

Task Force For Selecting New Children's Instruments

Synopsis of March 6, 2001 Meeting

A meeting of the Task Force for Selecting New Children's Performance Outcome Instruments was held on Tuesday, March 6, 2001, at the Sacramento Airport Host Hotel. The topics of discussion and the actions that were recommended are highlighted below.

- **Welcoming Remarks and Introductions** – Jim Higgins, Department of Mental Health (DMH), led introductions and reviewed the agenda. Representatives from the following counties were present: Astrid Beigel (Los Angeles County), Gary Spicer (Alameda County) Tracy Herbert, Uma Zykofsky and Sue Farley (Sacramento County), Rudy Arrieta (San Joaquin County), Brenda Rachel (Stanislaus County), Jan Perez (San Mateo County) and Karen Brown (Sutter-Yuba County). Ann Arneill-Py represented the California Mental Health Planning Council. Luis Zanartu represented the DMH Children's System of Care. Sherrie Sala-Moore, Rachel Luxemburg and Brenda Golladay represented the DMH Research and Performance Outcomes Development (RPOD).
- **Pilot County Report** – Participating counties present at the Task Force meeting presented an update of their current implementation status:

Sacramento: Approximately 200 more packets will be submitted.

Alameda: There were problems with Alameda county unions, so one of the sites that were trained that handled the more severely impaired children will not be included. La Clinica will continue to participate in the pilot. There was a question raised regarding instrument timing. Some concern had been expressed as to whether or not the clinician completed instrument would even be useful at intake considering the fact that the only information the clinician would have would be from the parent and the youth. This, in reality, is not a problem because clinicians have 60 days to complete the form thereby allowing adequate time to obtain the necessary information. Another important fact is that DMH relies heavily upon submission of the clinician form because it is the only instrument that is guaranteed over time since the parent and child can refuse to complete the form. Stanislaus county asserted that their clinicians feel the Ohio Scales are more accurate in assessing the child, even more so than the Achenbach instruments. All in all, all three informants are important in developing a baseline for which future assessments can be compared.

Los Angeles: After the recent pilot study training, Los Angeles county staff were concerned about the pilot study timeframe. To clarify, the Task Force asserted that all participating pilot study clinics will switch to the pilot study instruments until a final decision is made. Los Angeles county will begin the pilot in April. Even if the pilot study terminates before Los Angeles county has an opportunity to collect Time 2 data, county staff will still be able to contribute feedback regarding logistical issues (time to complete, ease of administration, etc.). Those entering the pilot study later should be aware of the fact that they might not be contributing Time 2 data. Additionally, it should be noted that the Time 2 data attrition is not going to be addressed if the pilot study is terminated early. This may not be an issue since the CMHDA, CMHPC and

DMH have already stated that, at this time, the longitudinal methodology is not going to change. Some Task Force members felt that this might be prone to change if there is data available to suggest alternatives. It was concluded that this might not be an issue at this time since the pilot study counties will continue to collect data even if the pilot is terminated early.

San Joaquin: San Joaquin county has implemented the pilot study and had no issues to report.

Stanislaus: The pilot study is going smoothly, but there are some problems with the spanish translations, which DMH is currently addressing.

- **Review Summary of Raw Data (by County) and Discuss Any Data Issues** – DMH distributed reports of the raw data that had been submitted thus far. Descriptive reports were also distributed. Task Force members mentioned that it is important to look at whether or not the questions are being answered because one issue is the notion that some of the items may ask for information that clinicians might not be able to get. Concern was then raised as to the criteria that will be used to determine whether or not a question will remain on the final instrument or be dropped altogether. Perhaps it would be best to develop multiple criteria based on what information is needed to get more money for the programs and then to figure out how DMH can get that information. The pilot study might be helpful if DMH follows up on the “unknown” responses, find out why it is missing, and then try to address the problem. The Risk Factor Assessment questions that have a high response of “unknown” might be dropped. There also needs to be a method for updating any changes in the Risk Factor data. For the next meeting, the pilot study county representatives requested that the analyses be broken down into the following age categories: 0-5, 6-11, 12-15 and 16-18. An analysis of the CAFAS scores by administration (intake versus mid-treatment), as well as a conservative analysis on the Ohio Scale responses (Spanish version versus the English version), was suggested.
- **Report on CAFAS Score Distributions from Existing System Database Compared with Pilot Study Scores** – After analyzing the CAFAS data from the existing system as compared to the CAFAS scores being collected from the Pilot Study, it appears that there is a moderate correlation between the two instruments overall. When examining the subscales, the correlation is small in some areas, but each scale measures different areas of impairment. There is still a lack of data for the higher impairment levels for the pilot study population. Perhaps California has more data than Ben Ogles and the California population might require different severity cut-off scores. Also, the CAFAS might make children look more severely impaired since the instructions require the clinician to choose and report the worst behavior of the child. Ohio, on the other hand, simply asks for a general rating. Task Force members stated that it made sense to correlate the CAFAS and the Ohio Scales. Another suggestion was to compare the Ohio Scales with the Services Provided (via CSI) to determine acuity. The potential downside to this approach is the delay with the CSI database. DMH will see if CSI is currently up-to-date.
- **Summary of Findings on Risk Factor Data from Literature Reviews** – DMH presented a report of a literature review that was conducted to identify potential risk factors, as well as any research to date that tested these risk factors. Task Force members suggested that DMH take the reported rate of risk factors from the pilot study and compare it to prevalence rates in the general population.

- **Development of CLESP Reference Sheet** – As with the Client Information/Risk Factor Assessment Reference Sheet, a reference sheet for the Client Living Environment and Stability Profile (CLESP) was developed. Definitions for key terms were as follows:

Stability Information: there should be at least one placement

Group Home: as defined by the Department of Social Services (Jan Perez will provide the definitions)

Community-based Services: Parent/Caregiver receiving services to be a better parent/caregiver including alcohol/substance treatment, medical treatment, mental health services, parenting classes, etc.

School Attendance: Use the numbers as a rating scale. In the future change the options.

- **Discussion of Developing a Flag for Children’s System of Care Clients** – The Children’s System of Care unit has requested the assistance of the Research and Performance Outcome Development Unit in evaluating the effectiveness of Children’s System of Care (CSOC). Legislatively, CSOC children are identified as children placed out-of-home or at-risk of being placed out-of-home.; however, measurement of CSOC is difficult because each county defines the program differently, and some counties use CSOC money for non-multi-agency groups of children. One idea was to drop the CSOC name since the name itself has become subjective from county to county and then come up with a new term that can be used to meet the demands of the original definition. Task Force members felt that the CMHDA SOC Committee should meet and develop a definition. The reality is that the definition needs to be fixed and there is nothing in the Performance Outcome database that can fix the problem. Thus far, DMH can only identify if more than one agency is involved. There needs to be more coordination on the end of the CMHDA to operationally define the term. Perhaps a controlled study can be conducted by CSOC or even an auditing process imposed to see if the current data is even valid at all.
- **Topics To Be Discussed at the Next Children’s Task Force Meeting**
 - ✓ Report on Pilot County progress
 - ✓ Follow up on any data issues
 - ✓ Review summary pilot data by age groupings
 - ✓ Update on additional prevalence rate information
 - ✓ Review draft Reference Sheet for Client Living Environment and Stability Profile (CLESP)
 - ✓ Review summary pilot data by Level of Services and by Level of Severity Ratings (CAFAS & Ohio Scales)

- **Next Meeting - Sacramento Airport Host Hotel, American Room**

April 3, 2001
10:00 AM – 3:00 PM