument is designed to assess the negative effects of emotional, behavioral, substance use, psychiatric, or psychological problems during the time period being assessed. A total CAFAS score is generated based on subscale scores for the following domains entitled: (a) school-work (functions satisfactorily in a group educational or work environment); (b) home (observes reasonable rules and performs age-appropriate tasks) and community (respects the rights of others and their property and obeys the law); (c) behavior toward others (appropriateness of daily behavior); (d) moods-emotions (modulation of the child's emotional life); (e) self-harmful behavior (extent to which the child can cope without resorting to self-harmful behavior or verbalizations); (f) substance abuse (use and the extent to which it is disruptive); (g) and thinking problems (ability to use rational thought processes). A total PECFAS score is generated from subscale scores for the areas of school-day care, home, community, behavior toward others, moods-emotions, self-harmful behavior, and thinking-communication problems. Both instruments were developed by Kay Hodges and adopted by the Virginia Office of Comprehensive Services in 1998 (A. G. Saunders, personal communication, August 16, 1999). Kay Hodges, Ph.D., ABPP, is professor of Psychology at Eastern Michigan University, and has published extensively in the areas of assessment of children and adolescents, childhood depression, and psychosomatic illness. Both instruments are typically found in the CSA office of each locality and the offices of FAPT case managers.

Procedure

Localities selected were based on data-retrieving capabilities and a willingness to participate in the study. Phone calls were made to CSA coordinators from pre-selected localities describing the study and asking if they would like to participate. Follow-up letters outlining the study, how it might benefit the locality, and asking for permission to proceed were mailed to CPMT chairpersons of localities voicing an interest. CSA coordinators from selected localities were given postage-paid questionnaire packets to be addressed and mailed to the parent fitting the definition of "parent" as described in the IDEA. Each parent packet contained a cover letter from this researcher and letter of support from the locality's CPMT chairperson, survey, and self-addressed return envelope. All professionals who are assigned to FAPT teams in CSA localities surveyed respond to a questionnaire handed to them at a FAPT meeting. These surveys were collected by the FAPT chairperson or local CSA coordinator and retrieved in person by this researcher. To address the issue of non-response bias, a three-cycle approach described by Dillman (1978) was used for surveys mailed to

parents, carefully documenting time of response. First, a complete survey package was mailed, followed by a 10-day waiting period. A reminder postcard was sent to non-respondents. After a second 10-day waiting period, another complete survey package was mailed to non-respondents. Once another 10 day waiting period had elapsed, a non-respondent study was conducted by calling as many of the remaining non-respondents as deemed appropriate, asking their reason for non-response, and all questions contained in the survey. A t-test was used to compare the results of the phone survey with data obtained by mail.

Analysis

The purpose of the analysis is to determine whether or not any statistically significant differences exist between parent perceptions of FAPT collaborative experiences and the perceptions of professionals who serve on the same teams. An experimental design measuring collaborative perceptions employing a 2 (group type) x 3 (phases) between-subjects matrix (Ary, Jacobs, & Razavich, 1972) was conducted. Two independent variables, one composed of group type participants (parents/professionals) and the other the three phases of the FAPT process were compared with collaborative perceptions. Hypotheses were tested utilizing ANOVA measuring one interaction effect comparing participant group differences across phases. More specifically, the analysis examined whether the effect of group type on collaboration score depends on phase. Secondly, two main effects were tested by exploring the effect either phase or group type had on collaborative perceptions. A test of internal consistency on the groupings of questions was obtained by computing reliability (alpha) coefficients (Ary et al., 1972). In order to address the validity of parental responses, a fifth response choice to each collaboration question worded "I don't understand" was added. This researcher ascertained, based on the frequency of this response, which families were to receive a newly-phrased version of troublesome questions. Based upon patterns that indicated limited "I don't understand" responses, no newly-phrased questions were mailed. Lastly, a simple correlation test compared changes in each child's CAFAS/PECFAS score with each family's perception of collaboration score. When building a correlation matrix where either a CAFAS/PECFAS score or collaboration score was missing, both scores were to be discarded as a function of pairwise deletion as a useful method for deleting missing values (NCSS 5.3, 1992).

Description of Results

A summaries of data describing the two main effects and interaction effect as F-ratios were displayed in table forms and graphs accompanied by narrative explanations. Correlation results or strength of relationship showing the extent to which a CAFAS/PECFAS score is associated with a parent's total perception of collaborative experience score were displayed by use of Pearson r coefficients, scattergrams, and narrative explanations.

CHAPTER IV

The Analysis and Findings

The present study sought to compare family perceptions of collaborative experiences to the experiences of professionals. Survey methodology was used to determine perceptions of collaborative experiences from the perspective of parents of children with emotional and behavioral problems who have been served by a FAPT, and the experiences of professionals who comprise the same team. The study also sought to establish a relationship between parental collaborative experiences and a child's treatment outcome.

The following chapter first briefly summarized research methods employed and presented the reliability of the survey instrument used, which was followed by a description of the research sample. Next, data and accompanying analysis are presented in a form that sheds light on the effect two key variables (the FAPT process itself, and the participant groups involved) had on collaborative perceptions. Lastly, data are presented that explore the important related question that focuses on the relationship between parent perceptions of collaborative experiences and treatment outcomes for children.

Method

A questionnaire was developed that merged a definition of family/professional collaboration (DeChillo et al., 1994) into a set of questions framed in the context of the Family Assessment and Planning Team (FAPT) process. The FAPT process is composed of three phases: gathering family information; decision-making about services; and evaluating the child's progress, the services rendered, and the outcomes of those services. One version of the questionnaire was mailed to parents who have had a child served by a FAPT and are still considered part of the active file membership list at the time of the questionnaire's mailing. The other version was handed to professionals to complete who were members of the targeted locality's FAPT. Survey items measured the degree to which characteristics of family/professional collaboration were taking place in the context of the FAPT process. The survey was divided into three sections, each representing a phase of the FAPT process. A reliability analysis of questions representing each phase utilizing standardized alpha coefficients, (phase 1) Alpha = .8898; (phase 2) Alpha = .9658; (phase 3) Alpha = .9247, suggested that respondents interpreted the meaning of questions quite similarly. Each child's clinical outcome was measured as the difference between a baseline score and the most recent score on a uniform assessment instrument adopted by the CSA's State Executive Council that was designed to measure a child's level of impairment. (The time interval observed between both scores was deemed sufficient to affect treatment outcomes.)

Sample

Data were obtained from five CSA localities: two cities, one with a population of 65,269, the other 24,747, and three counties with a population in descending order of 85,778; 83,629; and 30,496. Questionnaires were mailed to 240 families, of which 136 were

returned (a return rate of 57%). The following were based on the responses of 118 families that reported at least six months of contact with their FAPTs and with children who were 21 years of age or less. DeChillo et al. (1994) recommended this six month time frame as the minimum length of time necessary to have established a collaborative relationship. To keep the analysis focused on issues primarily relevant to minors, parents of children older than 21 were excluded from the analysis. In addition, questionnaires were handed to 58 professionals who were serving as FAPT members, of which 37 were returned (a return rate of 64%). All 37 surveys were used in the analyses.

To address the issue of parent non-response bias, a one-way ANOVA was conducted which compared mean collaboration scores from four groups of respondents. Three groups were identified by mailed responses, while a fourth group included responses elicited by telephone. Among parents responding by mail, the most positive perceptions of collaborative experiences were held by those responding first, with the two remaining response groups scoring progressively lower. Parents who were contacted by telephone had more positive perceptions of collaborative experiences than the group last to respond by mail, but lower than the group that needed a postcard reminder. This phenomenon could be attributed to influences associated with voice contact. Differences in mean scores were significant, $F=3.151$, $p<.05$ (See Tables A1-A3).

Table A1

Descriptives: Respondent Scores of Non-Response Bias Study

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
1.00	53	125.0000	30.1043	4.1351	116.7022	133.2978	45.00	160.00
2.00	33	120.4545	31.1529	5.4230	109.4082	131.5009	41.00	159.00
3.00	24	102.0417	36.9800	7.5485	86.4264	117.6569	39.00	155.00
4.00	8	111.2500	17.5967	6.2214	96.5388	125.9612	92.00	137.00
Total	118	118.1271	32.1685	2.9614	112.2623	123.9919	39.00	160.00

Table A2

Test of Homogeneity of Variances: Respondent Scores of Non-Response Bias Study

Levene Statistic	df1	df2	Sig.
2.742	3	114	.046

Table A3

ANOVA: Respondent Scores of Non-Response Study

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	9270.453	3	3090.151	3.151	.028
Within Groups	111802.640	114	980.725		
Total	121073.093	117			

P < .05.

Analysis and Results

The Total FAPT Experience – Parent and Professional Differences

A t-test was conducted to determine if there was a difference between the total collaboration scores of parents and professionals involved in the FAPT process. A total (sum of all 3 phases) of the FAPT process mean score for parents was compared to a similar score for professionals (See Table B1). The accompanying standard deviation score for both parents and professionals show that there is a much higher degree of variability in the total parent score, indicating a much wider range of collaborative experiences. A significant difference in mean score, $F=40.985$, $p<.05$, and $t=-7.439$, $p<.05$, indicate that there are differences in the degree to which parents and professionals perceive collaborative experiences taking place within the context of the FAPT process (See Table B2).

Table B1

Group Statistics of Total Collaboration Scores

	Group	N	Mean	Std. Deviation	Std. Error Mean
Total collaboration score	Parent	118	118.14	32.17	2.96
Total collaboration score	Professional	37	143.14	9.67	1.59

Table B2

Independent Samples Test of Group Differences Between Total Collaboration Scores

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
Total collaboration score	Equal variances assumed	40.985	.000	-4.653	153	.000	-25.00	5.37	-35.61	-14.38
Total collaboration score	Equal variances not assumed			-7.439	152.884	.000	-25.00	3.36	-31.64	-18.36

P < .05.

The Effects of Phase and Group Type

To assess whether collaborative scores were affected by group type (parents or professionals), or a particular phase of the FAPT process (phase 1: gathering family information; phase 2: decision-making about services; phase 3: evaluating child's progress, services, and outcomes), a univariate analysis of variance was used. The analysis examined whether the effect of group type on collaboration score depended on phase (the interaction effect), and explored the effect both phase and group type, individually, might have on collaborative perceptions (main effects). The analyses compared the differences between phase means, using the variable z-score. In regard to identification of any significant interaction effects, none was found, $F=.424, p<.05$. The analysis of data did reveal that when group type's effects on collaboration score were isolated, the difference in observed scores of the 2 groups was significant $F=57.745, p<.05$ (See Table C). A further analysis of the effect group type had on collaborative perceptions was conducted using a one-way ANOVA. When using the mean of total (across all 3 phases) raw score for each group as a dependent variable, as well as each group's mean score within each phase as additional dependent variables, one can see that significant differences existed when comparing total

scores, $F=21.648$, $p<.05$, as well as a comparison of scores within each phase, (Gathering Family Information) $F=13.267$, $p<.05$, (FAPT Meetings) $F=26.187$, $p<.05$, (Evaluating Child) $F=19.635$, $p<.05$ (See Table D). There is some evidence that group association affected perceptions of collaborative experiences. When *phases* were isolated as a possible factor affecting collaborative score, no significant effect was found, $F=.128$, $p<.05$ (See Table C). Further evidence that phases did not significantly affect collaborative perceptions was revealed by a *post hoc* comparison of phases through use of paired mean scores (See Table E).

Table C: Univariate Analysis of Variance

Tests of Between-Subjects Effects (Interaction and Main Effects)

Source	Type III Sum of Squares	df	Mean Square	F	Sig.
Corrected Model	52.292	5	10.458	11.726	.000
Intercept	13.922	1	13.922	15.609	.000
GROUP	51.503	1	51.503	57.745	.000
PHASE	.229	2	.115	.128	.879
GROUP * PHASE	.756	2	.378	.424	.655
Error	406.708	456	.892		
Total	459.000	462			
Corrected Total	459.000	461			

a R Squared = .114 (Adjusted R Squared = .104) $p < .05$.

Table D

ANOVA: Differences in Mean Collaboration Scores by Group Type and Phase

		Sum of Squares	df	Mean Square	F	Sig.
total collaboration score	Between Groups	17604.194	1	17604.194	21.648	.000
	Within Groups	124422.155	153	813.217		
	Total	142026.348	154			
Gathering Family Information	Between Groups	112.949	1	112.949	13.267	.000
	Within Groups	1276.991	150	8.513		
	Total	1389.941	151			
FAPT Meetings	Between Groups	46328.690	1	46328.690	26.187	.000
	Within Groups	270678.407	153	1769.140		
	Total	317007.097	154			
Evaluating Child, Service, & Outcomes	Between Groups	2189.743	1	2189.743	19.635	.000
	Within Groups	17063.353	153	111.525		
	Total	19253.097	154			

$P < .05$.

Table E: Based On Observed Means

Multiple Phase Comparisons
 Dependent Variable: standardized collaboration score
LSD

		Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
(I) phase	(J) phase				Lower Bound	Upper Bound
phase 1	phase 2	5.359516E-17	.1078054	1.000	-.2118570	.2118570
	phase 3	-1.6534068E-15	.1078054	1.000	-.2118570	.2118570
phase 2	phase 1	-5.3595163E-17	.1078054	1.000	-.2118570	.2118570
	phase 3	-1.7070020E-15	.1072774	1.000	-.2108193	.2108193
phase 3	phase 1	1.653407E-15	.1078054	1.000	-.2118570	.2118570
	phase 2	1.707002E-15	.1072774	1.000	-.2108193	.2108193

Parent and Professional Collaborative Perceptions

An analysis of data suggested that differences exist between parents and professionals in their perceptions of collaborative experiences during the FAPT process, and that the group to which one belongs is a determining factor which shapes those perceptions. Another important question is to determine which group has higher (more positive) perceptions of collaborative experiences. A review of parent and professional mean scores within each phase as generated by the univariate analysis of variance shows that professional scores consistently are higher (See Table F).

Table F

Descriptive Statistics of Mean Group Type Collaboration Scores by Phase
 Dependent Variable: standardized collaboration score

group	phase	Mean	Std. Deviation	N
Parent	phase 1	-.1611620	1.0839716	115
	phase 2	-.2133757	1.0557979	118
	phase 3	-.1882351	1.0731024	118
	Total	-.1878168	1.0680561	351
Professional	phase 1	.5009089	.3643891	37
	phase 2	.6804954	.1726302	37
	phase 3	.6003174	.2207100	37
	Total	.5939072	.2731216	111

The three phases of the FAPT process are distinctly unique in their purpose. Moreover, the context within which a family encounters a FAPT during any particular phase, varies. During phase 1 (Gathering Family Information) for example, a parent is more likely to meet with one member of the FAPT, leaving a few information gathering details for the group meeting whenever it occurs. Phase 2 (FAPT Meetings and Decision-Making About Services) takes place entirely in a group setting, while phase 3 (Evaluating a

Child's Progress, Services Rendered, and Outcomes) is likely to take place both in a group context, and during meetings with individual FAPT members. It was important to determine if the unique nature (purpose) of each phase had any significant effect on the collaborative experiences of either parents or professionals. While data reveal that phase alone does not significantly effect collaboration scores of either group, the data suggest that for professionals, meeting in the context of a group setting elicits more positive perceptions of collaborative experiences than meeting one-on-one. Parents, on the other hand, perceive higher degrees of collaborative experiences meeting one-on-one (See Table F).

Collaboration and Treatment Outcomes

To assess the strength of relationship between parent perceptions of collaborative experiences and treatment outcomes of their children, a Pearson r coefficient was obtained, $r = -.063$, that indicated that while the direction of the relationship supported the hypothesis that a high collaboration score is related to a low CAFAS/PECFAS score, the strength of relationship was not statistically significant (See Tables G1, G2, and Scatterplot).

Table G1

Descriptive statistics of Parent Collaboration Score and Pre/Post CAFUS/PECFUS Score

	Mean	Std. Deviation	N
Total Parent Collaboration Score	118.1356	32.1665	118
Difference Between Pre and Post CAFAS Scores	-10.59	29.48	118

Table G2

Correlation Between Parent Collaboration Score and Pre/Post CAFUS/PECFUS Scores

		Total Parent Collaboration Score	Difference Between Pre and Post CAFAS Scores
Total Parent Collaboration Score	Pearson Correlation	1.000	-.063
	Sig. (2-tailed)		.496
	N	118	118
Difference Between Pre and Post CAFAS Scores	Pearson Correlation	-.063	1.000
	Sig. (2-tailed)	.496	
	N	118	118

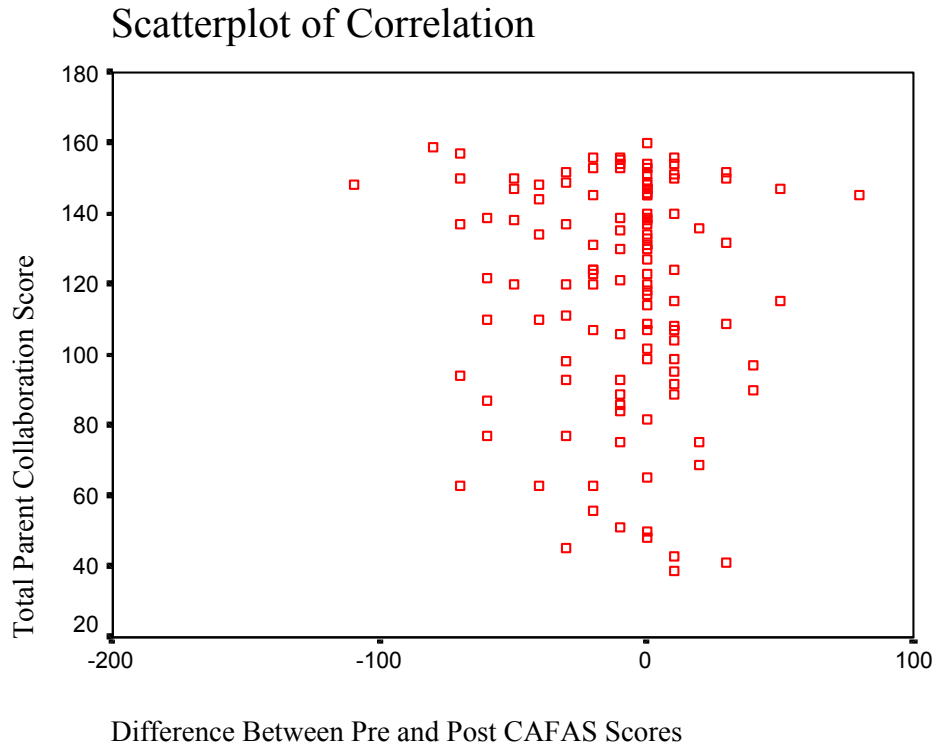


Figure 1. Scatterplot of correlation between a total parent collaboration score and the difference between a pre and post CAFAS/PECFAS score.

Summary

Analysis of the present investigation revealed that in the context of the entire FAPT process, parents and professionals do differ in their perceptions of collaborative experiences. Results show that as a group, professionals, with slight variation, are much more inclined to perceive their interactions with families as collaborative. While perception is the operative word, to what degree those perceptions reflect actual efforts at promoting partnership within the service delivery process vs. an exercise in professional arrogance, can not be determined within the confines of the present study. What is somewhat encouraging and perhaps a bit more realistic are data revealing that, while parents perceive the experience in a weaker collaborative light, there was a much larger degree of variability in their collaborative perceptions. Given the vicissitudes of human nature and the complexity of the FAPT process, an array of experiences is probably closer to the truth.

CHAPTER V

Summary and Conclusions

The purpose of this study was to determine whether parents who have had children served by a FAPT have similar perceptions of collaborative experiences as the professionals who comprise the same team. A second research question explored the relationship between parent perceptions of collaborative experiences and treatment outcomes of their children. An analysis of data revealed that there are significant differences between parents and professionals in their collaborative experiences across all phases of the FAPT process. Secondly, no significant relationship was found between parent's perception of collaborative experiences and their children's treatment outcome.

Implications for Research and Practice

An important system of care principle identified in the professional literature is the notion that family members should be seen as partners actively participating in all aspects of their children's treatment. Virginia's CSA system of care underscores this belief by urging that families be fully involved in the collaborative planning and delivery of services. The literature suggests that when service providers enable families to be meaningfully involved in the provision of services, children are more likely to experience better treatment outcomes.

Data from the present study indicate that while there are individual exceptions, parents as a group do not find their experience working with FAPTs as particularly collaborative. Data did suggest, however, that parents do experience a wide range of collaborative encounters. Some parents report quite positive collaborative experiences, while others give collaborative encounters low marks. Professionals serving on FAPTs, however, have a more positive view of their success (collaboratively) working with families. While this situation is not unusual in that professionals typically feel they are good at what they do, not being more successful at reaching this commonly acknowledged system of care goal is cause for concern. While the attitude of certain parents and professionals might be identified as a contributing factor, recent studies have shed light on identifying other characteristics that might also influence the degree to which parents are involved in the planning, delivery, and evaluation of services for their children. At the most recent annual research conference of the Research and Training Center for Children's Mental Health, held in Tampa, Florida, variables as diverse and numerous as marital status of the parent(s), family income, parent education, child characteristics, and a service provider's philosophy, policies, and supports were identified as factors that might also influence the level of family participation (Robinson & Friesen, 2001; Friesen & Pullmann, 2001). Further studies exploring the strength that each of these variables and others might have on reaching and maintaining parent/professional collaborative relationships would be a fruitful direction for future research.

Although the issue of parent/professional collaboration is a complicated one, possibly influenced by many factors, so, too, goes the issue of treatment outcomes. While the present study sought to establish a relationship between parent perceptions of collaborative experiences and treatment outcomes of children, future research that explores the degree to which other variables affect clinical outcomes is certainly in order.

Strong parent/professional collaboration appears to remain an illusive goal of some Virginia CSA localities. The Office of Comprehensive Services continues to emphasize that utilization management must be implemented in a manner consistent with the overall principles of the CSA (“Initial Assessment”, 1999). Strong collaborative linkages between families served by FAPTs and the teams themselves have been identified as a central tenet of Virginia’s system of care. However, to date, it has been left up to individual localities to decide if that goal is an important enough priority to devote the time, effort, and resources necessary to achieve it. Perhaps a state-initiated, on-going effort that incorporates the latest research into best practices will help all localities ensure optimum family participation in all aspects of assessment, planning, implementation, and evaluation of services for troubled youth, with the ultimate reward being better outcomes for children and their families.

The present study suggests that parents perceive collaboration taking place the most in the context of working one-on-one with a representative from the FAPT. Conversely, professionals see group FAPT meetings as most collaborative in nature. Typically, the person parents most often encounter in one-on-one meetings is the CSA coordinator. In the present study, all CSA coordinators were full-time employees of the locality they served, while all other members of FAPTs hold full-time jobs separate from their CSA duties. The demands of regular jobs, coupled with FAPT responsibilities can tax the most efficient of workers. Naturally, CSA coordinators, in comparison to other FAPT members, at least have the element of additional time in their efforts at establishing collaborative linkages with parents. Given the fact that all other professionals who serve on FAPTs will only have an opportunity to forge similar relationships with families in the context of group meetings, perhaps in-service efforts at sensitizing professionals to the dynamics of team-building with parents in the context of group meetings will also result in stronger collaborative bonds.

There are numerous factors that affect the goal of strong parent/professional collaborative linkages. Notions on the part of both parents and professionals on the dynamics of traditional professional/client relationships, limited knowledge and experience with team-building techniques and understanding and commitment to the parent/professional collaborative aspect of Virginia’s system of care, represent what can be characterized as key obstacles and opportunities. Further research using a discernable set of data unique to specific localities would certainly be helpful in ascertaining the source of specific parent/professional collaborative-building characteristics.

By virtue of the research process, this writer came into contact with several dedicated professionals whose tireless efforts at meeting the needs of children and families were quite evident. One characteristic that separated these professionals from less dedicated colleagues was their capacity to treat clients with genuine dignity and respect, coupled with a steadfast belief that families were equal partners in the task at hand. One can surmise that families fortunate enough to work with professionals who incorporate a strong sense of parent/professional collaboration in their work ethic would

be satisfied with services. A separate and most important next step for professionals is to cultivate the ability to use parent/professional collaboration as a vehicle for client empowerment. For it is from a position of empowerment, that parents can operate in their daily lives from a position of true strength.

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APPENDICES

APPENDIX A

SURVEY OF PROFESSIONALS
COLLABORATION IN THE FAMILY ASSESSMENT AND PLANNING TEAM

SURVEY OF PROFESSIONALS
COLLABORATION IN THE FAMILY ASSESSMENT
PLANNING TEAM

You have been identified as serving on a local **Family Assessment and Planning Team (FAPT)**. An important goal of the FAPT process is to work closely with families when developing a service plan. This survey is designed to measure your collaborative experiences with families during the development, implementation, and evaluation of **Individual Family Service Plans (IFSPs)**. Your answers will provide important information to help professionals work better with families. Names of survey participants will not be used. The survey will take approximately five minutes to complete. ***PLEASE ANSWER ALL QUESTIONS.***

Instructions: Please answer the following questions by circling **one** response number for each item.

I. Gathering family information in preparation for the development of an Individual Family Service Plan. **How often does the FAPT...**

1. ask the parent what they think about their child's problems and needs?

Not at all A little Somewhat Very much
1 2 3 4

2. ask the parent about their family, in addition to the child?

Not at all A little Somewhat Very much
1 2 3 4

3. explain to the parent the process of information gathering?

Not at all A little Somewhat Very much
1 2 3 4

4. explain to the parent why certain information is needed?

Not at all A little Somewhat Very much
1 2 3 4

II. FAPT Meetings and Decision-Making About Services. **How often does the FAPT...**

5. give the parent an opportunity to help set goals for their child?

Not at all A little Somewhat Very much
1 2 3 4

6. include the parent in decision-making about services for their child?

Not at all A little Somewhat Very much

1 2 3 4

7. encourage the parent to contribute ideas about their child's service plan?

Not at all A little Somewhat Very much

1 2 3 4

8. ask a parent to approve a service plan?

Not at all A little Somewhat Very much

1 2 3 4

9. ask a parent to write parts of the service plan?

Not at all A little Somewhat Very much

1 2 3 4

10. include all the important parts of a child's life when planning services?

Not at all A little Somewhat Very much

1 2 3 4

11. explain to the parent how the parent can contribute to planning services?

Not at all A little Somewhat Very much

1 2 3 4

12. give the parent information on what services might be possible?

Not at all A little Somewhat Very much

1 2 3 4

13. help the parent to plan how the parent would pay for services for their child?

Not at all A little Somewhat Very much

1 2 3 4

14. work with the parent to develop new services?

Not at all A little Somewhat Very much

1 2 3 4

15. work with the parent to find new services?

Not at all A little Somewhat Very much

1 2 3 4

16. help the parent get in touch with other professionals or agencies?

Not at all A little Somewhat Very much

1 2 3 4

17. help to make sure that the service plan involved all aspects of the child's life?

Not at all A little Somewhat Very much

1 2 3 4

18. work with the parent to find ways of paying for services?

Not at all A little Somewhat Very much

1 2 3 4

19. tell the parent the parent could call a meeting whenever they wanted to?

Not at all A little Somewhat Very much

1 2 3 4

20. set up a way for the parent to stay in contact between meetings?

Not at all A little Somewhat Very much

1 2 3 4

21. share information with the parent?

Not at all A little Somewhat Very much

1 2 3 4

22. attempt to answer all the parent's questions?

Not at all A little Somewhat Very much

1 2 3 4

23. talk with the parent in a clear and understandable way?

Not at all A little Somewhat Very much

1 2 3 4

24. express to the parent that they care about the families they serve?

Not at all A little Somewhat Very much

1 2 3 4

25. make an attempt to understand the problems the parent and family have had?

Not at all A little Somewhat Very much

1 2 3 4

26. show support to the family?

Not at all A little Somewhat Very much

1 2 3 4

27. show the parent that the team's opinion and judgement can be trusted?

Not at all A little Somewhat Very much

1 2 3 4

28. express to the parent that the team understands that the parent has other things to worry about in addition to caring for a child with emotional problems?

Not at all A little Somewhat Very much
1 2 3 4

29. express to the parent that they know that all parents have good and bad days in caring for their children?

Not at all A little Somewhat Very much
1 2 3 4

30. help the parent find a balance between caring for their child and taking care of other things they have to do?

Not at all A little Somewhat Very much
1 2 3 4

31. let the parent talk about their ideas and feelings?

Not at all A little Somewhat Very much
1 2 3 4

32. let the parent know their ideas and views are important?

Not at all A little Somewhat Very much
1 2 3 4

33. take the parents concerns seriously?

Not at all A little Somewhat Very much
1 2 3 4

III. Evaluating A Child's Progress, Services Rendered, and Outcomes. **How often does the FAPT...**

34. change the service plan based on the parent's opinion?

Not at all A little Somewhat Very much
1 2 3 4

35. consider all services that the child is receiving?

Not at all A little Somewhat Very much
1 2 3 4

36. ask the parent for their ideas or opinions about the services they have received?

Not at all A little Somewhat Very much
1 2 3 4

37. specifically ask for the parent's feedback about the way a service provider is working with them?

Not at all A little Somewhat Very much
1 2 3 4

38. express to the parent flexibility and a willingness to change services if needed?
Not at all A little Somewhat Very much
1 2 3 4

39. encourage the parent to suggest possible improvements in services?
Not at all A little Somewhat Very much
1 2 3 4

40. make changes in services based on a parent's feedback?
Not at all A little Somewhat Very much
1 2 3 4

THANK YOU FOR PARTICIPATING IN THIS SURVEY!

APPENDIX B

PARENT SURVEY
COLLABORATION IN THE FAMILY ASSESSMENT AND PLANNING TEAM

PARENT SURVEY
COLLABORATION IN THE FAMILY ASSESSMENT
PLANNING TEAM

Families with children who have emotional problems may need services. Your family has been referred and staffed by a **Family Assessment and Planning Team (FAPT)** as needing support. An important goal of the FAPT process is to work closely with families when developing a service plan. This survey is designed to measure your family's collaborative experiences during the development, implementation, and evaluation of your **Individual Family Service Plan (IFSP)**. Your answers will provide important information to help professionals work better with families. Names of survey participants will not be used. The survey will take approximately 6 minutes to complete. **PLEASE ANSWER ALL SURVEY QUESTIONS.**

- a. The current age of your oldest child receiving services: Age ____.
- b. How long has your family worked with the FAPT? ____ less than 6 months
____ more than 6 months

INSTRUCTIONS: Please answer the following questions by circling **one** response number for each item.

I. Gathering family information in preparation for the development of an Individual Family Service Plan. **How often...**

1. were you asked what you think about your child's problem and needs?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

2. were you asked about your family, in addition to your child?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

3. were you explained the process of information gathering?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

4. were you told why certain information was needed?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

II. FAPT Meetings and Decision-Making About Services. **How often...**

5. were you given an opportunity to help set goals for your child?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

6. were you included in decision-making about services for your child?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

7. were you encouraged to contribute ideas about your child's service plan?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

8. were you asked to approve a service plan?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

9. were you asked to write parts of the service plan?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

10. were all the important parts of your child's life included in planning services?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

11. was it explained how you can contribute to planning services?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

12. were you given information on what services might be possible?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

13. were you helped to plan how you would pay for services for your child?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

14. did the FAPT work with you to develop new services?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

15. did the FAPT work with you to find new services?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

16. did the FAPT help you get in touch with other professionals or agencies?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

17. did the FAPT help to make sure that the service plan involved all aspects of your child's life?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

18. did the FAPT work with you to find ways of paying for services?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

19. did the FAPT tell you that you could call a meeting whenever you wanted to?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

20. did the FAPT set up a way for you to stay in contact between meetings?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

21. did the FAPT seem willing to share information with you?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

22. were you satisfied with the way the FAPT answered your questions?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

23. did the FAPT talk with you in a clear and understandable way?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

24. did you feel that the FAPT really cared about your family?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

25. did you feel that the FAPT understood the problems you and your family have had?

Not at all A little Somewhat Very much Do not understand the question

1 2 3 4 5

26. did you feel that the FAPT was supportive?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

27. did you trust the FAPT's opinion and judgement?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

28. did you feel that the FAPT understood that you have other things to worry about in addition to caring for your child with emotional problems?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

29. did the FAPT let you know that all parents have good and bad days in caring for their children?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

30. did the FAPT help you find a balance between caring for your child and taking care of other things you have to do?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

31. did the FAPT let you talk about your ideas and feelings?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

32. did the FAPT let you know your ideas and views are important?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

33. did the FAPT take your concerns seriously?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

III. Evaluating A Child's Progress, Services Rendered, and Outcomes. **How often...**

34. were changes in the service plan made based on your opinions?

Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

35. were all services that your child is receiving considered?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

36. were you asked for your ideas or opinions about the services that you have received?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

37. were you specifically asked for feedback about the way a service provider is working with you?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

38. did the FAPT seem flexible and willing to change services if needed?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

39. did the FAPT encourage you to suggest possible improvements in services?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

40. did the FAPT make changes in services based on your feedback?
Not at all A little Somewhat Very much Do not understand the question
1 2 3 4 5

THANK YOU FOR PARTICIPATING IN THIS SURVEY!

APPENDIX C

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE (CAFAS)