Integrated Service Array Progress Review Data Analysis

The Integrated Service Array (ISA) was created to establish a range of services and supports for children needing more intensive treatment when the Children's System Change Initiative (CSCI) policy direction was established in 2004. A uniform level of service intensity process was established using the Child and Adolescent Service Intensity Instrument (CASII) and consideration of other risk factors. The (CSCI) established a structure providing for child and family teams to determine service coordination needs, utilizing care coordination as the primary vehicle to accomplish better service integration across systems for children and families. Intensive community-based treatment services (ICTS) were defined and established and the need for outcomes measurement was recognized and clarified. While it took a number of years to establish a process for outcomes measurement, this report reflects the concerted effort of many involved in the CSCI to create a tool (the ISA Progress Review) to accomplish that objective.

Significance to ISA Treatment and Supports:

This is the first analysis of data on children entering the ISA, based on contract amendments effective in 2009. A subsequent report will be released within the coming year analyzing changes in functional outcomes for children after one year in the ISA.

This report clearly outlines that the children entering the ISA are in fact in high need of these services and supports, based on their living situations, degree of family and social supports, and functioning in key areas: education, danger to self and others, delinquent behavior, and problems with substance abuse. The Behavioral and Emotional Rating Scale Version 2 (BERS-2) data further underscore the difficulties these children are having, even in relation to a normative group of other children with severe emotional disorders. These children are falling into a very low percentile relative to their peers. They are very much in need of high level mental health services; perhaps the most in need of all children in Oregon.

These data also portray a group of children who are seeking services and supports, or coming to the attention of others who seek services and supports for them, up until age 16, at which time the likelihood of ISA referral begins to decline.

Summary of Key Findings:

Nature and stability of child's living situation

- ***This population of children is highly mobile***. 34% of the children had changed residence at least once in the 90 days preceding the initial Progress Review.
- ***A sizeable minority of children were not living with a family member at the time of the initial review***. Only 64% of the children were living with a biological or adoptive family member at the time of the initial Progress Review.

Involvement of the family with treatment team and social supports

- ***Primary caregivers were present 84% of the time at the initial Child and Family Team meetings***.
- While caregivers most often indicated that they had *some* social support network which *could* help with raising their child ***many caregivers reported the need for a more extended and/or actively engaged social support network***.

Functioning of children

- ***Danger to self***. The majority of the children (66%) had a history of behavior which could have caused or did cause self-harm. ***30 children (3.8%) had, within the past 30 days, engaged in behavior that put these children at immediate risk of death.***
- ***Danger to others***. The majority of the children (72%) had a history of behavior which could have caused or did cause harm to others. Approximately 29% had a history of this behavior in the past 30 days.

- ***Delinquency***. Approximately 2 out of 5 children (41%) had a history of acts of delinquency. 16.5% had a history of acts of delinquency in the past 30 days.
- ***Educational Functioning***. Almost half (45%) of the children had only sometimes, seldom, or never produced schoolwork of acceptable quality in the last 20 scheduled school days.
- ***Substance Abuse***. 18% of the children had a suspected or known history of substance abuse in the 30 days preceding the initial Progress Review.

Analysis of Findings:

The report suggests several areas where system improvement could impact this group of children:

Living Situation Stability. We are currently, through the Statewide Children's Wraparound Initiative, beginning to address the issue of multiple, frequent placement changes through Child Welfare. There are a sizeable minority of this ISA referred group of children who are also not yet in permanent living arrangements. This is in part due to psychiatric residential treatment, which would be consistent with their participation in the Integrated Service Array (ISA). There are also a significant number who are in temporary/ therapeutic foster care or in another undefined living situation.

Child and Family Team Participation by Primary Caregiver. While a high number of primary caregivers were present for the initial child and family team meeting, it is concerning that about 16% were not. It would be worthwhile to investigate whether primary caregivers were not present in the child's life at that point or exploring what other reasons exist for the lack of participation.

Functioning of children
Danger to self. A clear majority of children are exhibiting very high risk behavior in this area. Approximately 30 children (3.8%) of the current sample had, within the past 30 days, engaged in behavior that put them at immediate risk of death.

This both underscores the importance of expedient level of service intensity determinations and also increases the need for vigilance at all levels of the system to protect these children. Identification through screening for suicide risk might be advisable as an adjunct measure.

Danger to Others. High numbers of these children (72%) had a history of behavior that could have or did cause harm to others. It is expected that with new administrative rule changes, more frequent screening for trauma will occur. Early trauma is linked with aggression later in a child's life[1]. Gathering a more detailed history and using sophisticated clinical tools could provide a better treatment focus in addressing the causes of aggression and alleviating the feelings and thoughts provoking aggressive acts. Vigilance is needed to protect these children from inflicting violence on others and to protect other children and adults.

Delinquency. High numbers of these children had a history of acts of delinquency, with 5% (37) committing severe acts of delinquency in the past 24 hours. Again, screening and proactive evidence based services might be helpful to consider in keeping these children from committing acts which move them into contact with authorities. Vigilance is needed to prevent these children from further delinquent acts.

Schoolwork. A significant portion, 12.7%, of the data are missing for responses regarding whether children produced schoolwork of acceptable quality, given the child's ability level, over the past 20 school days. Getting these data would provide additional information and strengthen the existing data set, where 20% seldom or never produce schoolwork of acceptable quality and another 25% "sometimes" produce schoolwork of acceptable quality. Better system interface between education and mental health is a significant challenge at present, making getting these data more difficult if they are not provided by a family member.

[1] Bruce Perry, M.D. *Child Trauma Academy*

Substance Abuse. Almost 1 in 5 children, approximately 140 children in this group, were suspected or known to engage in substance abuse.

Better screening and treatment options for these children are needed. Mental health and substance abuse treatment programs need to collaborate and begin to overcome siloed treatment options so that co-occurring disorder treatment is available for all young people who need it.

Young Adults in Transition. Young adults in transition (YAT) are defined by AMH as youth ages 14 through 25 who are transitioning to adulthood. Information revealed in this data set are highly consistent with what had been previously determined about the use of children's mental health services and supports by young adults in transition: that there is a drop-off in YAT receiving services. This is concerning, because it is unlikely that YAT are not in need of the integrated service array. Rather, it is possible that the array of available services and supports is either not appealing to, or not serving the needs of YAT, or both.

Methodology:

The majority of children evaluated using the ISA Progress Review had, as of the second quarter of 2010, been evaluated only once; therefore, this report summarizes data only on initial evaluations of children using the ISA Progress Review. Within-child changes in scores on the ISA Progress Review should become available in the near future, as additional data are submitted, entered, and "cleaned".

This report summarizes ISA Progress Review data on 787 unique children. It includes data that were: (a) submitted between the second quarter of 2009 and the second quarter of 2010; (b) entered by AMH personnel as of October 2010, and; (c) deemed to be complete and valid. The number of unique children on whom we had data meeting all criteria (a) – (c), by MHO, is depicted in Table A.

It is assumed that the subset of data meeting all criteria (a) – (c) yield findings broadly representative of the findings we would obtain if all ISA Progress Review data from 3/1/2009 through 6/30/2010 had been available for analysis. These data represent Intensive Service Array Progress Review data for children enrolled in a

mental health organization (MHO). Children who are Medicaid eligible, but not enrolled in an MHO, are not included.

Table A

MHO	Number of Unique Children Evaluated from Q2 2009 through Q2 2010
Clackamas	114
GOBHI	168
Family Care	28
ABHA	63
Mid-Valley	159
Verity	153
Jefferson	77
Washington	25
Lane	No data met criteria a-c above for analysis

Children's functioning per the Behavioral and Emotional Rating Scale (BERS-2)

The Behavioral and Emotional Rating Scale – Version 2 (BERS-2) is a 52-item instrument used to collect information on a child's emotional and behavioral strengths. The BERS-2 items load on 5 subscales: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength. Specific items measure degree of control over emotions and behaviors (interpersonal strength), participation in and relationship with family (family involvement), competence and accomplishments (intrapersonal strength), school functioning, and ability to accept affection from others and express feelings toward others (affective strength).

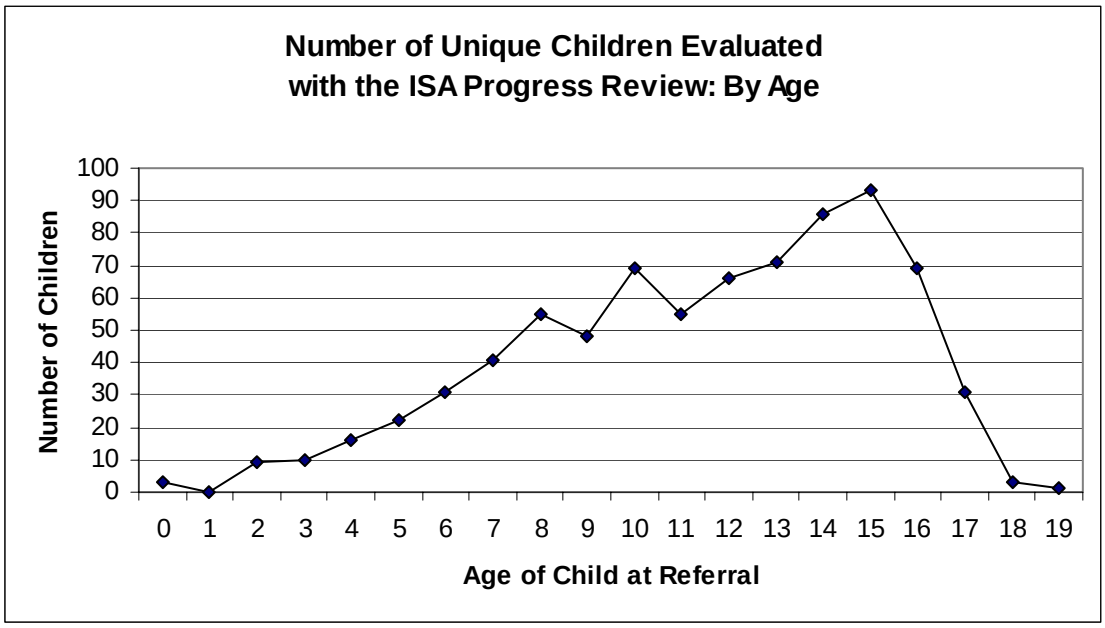
Summary of Findings from Behavioral and Emotional Rating Scale (BERS-2)

Total sample N = 783	**Valid scores**	**Matched for Sex of Child**	**Girls** **Boys**	**Mean Raw Score**	**Percentile Score – Children without ED[2]**	**Percentile Score - Children with ED**	**Rating**
BERS-2 Subscales							
Interpersonal Strength	**761**	**528**	**209**	**18**	**5th**	**37th**	**Poor**
			319	**16**	**16th**	**50th**	**Below Average**
Family Involvement	**744**	**518**	**205**	**14**	**5th**	**50th**	**Poor**
			313	**15**	**16th**	**63rd**	**Below Average**
Intrapersonal Strength	**753**	**523**	**207**	**17**	**5th**	**50th**	**Poor**
			316	**17**	**9th**	**63rd**	**Below Average**
School Functioning	**744**	**518**	**206**	**11**	**5th**	**37th**	**Poor**
			312	**10**	**5th**	**37th**	**Poor**
Affective Strength	**759**	**528**	**207**	**11**	**9th**	**50th**	**Below Average**
			321	**11**	**9th**	**50th**	**Below Average**

[2] [2] The BERS manual, measure, and norms, use the phrase "Emotionally or Behaviorally Disturbed" (ED) to describe children who have been identified as being in need of mental health services. Use of the phrase in this report should not be taken to mean that the Addictions and Mental Health Division supports use of this phrase to describe the children whom we serve.

Detailed Findings

Figure 1



The likelihood that a child would receive an ISA evaluation increased up to age 15, with age (see Figure 1). The modal (most frequent value) age of the children who were evaluated was 16; the mean (average) age was 11, and the median (half older, half younger) age was 12.

Table 2

Living situation	Number of children	Percent of children (non-missing), rounded
With biological or adoptive family member	498	64%
With another relative or friend	28	4%
In long-term foster care	46	6%
In temporary foster care	63	8%
In therapeutic foster care	31	4%
In a residential treatment center	78	10%
In another living situation	36	5%
Missing	7	--

Note: Shaded area indicates assumed temporary living situation, thus child will face further moves.

64% of the children in the sample were living with a biological or adoptive family member at the time of the evaluation. The remainder of the children was living in other settings, as depicted in Table 2.

Table 3

Caretaker Social Network	**Number of Caretakers**	**Percent of caretakers (non-missing), rounded**
No social network that could assist with raising the child	101	13%
Some social network that could assist with raising the child	305	39%
Some social network that actively helps with raising the child	194	25%
Significant social network that actively helps with raising the child	108	14%
Missing	75	--

In most but not all instances (84% of the time), a primary caregiver was present at the initial Child and Family Team Meeting. These caregivers reported a range of social support, from those who said that they have "No social support network to help with raising the child" (13%) to those who said that they have "A significant social network that helps with raising the child" (14%) (see Table 3). The typical caregiver reported that s/he has "*Some* social support network that *could* help with raising the child."

Residence changes

Data indicate that, upon intake, about **34% of the children had changed residence at least once in the past 90 days**. Approximately 17.6% of the children had changed residence exactly once; 8% exactly twice; 3.5% exactly 3 times, and 2.3% exactly 4 times. 2.6% of the children had changed residence 5 times or more in the 90 days prior to the initial Progress Review.

Figure 3

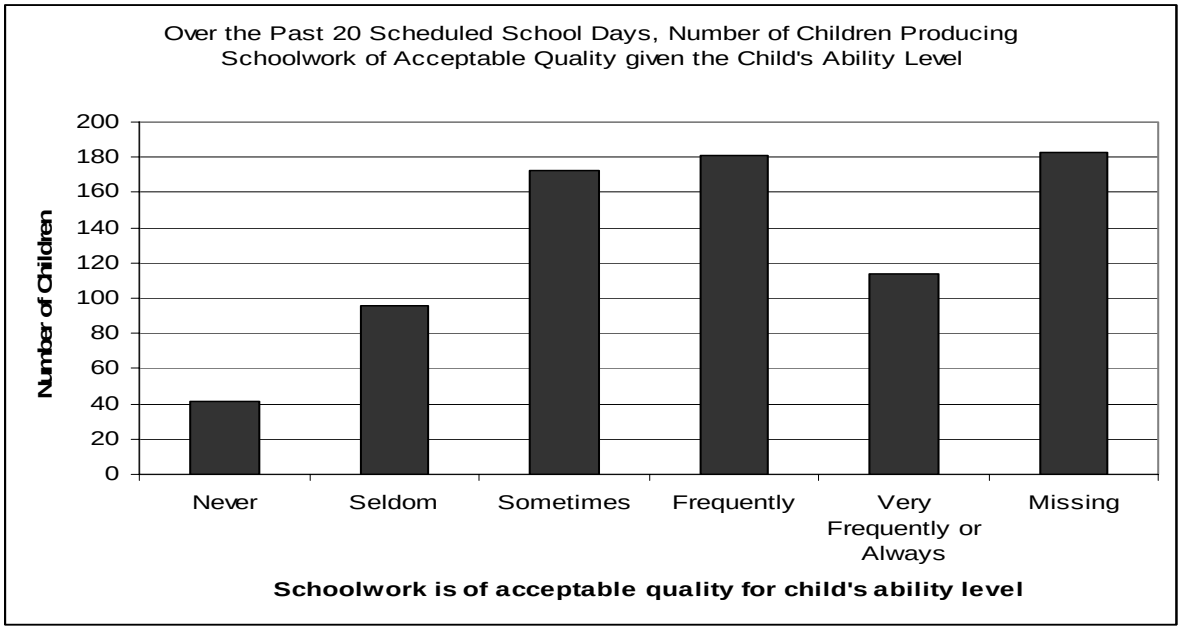


Figure 3 shows how many children were producing schoolwork of acceptable quality, given the child's ability level, over the past 20 school days. **Over the past 20 scheduled school days, about 6% of the children had never produced schoolwork of acceptable quality, about 14% had seldom produced schoolwork of acceptable quality, about 25% had sometimes produced schoolwork of acceptable quality**, about 26% had frequently produced schoolwork of acceptable quality, and about 17% of the children had very frequently or always produced schoolwork of acceptable quality. (*Note that 12.7% of the data for this measure of school functioning are missing)*.

<u>Data on substance abuse, delinquency, and risk of harm to self or others</u>

Figures 4 through 7 give us an idea of the functioning of the children during the 30 days prior to intake with respect to substance abuse, delinquency and risk of harm to self or others.

Figure 4

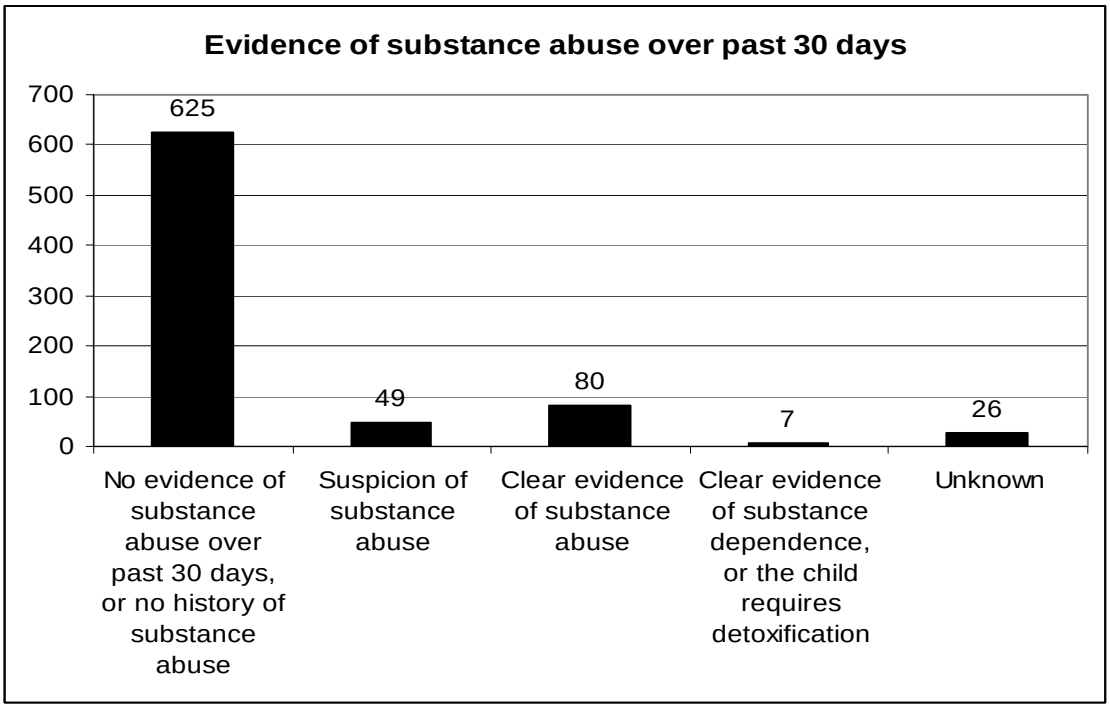


Figure 4 depicts the data on evidence of substance abuse over the past 30 days. 82% of the 761 children with data on this measure had no history of substance abuse over the past 30 days, though some of these children may have had a history of substance abuse in the past. **The remaining 18% of the children with data on this measure had a suspected or known history of substance abuse in the past 30 days**.

Figure 5

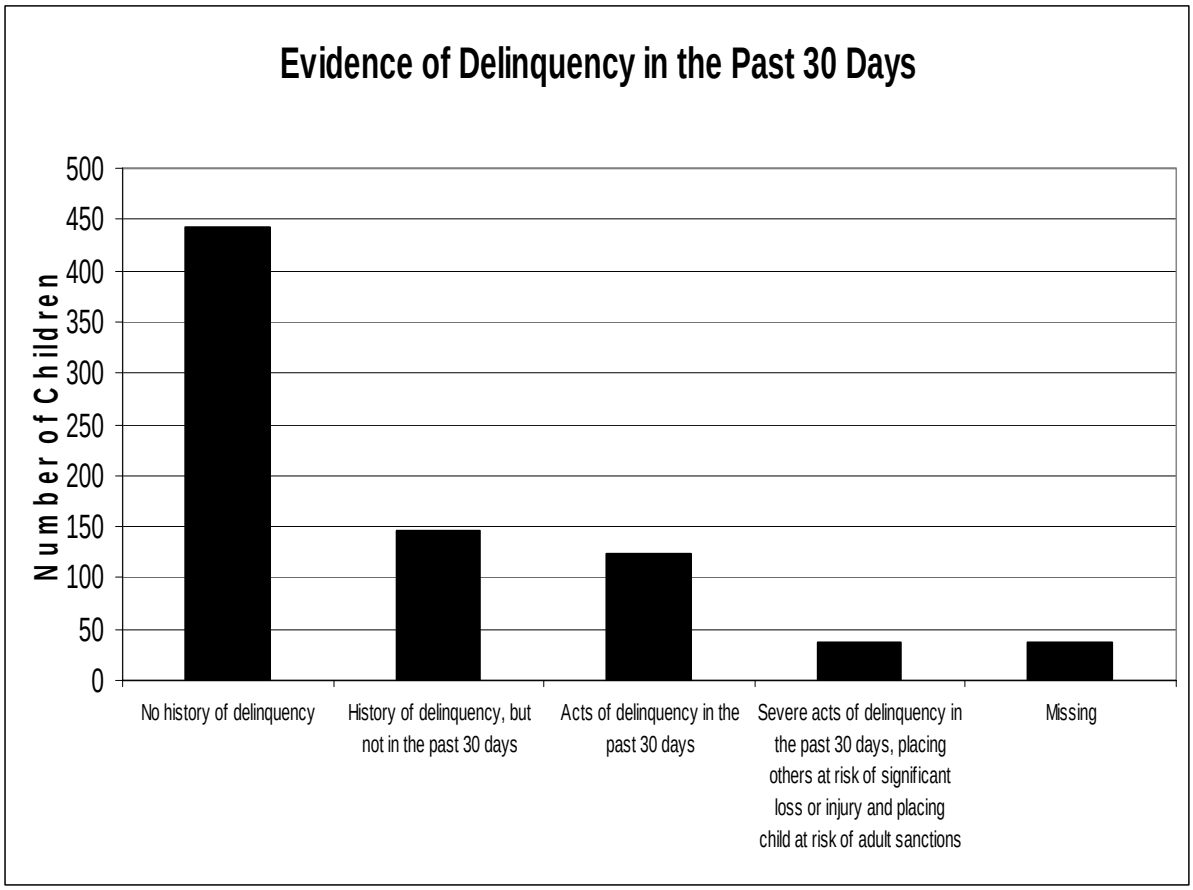


Figure 5 depicts the number of children reportedly involved in acts of delinquency. **A sizeable minority (308, or 41%) of the children evaluated had a history of acts of delinquency**. 124 (16.5%) of the children had committed acts of delinquency within the past 30 days but not in the past 24 hours, and 37 (5%) of the children had committed severe acts of delinquency in the past 24 hours.

Figure 6

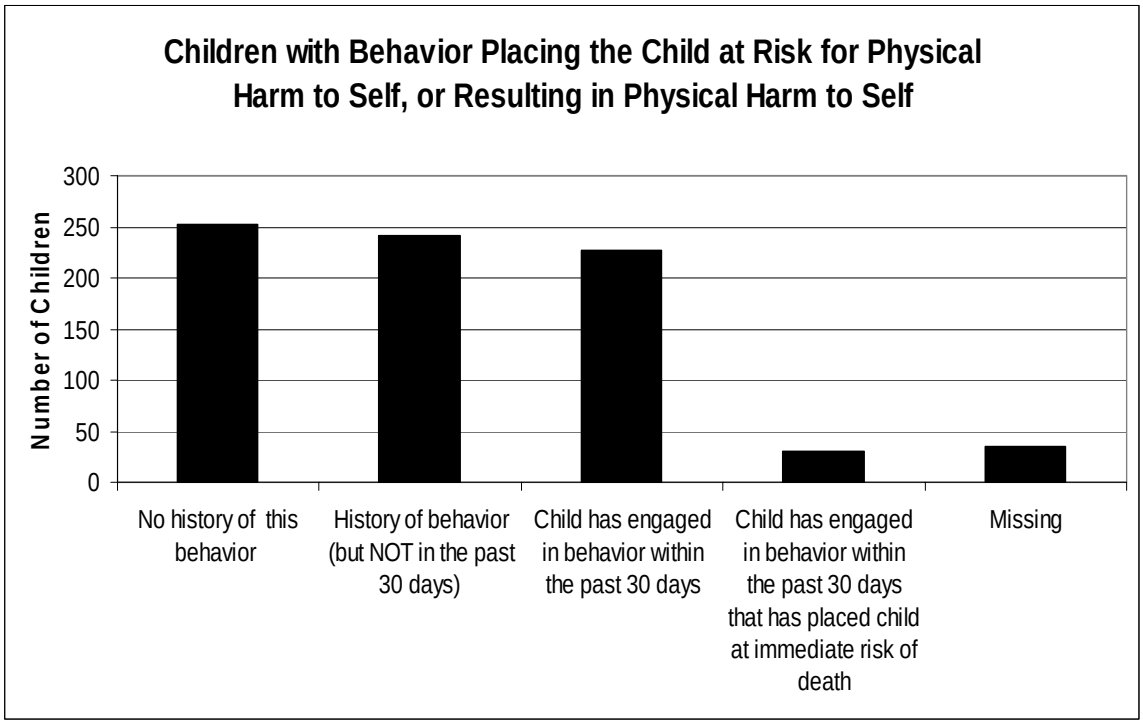


Figure 6 shows the number of children with a history of behavior which could have caused self-harm or did cause self-harm. **The majority (499, or 66%) of the children evaluated had a history of behavior which could have caused or did cause self-harm.** ***3.8% of the children had, within the past 30 days, engaged in behavior that put these children at immediate risk of death.***

Figure 7

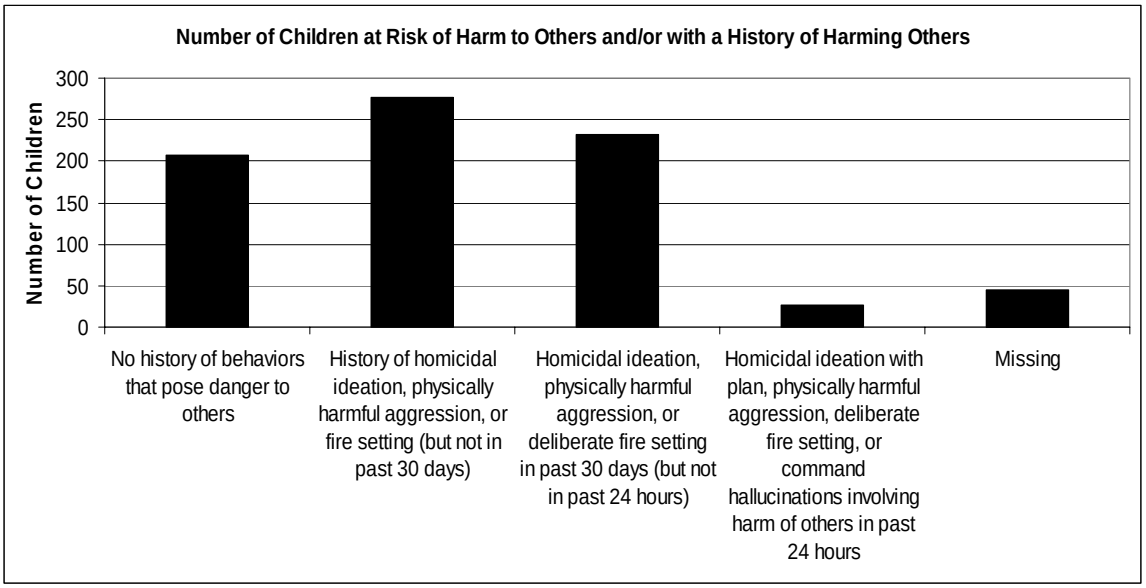


Figure 7 shows us the number of children with a history of behavior which could have caused harm to others or did cause harm to others. **72% of the children evaluated had a history of behavior which could have caused or did cause harm to others.**

Next Steps

1. Data Reporting. AMH should convene a workgroup of stakeholders and AMH staff to review proportion of usable to unusable data, improve data reporting and provide consistency across MHOs in the manner data is reported. The ISA Progress Review-BERS-2 should be administered more frequently to measure changes in children over a shorter time than one year.
2. Decline in ISA Services at age 16. Consideration should be given to reasons why children are less likely to enter the ISA after age 16 and what might be done to address this.
3. Danger to Self. Explore extent and feasibility of suicide risk screening across the state.
4. Improved Child and Family Team participation by primary caregivers. Exploration of how more primary caregivers could be encouraged/ incentivized to attend their child's Child and Family Team.
5. School work for ISA children.
   Active work on how to obtain education system data, specifically around whether or not children are producing acceptable quality schoolwork when they are in the ISA and how this could happen on a more frequent basis.
6. Delinquency. Screening for, and use of evidence based practices to prevent delinquent behaviors in this group of children.
7. Aggression. Use of trauma informed services to ameliorate/reduce instances of aggression. Increase use of effective practices such as Collaborative Problem Solving, Neuro-sequential Model of Therapeutics© (Child Trauma Academy) or Cognitive Behavioral Therapy.
8. Substance Abuse. Work should continue on integration and collaboration around co-occurring treatment options for youth in the early stages of substance abuse, and for those at risk/suspected of it.