°CSA

Utilization Management Guidelines
(Revised June 2009)

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Section 8.1. Utilization Management

I.   Introduction

Health and human service delivery systems throughout the country are experiencing considerable pressure to enhance accountability and control costs. A variety of approaches have been used to accomplish these goals. In some instances, external entities such as managed care organizations have been brought in to manage utilization and cost of services. In other cases, policy makers and funding sources have chosen to work within the existing decision making structure, developing guidelines and data bases that facilitate rational planning and prudent decision making among those responsible for delivering health and human services. The Comprehensive Services Act [CSA] was enacted by the General Assembly in 1992 for the purpose of improving care for troubled and "at risk" youth and families, as well as to control the escalating cost of residential treatment for this population. While much progress has been made, concerns about the overall increase in cost as well as concerns about out-of-home placements instigated the State Executive Council to commission the Commonwealth Institute for Child and Family Studies to conduct a feasibility study. The study focused on the application of utilization management principles to the service delivery system mandated by the CSA. Data were gathered from key stakeholders including parents, providers, FAPT members, CPMT members, and the State Management Team. Based upon the data gathered from feasibility study, it was apparent that there is need and support for utilization management.

In the feasibility study it was found that even with the implementation of CSA, the gross cost for services has continued to increase. This overall increase in cost makes it necessary to assess continually the functioning of the CSA in order to improve cost-effective performance. In designing a utilization management strategy for the CSA, the State Executive Council took into account the CSA's strong emphasis on retaining responsibility and authority at the local level as well as its focus on individualized service planning. The Council chose a utilization management strategy that supports local empowerment and accountability through a decision support process that provides pertinent data and guidance to individuals and groups responsible for service planning. This decision support system is based on the conclusions of the feasibility study, which generated the following principles:

- Decision making authority should remain with the locality.
- Decision makers, including consumers, FAPT, and CPMT members need to have a rational basis for assessing child/family needs/strengths and matching them with the most appropriate services.
- The guidelines need to be sufficiently flexible to account for uniqueness of each locality and the current capacity of caregivers and communities to respond to children with emotional/ behavioral disorders.
- The utilization management system must strike a balance between providing responsive, appropriate services, and being sensitive to the limited resources available to meet the needs of the many children and families requiring services.
- The system should distinguish between level of placement, i.e., psychiatric hospital, residential, group home, family, and intensity of service, with both factors being important but not necessarily interdependent. For example, for some children it is possible to provide intensive services while they remain at home, thus providing a less restrictive environment for the child while also potentially reducing the cost of services.

The following guidelines and processes have been developed to assist localities in assessing child and family strengths and needs, developing viable service plans, and implementing these plans in a responsive, cost efficient manner. In keeping with the principles of the CSA, these guidelines are not intended to provide localities with a formula-based decision making process, with rigid exclusionary criteria that result in a child being found eligible or ineligible for services. Instead, the system is designed to give decision makers a child and family-centered rational framework for assessing the most appropriate care for a given child and family. The guidelines provide a template for determining which services, and placement might be most suitable for a child and family with specific characteristics. In keeping with the child/family-centered framework, consideration of mitigating circumstances is an important part of determining the most appropriate services and placement for the child and family. These guidelines are applicable for all children who receive CSA services beyond basic maintenance for foster care children and a minimal service level. These guidelines shall, however, take into account and be applied in a manner that complies with agency requirements for specific populations, i.e., special education.

OCS suggests that localities use these guidelines as one would use a road map. Knowing that there is a direct route to one's destination may be helpful, but having first hand knowledge of road conditions, weather, and other factors may lead one to select an alternative route which may prove to be faster, safer, and even less costly than the suggested pathway. The CSA decision support guidelines provide a framework that enables local stakeholders, including family members, to work together in a rational, accountable manner to provide responsive, cost efficient services for children. While the guidelines should facilitate this process, they are not a substitute for sound knowledge and understanding of the needs and strengths of children and families and unique conditions of local communities.

II. Summary of Utilization Management Implementation Process for Services Provided under the Comprehensive Services Act

During the 1997 budget process, the General Assembly added a requirement that all Community Policy and Management Teams [CPMTs] must incorporate utilization review of residential placements utilizing CSA funds in order to be considered for supplemental funding. For those who choose to participate in this utilization management process, the required criteria are listed below. The requirement provides local government options when considering which utilization review technology they intend to employ. Localities may choose the CSA endorsed guidelines or they can create their own guidelines that follow the criteria below. Localities also have the option of choosing how to implement the utilization review process. Those following the CSA endorsed guidelines may either manage this process on their own, or receive assistance at no cost from the State Sponsored Utilization Management through OCS. Those who choose to create their own guidelines may either manage the utilization review process internally, or contract with a utilization review organization. While the legislative requirement applies only to residential placements, localities may also conduct utilization processes for other children whose intensive and multiple needs make them appropriate for CSA services.

COLLECT INDIVIDUAL AND FAMILY ASSESSMENT DATA (using CSA-endorsed instruments and process or alternatives chosen by localities)
IDENTIFY DESIRED OUTCOMES
IDENTIFY THE SERVICES NEEDED FOR CHILD AND FAMILY
CONSIDER MITIGATING CIRCUMSTANCES
FINALIZE THE CHILD SERVICE PLAN
NEGOTIATE WITH PROVIDERS, INCLUDING CLARIFICATION OF EXPECTATIONS FOR FAMILY INVOLVEMENT AND EXPECTATIONS FOR MONITORING OF PROGRESS
IMPLEMENT PLAN AND PROVISION OF PRESCRIBED SERVICES
PERIODIC REGULAR REVIEW OF CHILD AND FAMILY PROGRESS TOWARD TREATMENT GOALS*
PERIODIC REGULAR REVIEW OF CHILD AND FAMILY PROGRESS TOWARD TREATMENT GOALS* (after time period specified in Level of Need chart)

POSSIBLE ACTIONS AS A RESULT OF REVIEW (Repeat the **Decision Support Process**, if indicated, to assist in evaluating and revising the current plan) **:

- continue to follow the current plan
- change length of time for current service(s) and objectives
- change service objectives
- change aspects of the environment
- change provider
- change treatment modalities at same level of need
- change placement

*Decision Support Guidelines need to meet CSA's general criteria for decision support processes. Localities may choose from other measurement instruments that are validated and appropriate for the utilization review of child and family services (i.e., CANS).

SYSTEM-LEVEL UTILIZATION MANAGEMENT: The above outlined utilization review process may be followed at both an individual level and at a larger system level. Components of the utilization management process can be compiled for all CSA cases in the locality and analyzed to review the process at the system level. Such a system level review would entail summaries of:

       (a) characteristics of children and families;
       (b) recommended services for CSA cases;
       (c) safety and security needs identified through CANS and other assessments as needed
       (d) mitigating circumstances;
       (e) decisions regarding placements outside the home
       (f) child and family progress toward treatment goals;
       (g) changes in level of care as a result of review of progress

III. Implementing a Utilization Management System at the Local Level

Localities wishing to receive CSA supplemental funds need to decide how they will conduct utilization review of residential placements. Localities can choose from the following options:

State endorsed model for utilization review by State Sponsored Utilization Management through OCS

State endorsed model in which locality will be responsible for utilization review

Locally designed model which will incorporate all utilization management criteria as outlined in this document and appropriate sections of the Code of Virginia and State Policies. All localities participating in the utilization management process must follow the criteria of the implementation process

A.   **Gathering individual child/family assessment data**

    1. Guidelines for using archival data:
        If the information is more than six months old, data that are not related to the child's history should be collected again.

    2. Completing the assessment instruments

        a. Identify a key person who is knowledgeable about the child and family, and who has a supportive relationship with them to coordinate the assessment.

        b. Options for completing the instruments:

      i. Case manager or other key person completes on the basis of the child's record and his/her own knowledge.

      ii. Instruments are completed by knowledgeable participants during the FAPT.

      iii. Key person visits the child and his/her residence and interviews parents, caretakers, and providers.

      iv. Key person contacts external assessment team and coordinates interviews and records reviews.

3. Sources of information for assessment: Assessment data should reflect the perspective of children, families, current providers (including case managers), and the historical record (from the child's case record).

4. Dealing with discrepant data

   a. Common sources of discrepancy

      i. Differences in child's presentation across time

      ii. Differences in child's presentation across settings

      iii. Differences in primary service objectives across involved parties

   b. Method for resolving discrepancies

      i. Respecting the family perspective

      ii. Judicious evaluation of the historical record

      iii. Empowering parents as advocates

      iv. Negotiation over the service plan.

   c. Dealing with missing data

      i. Clarify a process for ensuring that all assessment data are available at the time for review and decisions.

C.   What are the services required?

1. Engaging the family in identifying service needs
2. Interpreting assessment data regarding service needs

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3. Negotiating frequency and intensity of services
4. Principles for service planning:
    a. Is it what the family wants and/or does it facilitate permanency-planning principles for children in foster care?
    b. Is it necessary?
    c. Is it a wise use of resources?
    d. Does it consider the legal requirements for mandated children, i.e., foster care and special education?

D. Analyzing and interpreting individual assessment data

1. Using the decision guidelines
    a. For children with special education needs, decision support guidelines are outlined in IDEA (1997; See Attachment A).
    b. For children in foster care who utilize services that are CSA funded beyond basic maintenance and a minimal service level (defined by local CPMT), decision support guidelines will be applied. For new cases, the results of the review process should be incorporated into the foster care plan reviewed and approved at the dispositional hearing by the court (under no circumstances can the use of the guidelines delay the court hearing and the action by the court on the service plan). All foster care regulations apply to all children in foster care and need to be incorporated into the CSA decision support guidelines process.
    c. For all other children, identify a key person who will apply decision guidelines to assessment data to identify matching level of need.
    d. Clarify the process for presenting the results of the decision guidelines to child, family, FAPT and the court.
    e. Clarify the process for facilitating discussion of the results of the decision guidelines that allows for airing of dissenting opinions.
    f. In cases where there is an IEP and a need for further services through the CSA, with parental permission the IEP can be reviewed as part of the individual assessment process. However, only the IEP committee is authorized to make changes to the IEP.

2. Using dissenting opinions to clarify potential mitigating circumstances that might influence decision guidelines
    1. "Amenable to treatment?"
    2. Medical needs
    3. Activities of daily living (ADL) support needs
    4. Child/family strengths

E. Reconciliation and decision-making

1. What is involved in the decision regarding level of need?
    a. CSA guidelines
    b. Principles of family centered planning being consistent with principle of permanency planning for children in foster care.

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   c. Consideration begins at the lowest level of need
   d. Principle of placement in the least restrictive environment

  2. Finalize the service plan, which should include:
   a. Initial level of need with corresponding review period.
   b. Services the child is to receive.
   c. Most appropriate location for provision of those services.
   d. Measurable goals/expected outcomes with timelines.
   e. Step-down plan for transition to less restrictive placement, including specific discharge plans.

  3. Identifying potential service providers
   a. Identify key person to contact potential providers.

F. Implementing the service plan

  1. Negotiating with providers
  2. Clarifying (for providers) expectations regarding family involvement in treatment planning.

G. Monitoring progress and treatment outcomes

  1. Clarifying (for providers) expectations regarding monitoring of progress
  2. Identifying key person for implementing monitoring program.

H. Reviewing individual child level of need and service needs

  1. Clarifying schedule for review of level of need and service needs
  2. Clarify process for using progress/treatment outcome data in review
  3. Clarify process for returning to level of need/service planning steps
  4. Clarify expectations regarding step-down.

I. Evaluating the local service system

  1. Incorporating group data from decision guideline process to identify gaps in service system
  2. Examining group data (by provider) to monitor quality of service
  3. Examining group data by type of child/family problem (Is the system serving some kinds of children better than others?)
  4. Examining group data by step-down progress (Are children moved to less restrictive settings when treatment goals are met?

V. Mitigating Circumstances to Be Considered in Placement Decisions

  Mitigating circumstances may provide a rationale for selecting certain services and/or placements over others. The following list is not meant to be inclusive. Individual cases often present unique and challenging circumstances that contribute to the amazing capacity to provide

community-based care. Certain mitigating circumstances may also warrant consideration of more restrictive placements than those identified after initial assessment.

System Factors

- Placement safety: The degree to which the placement is safe and does not present a risk of harm, neglect, or abuse for the child.

- Community safety: The degree to which the community would be at risk of harm from the child.

- Community capacity for Systems of Care: The degree to which the community possesses the knowledge, skills, and/or resources to implement a system of care. Services included in a system of care can also include Wraparound services which are defined as interventions that are "developed and approved by an interdisciplinary service team, are community-based, and unconditional, are centered on the strengths of the child and family, and include the delivery of coordinated, highly individualized services in three or more life domain areas of a child and family (The International Initiative on Development, Training, and Evaluation of Wraparound Services, 1992, p. 1)."

- Ability of agencies to work together: The degree to which multiple agencies are willing and able to coordinate services to meet the child's needs and to facilitate the child's progress.

- Community attitude towards children with serious emotional disturbances.

- Legal constraints

- Resources of the community

Individual Factors

- Ineffectiveness of current treatment

- Child's unwillingness to cooperate with treatment

- Family preferences for or against particular treatment modalities: Family needs and preferences must be considered in the all levels of the planning and provision of services. With the exception of extenuating circumstances, the provision of services is contingent upon family acceptance. However, family and cultural preferences may preclude certain services. Refusal of services does not necessarily move the child to a higher level of need, but may warrant negotiation of different services and/or placements at the same level of need.

- Resources of the caregiver, family, and extended family.

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VI. Implementing Service/Placement Decisions

Having reached a decision about the most appropriate service plan for a child, the next challenge is to identify a suitable provider and negotiate a responsive, cost effective service arrangement. Successful implementation of this phase is contingent upon at least two factors: [1] the availability of sufficient service capacity at all levels of the continuum of need, and [2] the ability to work with the provider to establish a service arrangement that responds to meet the child and family's needs/strengths while being sensitive to the importance of allocating scarce resources wisely.

<u>Assessing Capacity</u>

Effective utilization management requires that localities have ready access to service settings that can respond appropriately to the needs of children participating in CSA. Developing a profile of service needs of existing children currently engaged in CSA and taking an inventory of current service resources will enable a locality to determine the extent to which current service needs can be met as well as to identify existing gaps. The attached Child Service Needs/Strengths Assessment Form can be used to develop a profile of child service needs. The service description/criteria form can be used as a basis for creating an inventory of existing service capacity. This information can be used to construct a plan for developing additional needed service capacity. The plan should identify priorities for service development and strategies for creating a more complete continuum of services. New services can be created by attracting new providers to develop services, or by negotiating with existing providers to reconfigure the array of services they are able to offer.

<u>Assuring the Provision of Responsive, Cost Effective Services for Children with Serious Emotional/ Behavioral Disorders through Constructive Partnerships between Localities and Providers</u>

The purpose of this section is to assist representatives of CSA localities to become smart consumers. The likelihood of children receiving services that are appropriate to their needs/strengths and cost sensitive will be significantly increased if localities play a proactive role in defining the services they wish to purchase and working with providers to establish expectations and procedures for identifying service objectives, approving service plans, and creating processes to monitor and evaluate progress in a timely manner. Establishing clear expectations benefits children and families as well as the purchaser of service. Service providers also benefit by having clear criteria on which they can be assessed and held accountable.

By incorporating the following questions as well as others into the service negotiation process, CSA localities can become better-informed and more effective purchasers of service.

- *What is the least restrictive placement that can be provided to assure safety as well as effective treatment?*

- *What involvement do you require/expect from families?*

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- *What requirements does your program have for the child to move to a less restrictive placement?*

  If services are to be appropriate and efficient, localities need to outline specific goals or objectives to be addressed in more restrictive placements so that the child can receive services in less restrictive settings and maintain connections with the community as a whole and the family in particular.

- *What is a reasonable time frame in which to expect the specific objectives to be accomplished?*

  These objectives become, in essence, discharge criteria. Obviously, it is not possible to predict precisely how long it will take to reach the agreed upon level of improvement. Child circumstances may change, the objective that was originally established may be more difficult to achieve than initially anticipated, or may be supplanted by a more critical objective. Recognizing that we may have to alter our initial expectations, it is still useful to establish specific quantitative targets and a defined time line in order to introduce a measure of accountability into the process.

- *What methods will be used to measure progress toward objectives?*

- *What communication and reporting processes will be utilized to keep localities informed of progress and other changes, as well as to enable key stakeholders to have appropriate input into the treatment and discharge planning process?*

- *Are there financial arrangements that serve as positive incentives for both the provider and the locality in working toward treatment/discharge objectives?*

  For example, by paying providers at a case rate in which they receive a flat fee for a specified time the provider has incentive to move the child to a less restrictive placement as soon as this is appropriate. If the provider agrees to take full responsibility for the child's service, this may mitigate against providers delivering less than needed services.

- *What procedures can be put in place to ensure that planning for transfer/discharge of the child takes place early enough in the treatment process to avoid unnecessary delays due to not having an appropriate placement available?*

  Discharge planning should begin at admission to any level of service. It is always better to begin with the end in mind.

- *Is there a sufficient review and tracking system in place to enable the locality to monitor patient function, movement, and outcome; provider performance; costs; and consumer satisfaction?*

While there is room for individual difference among localities, it is essential to have a basic data tracking and utilization review process at both individual and aggregate levels in order to assure that resources are being used wisely.

- *Is there a proactive performance improvement process in place that engages relevant stakeholders?*

These questions are intended to serve as guidelines for communities to assure that children with serious emotional/behavioral problems and their families receive services that are responsive to their strengths and needs, appropriate for their level of functioning, and cost efficient. Given the unique nature of each locality and its relationship with service providers, the questions have deliberately been framed to allow for individual differences among localities. While it would be simpler, in some ways, to provide precise prescriptions and formulas for managing the utilization of services, OCS believes that allowing localities to shape processes and procedures to fit local conditions is consistent with CSA principles and ultimately yields a more viable service system for children and families.

Please note that these guidelines are applicable at multiple levels of local CSA system. For instance, having a clear description of service objectives is critical for all stakeholders. Children need clear objectives so that they know what is expected of them and understand what it will require for them to move to a less restrictive setting. Families need to have input into service objectives because they know what children need to function well within the home. The existence of these objectives also provides families a basis for holding the service delivery system accountable. For the case manager, quantitative service objectives provide a tangible, shared reference point for discussing, evaluating, and assessing treatment progress with providers. By having explicit objectives, FAPT members are better able to track the progress of individual children as well as the performance of providers during their periodic reviews. Providers, who in some instances have been forced to establish objectives without sufficient guidance from referring agencies, will have clear lines of expectation and less risk of being mis-evaluated if there are specific objectives. Finally, CPMTs can use data about service objectives as they perform their function of developing policies and procedures that will improve the performance and cost efficiency of CSA.

ATTACHMENT A:
INDIVIDUALS with DISABILITIES EDUCATION ACT [IDEA, 1997]
CHECKLIST

The utilization review process for children mandated through the special education process is done at the school level by the IEP team for those services specified in the IEP. Any services being provided through the IFSP are reviewed utilizing the locality's chosen UM process. The following is a checklist for IEP teams.

YES	NO	SPECIAL EDUCATION CHECKLIST The IEP includes the following as required by federal law (IDEA, 1997)
		1. A statement of the child's present level of educational performance. [Sec. 614 (d)(1)(A)(i)]
		2. A statement of measurable annual goals related to meeting the child's needs to enable the child to be involved and progress in the general curriculum. [Sec. 614 (d)(1)(A)(ii)]
		3. A statement of the special education and related services and supplementary aids to be provided to the child, or on behalf of the child. [Sec. 614 (d)(1)(A)(iii)]
		4. A statement of the program modifications or supports for school personnel that will be provided for the child to be educated and participate with other children with disabilities and non-disabled children in academic and nonacademic activities. [Sec. 614 (d)(1)(A]
		5. An explanation of the extent, if any, to which the child will not participate with non-disabled children in the regular class and in the activities described above. [Sec. 614 (d)(1)(A)(iv)]
		6. The projected date for the beginning of the services and modifications described in clause (iii), and the anticipated frequency, location, and duration of those services and modifications. [Sec. 614 (d)(1)(A)(vi)]
		7. Beginning at age 14, and updated annually, a statement of the transition service needs of the child under the applicable components of the child's IEP that focuses on the child's courses of study (such as participation in advanced placement courses or a vocational educational program); beginning at age 16 (or younger, if determined appropriate by the IEP team), a statement of the interagency responsibilities or any needed linkages; and beginning at least one year before the child reaches the age of majority under State law, a statement that the child has been informed of his or her rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m). [Sec.614 (d)(1)(A)(vii)]
		8. A statement of how the child's progress toward the annual goals described in clause (ii) will be measured. [Sec. 614 (d)(1)(A)(vii)(I)]
		9. In developing the child's IEP, the IEP Team has considered the strengths of the child and the concerns of the parents for enhancing their child's education. [Sec. 614 (d)(3)(A)(i)]
		10. In developing the child's IEP, the IEP Team has considered the results of the initial evaluation or the most recent evaluation of the child. [Sec. 614 (d)(3)(A)(ii)]
		11. If the child's behavior impedes his/her learning or that of others, consider appropriate strategies, including positive behavioral interventions and supports, to address the behavior. [Sec. 614 (d)(3)(B)(i)]
		12. The regular education teacher, as a member of the IEP Team, has, to the extent appropriate, participated in the development of the child's IEP. [Sec. 614 (d)(4)(A)(i)]
		13. The IEP Team reviews the child's IEP annually to determine whether the annual goals for the child are being achieved. [Sec. 614 (d)(A)(i)]
		14. The IEP Team revises the IEP as appropriate to address any lack of expected progress toward the annual goals and in the general curriculum, where appropriate. [Sec. 614 (d)(4)(A)(ii)(I)]
		15. The IEP Team revises the IEP as appropriate to address the results of any reevaluation conducted under this section. [Sec. 614 (d)(4)(A)(ii)(II)]
		16. The IEP Team revises the IEP as appropriate to address information about the child provided to, or by, the parents, as described in subsection (c)(1)(B). [Sec. 614 (d)(4)(A)(ii)(III)]
		17. The IEP Team revises the IEP as appropriate to address the child's anticipated needs and other matters. [Sec. 614 (d)(4)(A)(ii)(IV), Sec. 614 (d)(4)(A)(ii)(V)]
		18. The child is being educated in the least restrictive environment possible. [Sec. 612 (a)(5)(A)]

ATTACHMENT B: CANS DESCRIPTION

The CANS is a very different type of assessment instrument than other assessments that have been used in Virginia and requires people to think about the "what", not the "why". It is easy to "overthink" the answers. CANS is not a psychometric measure of a child's functioning. Dr. Lyons, the developer of CANS, refers to CANS as a communication tool designed to focus service providers on the "shared vision of children and families." CANS is an assessment of the child's and family's strengths and needs, a way to assess service needs, and measure human service delivery outcomes. CANS TOOLKIT

ATTACHMENT C: Description of Types of Services in a Comprehensive System of Care

THERAPEUTIC
Early interventions
Counseling and Therapy Services
Home Based Services
Day Treatment
Therapeutic Nursery Program
Non-residential Emergency Services

INSTRUCTIONAL
Regular Classroom
Resource Room
Self-Contained Classroom
Special and Alternative Schools
Homebound
Related Services
Life Skills Training
Social Skills Training

HEALTH CARE
Health Promotion
Primary Care and Screening
Acute Medical Care
Chronic Medical Care
Dental Care

VOCATIONAL
Career Education
Vocational Assessment
Job Survival Skills Training
Vocational Skills Training
Work Experiences
Job Finding, Placement and Retention Services
Supported Employment
Sheltered workshops

SUSTENANCE SERVICES
Housing
Food
Clothing Financial Services [e.g., food stamps, AFDC, Medicaid, fuel assistance, WIC, SSI]

RECREATIONAL/SOCIAL
Neighborhood Programs
After School Program
Summer Camps
Special Recreational projects
Self-help and Support Groups
Community Service
Individualized Skills Training

FAMILY
Respite Care
Parent Education and Family Support
Mediation
Family and Parent Counseling
Home Aid Services
Relatives, Friends, Spiritual Affiliations
Shelter
Therapeutic Camp

SUPERVISORY/PROTECTIVE
Diversion
Probation
Intensive Supervision Services
Outreach Detention
Post-dispositional Detention
Child Protective Services
Individual Supervisory/Support Staff
Maundering

OPERATIONAL
Assessment
Service Planning
Case Management
Advocacy
Transportation
Legal Services

ATTACHMENT D: Guidelines for Parent and Family Involvement in the CSA Process

Involvement of families is recognized as a critical factor in effective treatment and services for children. The importance of this involvement is stressed in the Comprehensive Services Act (CSA) that mandates family involvement in service delivery and management. Since the implementation of the CSA almost in 1993, many Virginia communities have included a parent representative on their Family Assessment and Planning Teams (FAPT) and have encouraged families to attend FAPT meetings when services for their children are being discussed. However, the extent of parent involvement in the service system varies from community to community.

In children's services, family involvement is facilitated by service providers and is referred to as a partnership or a collaborative relationship between families and service providers with shared responsibilities and powers. Family involvement then relates specifically to the family's participation in the service delivery system and particularly in the planning and provision of services for their child or family.

The following are guidelines and recommendations for involving parents in a meaningful way. They have been drawn from focus groups with both professionals and parents; studies conducted with professionals and families in Virginia on family involvement; consultation with staff and members of Parents and Children Coping Together (PACCT); and the Principles of Family Involvement adopted by The Federation of Families for Children's Mental Health. Involvement of the family includes involvement of the child for whom services are being sought.

GENERAL GUIDELINES FOR FAMILY INVOLVEMENT

There are several actions agencies can take that will help families increase their ability to work in partnerships with professionals.

1. Support the establishment of a parent support group or groups, which have been shown to be effective vehicles for providing support and information for parents, are not widely available. Agency efforts to assist in the establishment and functioning of such a group offer obvious benefits. These groups have been effective in helping families understand the service system, prepare for FAPT meetings, and use services effectively.

2. Educate service providers on parent involvement.

   Many service providers, particularly in residential care, may be accustomed to working with agency staff instead of families. In some instances, providers may believe that the child needs to break contact with his family in order to focus his attention on the treatment program in the new placement. Visits and telephone calls may be unreasonably restricted and little effort made to involve the family in the treatment process. Among other problems, this philosophy of treatment is contrary to the CSA tenets and is not conducive to a quick return home.

3. Support cultural diversity among professional staff in the community.

   Such diversity enriches all professional staff and the community. It also ensures that when desired, families can receive treatment from providers who hold similar belief systems as their own.

4. Provide flexible funds and services that can be used to meet both individualized and unplanned needs with a minimum of bureaucracy.

5. Provide an orientation for families applying for services for their children. In order for a family to participate in a meaningful way in any service provision process, they must first understand the system within which the services are being provided and the processes that are used to determine service needs. An orientation to service provision should include complete information about the following:

   (a.) Agencies providing services to children and their families. Family participation can be greatly enhanced by information about both public and private agencies and the kinds of services they offer.

   (b.) The information gathered about a child/family. Currently, localities request families to sign release of information forms to allow access to reports such as psychological and psychiatric evaluations, school records, and social histories. Parents often do not know what kinds of information are contained in these reports.

   (c.) How decisions are made. Discuss with parents all the factors that affect decisions about services, i.e., child and family's needs, risk, cost, history of service use, and assessments.

   (d.) Service alternatives. Rarely is there only one way to meet the needs of the child and family. Families need to know the benefits and limitations of all treatment alternatives for their child. They also need to feel that professionals are open to hearing their ideas about what would help.

PARENT INVOLVEMENT IN THE SERVICE PROVISION PROCESS

In addition to the above general principles, support of family involvement is necessary at each step of the service provision process. Guidelines and methods of family involvement are given for: (1) the process of gathering information for a case review; (2) FAPT team meetings and decision making about services; and (3) evaluation of a child's progress, services rendered, and outcomes.

1. Gathering information for case review

A. Help parents and children identify strengths, problems, and solutions. Parents are sometimes overwhelmed with "the problems" and forget about the strengths of their child, their family, and themselves. Also, they often need help with understanding the problem and thinking about the kinds of services that would be beneficial. Whether it is an aide to ride with the child on a school bus, recreational activities, treatment, or residential care, most families know little about possible services. Often, they may have heard positive reports about a service being provided to another child and hope that their child can benefit in the same way. Assistance in developing problem solving and decision-making skills will help them to focus attention on the child's individual problem and the kind of services most likely to be effective.

B. Ensure that all assessments, diagnoses, and treatments are aligned with the cultural beliefs of the families. Explore with the parents how a service will fit within their family, culture, and lifestyle. In a study with parents in Virginia, some of the parents who were interviewed reported discontinuing a service or treatment plan because they disagreed with the plan. None of the parents had shared this information with the treatment providers; instead, they withdrew from the service. Most of the dissatisfactions reported by these parents concerned cultural, religious, and family issues. A couple of common statements were "My family doesn't believe in that" and "it just didn't fit our family."

C. Whenever possible, have the parents work with the case manager to collect the assessments needed for the FAPT, i.e., educational and psychological evaluations, reports from previous treatment providers. Involve parents in deciding what is to be assessed and who will do an assessment.

D. Ensure that treatment plans incorporate the strengths of the child and family. One community reported working with a child with severe behavioral problems who through karate classes was able to learn to control his aggressiveness. The community recognized the child's interest in martial arts and used that to help accomplish the treatment goals.

E. Allow the family to take responsibility for exploring treatment alternatives. Explain the possible treatments and services and help them to think through the kinds of questions they have about services. Encourage them to meet with service providers and tour facilities before making decisions. Once they have made a decision about the kind of service they feel will best help their child, support their decision by advocating for access to that service.

F. Help parents explore their own support system (i.e., families, friends, church) and identify ways that this system can be helpful. Many parents have found that church members or friends are able to help in unexpected ways.

2. Making decisions about services to be provided.

Section 8.1 Utilization Management

For FAPT meetings:

A. Prior to the meeting, review with the parent(s) all information to be presented. Provide them with copies of reports on which the presentation is based. Be sure that parents are included in the distribution of whatever forms or written information is given to FAPT members. Frequently, parents sit in meetings and watch while the professional members of the team refer to stacks of reports on their child and family.

B. Share with the family information on regulations and cost constraints of service provision. Parents understand and accept that funds for services are not unlimited. Their expectations are usually much more realistic and less idealistic than those of professionals.

C. Wherever needed, make efforts to provide transportation and childcare to allow parents to attend meetings.

D. Schedule meetings at times convenient to parents.

E. Include the parents in setting treatment goals.

3. Involve parent(s) in evaluating their child's progress during service provision and evaluating services after completion.

A. Ensure that the evaluation reflects family and cultural issues. When evaluating a child's progress, include achievements and goals that have been jointly decided with the family. When using standardized evaluation instruments, ensure that they are valid for the family's culture.

B. Ensure that information collected is only what is needed. Whatever the reason for the evaluation (program modification, monitoring a child's progress, or overall service evaluation), parents are usually happy to participate if they feel that what they have to say is valued and that questions are not unnecessarily intrusive.

C. Use evaluation processes that include the parent's assessment of a child's progress, the benefits and problems of the service, and outcomes.

D. Explain the locality's Utilization Review process to the parent and how it is an important quality assurance tool, but that the ultimate decisiona are always made by the FAPT , of which the family is an integral member.

The following references provide additional information:

Curtis, W.J., & Singh, N.N. (1996). Family involvement and empowerment in mental health service provision for children with emotional and behavioral disorders. *Journal of Child and Family Studies,* 4, 503-517.

Federation of Families for Children's Mental Health. *Principles of Family Involvement in the Development and Operation of Managed Health and Mental Health Care Systems for Children and Youth.* July 7, 1995.

Singh, N.N. (1995). In search of unity: Some thoughts on family-professional relationships in service delivery systems. *Journal of Child and Family Studie*s, 4, 3-18.

Singh, Nirbhay N. (in press). Cultural diversity: A challenge for evaluating systems of care. Chapter in Michael H. Epstein, Krista Kutash, and Al Duchnowski (Eds.), *Community-based Programming for Children with Serious Emotional Disturbance and Their Families: Research and Evaluation.* Austin, TX: Pro-Ed.