

**THE MULTNOMAH COUNTY CAPS PROJECT:
AN EFFORT TO COORDINATE SERVICE DELIVERY
FOR CHILDREN AND YOUTH CONSIDERED
SERIOUSLY EMOTIONALLY DISTURBED**

A PROCESS EVALUATION

Therapeutic Case Advocacy Project

**Research and Training Center to Improve
Services for Seriously Emotionally
Handicapped Children and Their Families**

**Regional Research Institute for Human Services
Portland State University**

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A Process Evaluation

October 1986

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to Improve Services for Seriously Emotionally
Handicapped Youth and Their Families**

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The authors of this document, the Therapeutic Case Advocacy (TCA) Project, would like to acknowledge the work of many individuals who made the CAPS Project possible. The project is a significant attempt to enhance the delivery of service to seriously emotionally disturbed (SED) children and youth in Multnomah County. Several individuals must be mentioned when considering the project's success in its first year, including: Davene Cohen, Program Developer for the Multnomah County MED Program Office; Dave Pump, Supervisor of the Multnomah County School Mental Health Program; Elizabeth Geishecker, Shari Teasdale, and Tracy Waters, the CAPS Coordinators; the CAPS Work Group; and the Multnomah Board of County Commissioners.

As we have experienced with the TCA Project, it takes courage to assert and implement innovations in human service delivery, particularly with a population as vulnerable and volatile as SED children, youth, and their families. Indeed, one has to be even more courageous to subject a first year pilot project to outside scrutiny or evaluation. Therefore, in addition to those mentioned above, we acknowledge the efforts of the MED Program Office, the Center for Community Mental Health, Delaunay Mental Health Center, Mental Health Services West, Morrison Center, and a host of autonomous agencies who participated in and supported the project.

Undoubtedly the first year achievements of the CAPS Project were largely dependent upon the cooperation between multiple agencies, and to a degree, demonstrates what can be accomplished through coordination and collaboration. If this inter-agency interdependence is nurtured and cultivated, the Multnomah County CAPS Project will improve the lives of children and youth considered emotionally disturbed and their families. Further, the CAPS Project can only add to the theoretical knowledge base with respect to coordinating service delivery to this troubled and troubling population.

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B. Multnomah County School Mental Health Program Supervisor

INTRODUCTION

In October 1984 a Research and Training Center to Improve Services for Seriously Emotionally Handicapped Children and Their Families was established at the Regional Research Institute (RRI) of Portland State University's Graduate School of Social Work. The Center was funded conjointly by two federal agencies: the National Institute for Handicapped Research (NIHR) within the U.S. Department of Education and the National Institute for Mental Health (NIMH) within the U.S. Department of Health and Human Services.

The Center houses several projects devoted to improving services for emotionally handicapped children and their families and a Resource Service that issues a newsletter quarterly entitled Focal Point. Although each project has its own specific emphasis, all of them reflect the Center's general view that services for emotionally handicapped children and their families can be improved to the extent that they are ecologically based, family centered, advocacy oriented, and functionally specific.

The Therapeutic Case Advocacy Project is developing a model of interagency collaboration that combines case advocacy, case management, and therapeutic interpersonal skills in order to establish and maintain a system of care surrounding these children and their families. We think of the model as being multi-level in nature because it addresses the family and child, the organization employing the Therapeutic Case Advocate, and the interagency network that makes possible the coordinated provision of services that help make up the system of care.

The details of the model, including the skills that have to be acquired and the kind of organizational support that must be developed to sustain it, are being assembled in a Therapeutic Case Advocacy Training Manual and Worker's Handbook that will be distributed nationally along with a videotape illustrating the model's application and an extensively annotated bibliography on case advocacy.

This report is itself a product of interagency collaboration that we have decided to publish separately as a case study in the process of developing interagency collaboration on behalf of emotionally handicapped children and their families. Technically, it is a process evaluation we agreed to carry out for the Multnomah (Portland, Oregon) Board of County Commissioners. The Board had set aside special funds for a demonstration project (the CAPS Project) to promote greater coordination among the County's School Mental Health Program and the five Community Mental Health Centers serving Multnomah County. They asked us, through Davene Cohen, Program Developer for children's mental health services, to conduct an evaluation of the process through which the project organized, publicized, and established itself during its first year, fiscal year 1986. This provided us with an unusual opportunity to observe firsthand the trials and tribulations of creating a multi-agency pilot project. We are grateful particularly to Dave Pump, Supervisor of the Multnomah County School Mental Health Program, for the access he provided us to all of the planning meetings among the participating agencies.

We feel very fortunate to have had this opportunity. It allowed us to study the problems involved in creating an interagency service network without having to defend or justify our own model. As it turned out, the CAPS Project provided us with repeated illustrations of the need for such a model that could serve to unify and integrate a worker's (or several workers') efforts with their own agency, the child and family, and the network of agencies working together to provide a coordinated system of service and care.

The Table of Contents follows the outline for the evaluation we developed with Ms. Cohen, Mr. Pump, and the CAPS Coordinators. We call attention to it here because some readers may wish to focus on different aspects of the process. For example, although CAPS did have the benefit of new resources to develop a

program, there was no administrative mandate requiring agencies' participation. Indeed, for many agencies, there was not even a financial incentive to collaborate. Thus, the sections on Project Background (I) and the CAPS Work Group (II) provide contextual information that may be of considerable importance to readers working in other jurisdictions.

Similarly, the CAPS Team Process (III) section describing roles and the possibilities for role confusion may be of even greater interest to those readers who are trying to figure out a way to coordinate services among agencies without creating either a separate agency or yet another layer of administration within each of the participating organizations. Finally, the Recommendations (V) will be of considerable interest to program developers and supervisors at the local level like Davene Cohen and Dave Pump. These recommendations reflect their concern for the programmatic "nuts and bolts" necessary to get the job done.

I. Project Background

A. Source of Funding Rationale

The CAPS Project was influenced by the work of several local committees, individuals, and agencies. In 1984, the Multnomah County Children's Mentally or Emotionally Disturbed (MED) Work Group recommended that a multi-system pilot project was needed to demonstrate the feasibility of coordinating the delivery of services to seriously emotionally disturbed (SED) youth and children. The Public Agency Forum considering the same issue identified the need for integrating services delivered to SED youth in transition (i.e., youth "aging" out of the youth mental health system into the adult system). The Multnomah Target Child Committee suggested that SED youth with multiple problems or involved with multiple agencies often fall through the cracks in the absence of service coordination. And, the Multnomah Board of County Commissioners' Youth Resolution identified the need for service coordination to enhance service delivery for youth and children involved with multiple agencies.

The efforts of these local entities had a common focus. Essentially there was consensus in the perceived need to align school mental health services, youth mental health providers, auxiliary services, and resources in a given community such that: (1) programs do not compete over the same children; (2) the respective roles of providers of treatment, services, and resources are better understood, utilized and supported; and (3) providers would recognize their common interests and develop methods of interagency collaboration to comprehensively deliver services to SED youth and children.

Multnomah County responded to this documented and perceived need on the part of SED youth and children by requesting "add" packages in FY 84-85. The add packages revealed that submitters focused on two primary areas: (1) mental health outpatient services; and (2) school mental health services. Eventually this dual focus was collapsed into one general concept that would have one funding base.

The concept that was funded provided service coordination for SED youth and children who are involved with two or more service agencies, or in cases where more than one type of service (including mental health) is required and where an integrated service plan that involves the County's School Mental Health Program, the mental health provider agencies, child welfare agencies, juvenile justice programs, or other services are required.

Multnomah County appropriated \$100,000 to develop and implement a SED youth service coordination program. The program, operated over FY 85-86, was administered by the Multnomah County School Mental Health Program. The School Mental Health Program hired two CAPS Coordinators to assemble service teams and facilitate interaction between interagency representatives and service staff.

B. Selection of Participating Organizations

Multnomah County provides child mental health services through community mental health centers (CMHC's) in each of the five geographic areas. These agencies are:

1. The Center for Community Mental Health (Northeast Portland)
2. Delaunay Mental Health Center (North Portland)
3. The Morrison Center (Southeast Portland)
4. The Morrison Center (East County)
5. Mental Health Services West (West Portland)

The participation of the provider agencies was essential in that they would provide CAPS with service assured slots to youth mental health services in a given geographic area. The service assured slots were needed since many youth and families seeking services fall through the cracks while awaiting mental health treatment. Part of the CAPS eligibility criteria requires attendance at a publicly funded school, necessitating involvement by the Multnomah County School Mental Health Program. Hence the CAPS staff and provider agency staff would comprise the nucleus of a unique, interagency service team. In addition to CAPS and School Mental Health staff on a child's personal service team, other agencies represented would be determined by several factors including:

- o the needs of the child identified on the CAPS service plan;
- o needs identified by the family, workers, or the child; and
- o needs identified by agencies who provided service to a given child.

The CAPS approach by design establishes an interagency team around the child which extends beyond the more frequently used, yet limited, intra-agency service team.

An important consideration in the development of any team process would be the team's ability to recruit and draw upon the experience, wisdom, and expertise of those working on behalf of SED children. Of special importance to the CAPS Team was the identification of all agencies and individuals who were currently providing or who have previously provided services to SED children. This focus would aid in the development of comprehensive systems of service.

In considering the range of services needed for SED children and youth, it was recognized that many auxiliary services and resources, in addition to mental health services per se, could be coordinated to affect mental health in youth and children positively. For example, agencies such as Adult and Family Services (AFS), Children's Services Division (CSD), the Juvenile Court, the Private Industry Council (PIC), youth service centers, and the Park Bureau could be integrated into the system of care in order to enhance and support a CAPS service plan.

It was essential for the CAPS Coordinators to make outreach efforts to a variety of community based service providers who could be potential CAPS Team Members. "Autonomous" agencies or voluntary participants would not be compensated monetarily for their involvement with CAPS; however, their support would be solicited with the idea that mutual service goals could be met through collaboration and coordination to establish systems of service or continuums of care for SED youth and children. Moreover, autonomous participant agency efforts would be greatly facilitated by the activities of an interagency task group in achieving a youth's service or treatment plan.

In time, involvement of such a coordinating body such as CAPS could lead to quicker and less obstructed access to services, reduce duplication and fragmentation, and generally allow the evolution and delivery of comprehensive services. In this light, participation on behalf of autonomous agencies on the CAPS Team can benefit both the client and family as well as the agencies involved with a given youth or child.

C. Initial Goals and Assumptions

By design the CAPS Project seeks to coordinate mental health and auxiliary services delivered to SED youth and children in a given community. From a program development perspective, CAPS is a pilot project that enhances the

impact of mental health treatment by reducing the number of children falling through the cracks and by aligning school mental health and youth mental health resources with other community based resources and services. The end result is a comprehensive service plan, coordination, and the establishment of a system of service continuum for youth and children in their respective communities.

The CAPS concept resulted in the intent summarized below:

1. To enhance networking efforts by mental health, social service and school representatives for children/families who need mental health treatment services.
2. To bridge gaps in service between out-of-home day treatment programs and community-based outpatient treatment.
3. To weave a web of support for children in transition.
4. To reduce duplication of services.
5. To reduce services at cross purposes.
6. To improve continuity of care for children and families.
7. To weave a web of support for agency representatives involved in providing care for these difficult children and families.
8. To contribute to the knowledge base of eligible youth unserved by CAPS.

D. Revised Goals and Assumptions

It is not easy to discern if there was an actual shift in the goals and assumptions supporting the project. However, as the project unfolded CAPS personnel recognized the difficulty in assembling and coordinating an interagency service team comprised of individuals from diverse backgrounds, disciplines, fields of practice, work styles, and personalities. Despite the documented pervasiveness of problems caused by poor coordination between organizations, current literature on this subject contains surprisingly few guidelines for solving them and even fewer recommendations for designing interorganizational linkages to achieve better coordination.

The CAPS Coordinators focused on two primary objectives: (1) assembling and facilitating the interorganizational service teams; and (2) recruiting support from autonomous agencies who could provide a service or resource essential to mental health treatment of SED children and adolescents. The former proved to be a real chore initially, but was handled as the CAPS Coordinators became more comfortable with the coordinating role. The latter, however, proved to be an ongoing responsibility in the sense that it may not be possible to predict the range of resources, services, and supports necessary to deliver comprehensive and coordinated mental health treatment. Thus, a shift in goals and assumptions may be seen in terms of the rigors faced by CAPS Coordinators in: (1) coordinating the CAPS Teams; (2) recruiting and sustaining membership; and (3) establishing additional supports (both formal and informal).

Indeed, one measure of CAPS' achievement in its first year was the degree of interagency involvement and cooperation it was able to foster. Another achievement was the awareness that this was a project that would need to be nurtured if it was to mature or develop properly in future times.

E. The Planning Superstructure

The project was to be field developed and because of its complexity would require considerable planning. As a result, the MED Program Office assembled a planning committee or a CAPS Work Group to further flesh out the CAPS model. The Work Group consisted of:

- o representatives from each of the contract agencies;
- o the Multnomah School Mental Health Program Supervisor;
- o the MED Program Office Program Developer responsible for child and youth programs;
- o the CAPS Team Coordinators; and
- o staff of the Therapeutic Case Advocacy Project of the Research and Training Center to Improve Services to Seriously Emotionally Handicapped Youth and Their Families.

The work group would meet regularly to determine how CAPS should be implemented. The staff of the Therapeutic Case Advocacy Project would monitor the progress of CAPS and subsequently conduct a process evaluation.

F. Definition of the Target Population

In a preliminary draft, the population to be served by CAPS was identified for discussion by the Work Group. The children and adolescents eligible for the CAPS Team Project would be:

- o children who have experienced multiple out-of-home placements;
- o victims of abuse, neglect, parental death, and custody shifts;
- o children presenting symptoms of mental disorder who are at risk of removal from school and/or home;
- o children whose parents are chronically mentally ill, acutely mentally disabled, substance abusers, or in the correctional system; and
- o children exhibiting impaired relationship capacity or bizarre behavior.

In addition, the children and adolescents eligible for the CAPS Team Project will be those who:

- o have a need for mental health services as documented by a qualified mental health professional;
- o will benefit from networking services from mental health, social, justice and educational agencies and are able to attend a publicly funded school;
- o present one or more of the following characteristics:
 1. are currently placed out-of-home
 2. have returned to the community within the last six months, or
 3. require transition support to sustain intervention gains or maintain current placement.

This was a working definition subject to amendment by and approval of the CAPS Work Group. Section II,B contains the final version.

II. The CAPS Work Group: Planning the Project

A. Work Group Formation

The formation of a CAPS planning committee was an essential step to implementing the concept. The planning committee or CAPS Work Group was comprised of representatives of children's mental health provider agencies and School Mental Health Program staff. By including the primary participants in planning the implementation of CAPS they gained ownership

of the applied concept and were assured that CAPS would not create a new imposition on participating agencies.

Establishing a CAPS Work Group was to a marked degree an acknowledgment that the County's providers of children's mental health services operate differently. Moreover, the project required a different approach to receiving cases. This is a particularly important issue because many SED youth fall through the cracks at this juncture. This variation reflects the notion that the provider agencies in their respective geographic areas are designed and structured to best meet the service needs and environmental contexts of their constituents.

On the other hand, this diversity makes the quest for consensus over programmatic issues a little harder to achieve. This is exacerbated in two ways: (1) the represented agencies had to uphold the integrity of their programs with respect to varying service objectives, operating procedures, service capabilities, and community resources; and (2) convening a group of individuals of diverse backgrounds, disciplines, fields of practice, work styles, and personalities is often very difficult.

Their collaboration appeared to occur based on mutual service goals and objectives. Understandably, as the perception that CAPS would not be imposed from the top down (i.e., from the County administration to program staff), cooperation increased.

The concept was not difficult to market as many agency representatives suggested that "some of us already do what CAPS intends to do." This comment serves as a backhanded endorsement of the CAPS concept, but it also implies even more. Collaboration or coordination previously took place as a result of a worker's individual initiative as opposed to reflecting any programmatic goal or objective. The CAPS Coordinator role became better articulated as a result of Work Group discussions. Essentially, coordination of services delivered to SED children and youth was perceived by the Work Group as the primary focus of the CAPS Coordinator and the direct provision of service (i.e., mental health treatment) remained the primary responsibility of the provider agencies.

The CAPS Work Group met to develop operational procedures including defining the target population, eligibility criteria, referral procedures, releases of information, and case follow-up, for example.

The CAPS Work Group was a critical element in the implementation of the project. Its work did not end as CAPS became operational. In fact, the Work Group continues to convene to discuss and evaluate the project, its procedures, and its impact.

B. Establishing Procedures for CAPS Team

A primary responsibility of the CAPS Work Group was to establish project operating procedures. Two central issues emerged that were strongly considered: (1) if coordination posed a threat to the autonomy of the provider or volunteer agencies to be coordinated, then they may be less likely to fully participate; and (2) the ability to reach consensus or make decisions between provider agencies would greatly affect the degree of cooperation, and ultimately CAPS progress. Essentially the Work Group had to remain sensitive to the varying requirements in coordinating a child and adolescent mental health service team model comprised of multiple agencies.

The Work Group as often as possible attempted to reach consensus on standards and procedures; however, this was not always possible. For example, the way in which the CAPS Coordinators make referrals to the provider agencies could have been an obstacle to progress. This was due to

the varied approaches in which the providers conduct intake. Since many SED youngsters get lost at this juncture, it was essential that a referral process be developed that accommodated the providers' differences, yet did not create problems for others (e.g. CAPS Coordinators, youth, families, etc.) involved in the process. Each Work Group member identified how their intake system worked generally, but more importantly, particularly outlined how intake would work for CAPS referrals.

The Work Group agreed to holding eligibility meetings to determine the appropriateness of referrals and would guarantee access to cases and potential interagency team members. This procedure would both refine and expedite the referral process, and greatly reduce the possibility of losing an SED youth or child at this critical stage.

Another procedural issue that was resolved with some effort involved the release of confidential information. Interagency linkages and lines of communication are necessary because (except in rare cases) no agency is capable of meeting the needs of SED children in isolation. However, sharing sensitive information is not something that can be informally pursued--most administrators fear the possibility of lawsuits resulting from the abrogation of mandated confidentiality. Moreover, the release of information policies were not standardized to the point that agency representatives could guarantee the transfer of information without speaking with their boards, attorneys and agency directors. The County's attorney developed a release authorization form that was eventually agreed upon by all provider agencies. This allowed the agencies to collaborate, brief one another as to relevant information, review prior intervention, and ultimately develop the interagency or CAPS Team service plan.

Perhaps the most frustration resulted from establishing eligibility criteria. For the first year of CAPS the target population was clarified to those who:

- o had a documented need for mental health services;
- o will benefit from networking services from mental health, social service, juvenile justice, and educational agencies and who were eligible to attend a publicly funded school;
- o present one or more of the following characteristics--
 1. are currently placed out-of-home; or
 2. have returned to the community within the past six months; or
 3. require transition support to sustain intervention gains.

In addition, target children and adolescents would be selected from the following high risk populations:

- o Children who have experienced multiple out-of-home placements.
- o Victims of abuse, neglect, parental death, and custody shifts.
- o Children presenting symptoms of mental disorder, who are at risk of removal from school and/or home.
- o Children whose parents are chronically mentally ill, acutely mentally disabled, substance abusers, or in the correctional system.
- o Children exhibiting impaired relationship capacity or bizarre behavior.

By refining this two-level screening system, the Work Group was able to practice their problem solving and decision making skills by establishing

the various procedures. This served as the foundation for their future interaction in developing a CAPS model that would prove compatible with existing provider agency policies and standards.

C. Special Issues/Potential Barriers: The Planning Stage

1. Initial Barriers to Implementation

Perhaps the most significant barrier to CAPS' implementation was developing a referral process from the children's social service community to the project. Some staff from the public schools, Children's Services Division and the juvenile court initially referred children to CAPS for an assessment--not understanding that it was their (the referral source) responsibility to obtain assessments prior to referral to CAPS--and further, that the referral was also an implied commitment to participate in a team process. Keeping the referring and other agencies involved was the second major barrier to program implementation.

The first barrier has been removed. The County's provider agencies of children's mental health services appeared to understand how the CAPS referral process will work. Further, the Work Group meetings discussed what "priority access" would mean operationally to the provider agencies. The Work Group also identified what interagency "team participation" meant operationally when they considered what activities the "CAPS enhancement" of the usual cost reimbursement formula would cover.

The other providers of services, however, are not yet as clear in their understanding. They were not participants in the Work Group and, for the most part, do not receive any financial reward for participating in the inter-agency team process. While the CAPS Coordinators should be credited with soliciting the support of autonomous agencies, there is still more community education about the project necessary. More importantly, the County's MED Program Office may need to spend more time defining the CAPS target population. At this point in time, the current definition appears to be weighted in favor of enhancing services for children returning to community placements from residential treatment facilities.

2. The Process of Overcoming Barriers

The Work Group will continue to play a major role in surmounting barriers. They must refine the target population so that potential referral sources from the children's social service community can make more appropriate referrals. The Work Group members must take a more active role in identifying additional autonomous agencies who are willing to participate in CAPS.

The Work Group's approach to problem solving and decision making was quite valuable to CAPS. They discussed a range of issues and implications surrounding the project's implementation. The School Mental Health Program and provider agency participation will serve to increase the planning and problem solving resource base of the project. For the first year their interaction was invaluable and certainly in the next year the Work Group's role will be equally vital.

3. Financial Concerns

The provider agencies were very concerned about reaching the service objective of 16 (sixteen) cases to receive CAPS "enhancements" (i.e.,

services). This apprehension stemmed from the fact that provider agencies would only have six months to achieve this goal. The MED Program Developer reluctantly agreed that eight of the 16 cases could be existing cases in the provider agency's open files. This compromise was politically necessary to deflect attention from the service objective issue so that cooperative planning and field development could continue.

The cases served by the County's provider agencies are funded through a variety of revenue sources. However, provider agencies were expected to provide 16 cases with the CAPS enhancements. The provider agencies and the MED Program Office agreed to this arrangement since it eliminated the possibility of CAPS providing and funding services that could be paid through other revenue sources.

4. Confidentiality

As mentioned previously, mental health agencies are quite guarded about releasing sensitive information. The key to many interagency task groups is directly related to their ability to share relevant information. The Multnomah County MED Program Office spoke with the County's attorney to develop a release authorization form that could accommodate the CAPS interorganizational model. This document was approved by the legal representatives of provider agencies; however time consuming, it was a very necessary activity.

III. The CAPS Team Process: Interagency Collaboration to Provide Coordinated Services

A. Clarifying Roles

As the CAPS Project began to unfold it was important to delineate the respective roles of CAPS team members. In particular, the roles of the CAPS Coordinator, the provider agencies and the case coordinator were identified.

The CAPS Coordinators, as seen by the Multnomah County School Mental Health Program, have three primary functions. They are listed below:

1. Coordinating the assembly and continuity of the inter-agency team for each child;
2. Serving as a primary provider of mental health services for some children; and
3. Serving as a secondary provider of mental health or mental health related services for some children.

This is obviously a tall order to fill, and required that the CAPS Coordinator possess skills in affiliation building, skills in case management, and skills in providing direct services to SED children and youth.

The CAPS Coordinators must also be politically astute, systems oriented, and adept at group management. The interagency team is, by design, unique to each child and the job of the coordinator is to bring about consensus and maintain it. (This is not always a simple task. Some of the agencies represented in the Team may have had some unpleasant histories with each other, or no history at all in integrated service delivery.)

The CAPS Coordinators were central and indispensable to the first year success of the project. A major obstacle for the future, however, is that

CAPS Coordinators must identify a case coordinator for each CAPS Team. Otherwise, the CAPS Coordinators are thrust into a case coordinating role which may yield a logjam that prevents the CAPS Coordinators from responding to the needs of new cases. Further, as CAPS Coordinators perform more marketing of the concept and outreach, assembling and facilitating interagency teams, and generally coordinating service teams, case coordination becomes even more of an imposition.

The CAPS Coordinators spend considerable time on pre-meeting and post-meeting activities. Typically, this involves briefing and de-briefing interagency team members. Pre- and post-meeting activities are essential for soliciting participation by provider and autonomous agencies, but it also helps focus the team's activities and resolves. Coordinating the initial meeting and review meetings are demanding; however, fully coordinated initial and review meetings are a critical element in securing and maintaining the voluntary participation of the many autonomous agencies providing services to youth and children in and around the County.

The provider agencies are integral to CAPS because of the assured slot they offer. Provider agencies, in addition to providing mental health services, were also required to participate on the CAPS Work Group and the CAPS Team.

B. Accountability

The CAPS Project established criteria for review meetings which were the primary mechanism for accountability. As long as they are scheduled, the (peer group's) social pressure keeps most participants accountable. This, of course, illustrates why initial understanding of the project and the process is so important; except for the primary providers of mental health services, participation is and remains voluntary. Thus, at the interagency level, CAPS relied on peer pressure and review meetings to keep team members focused and committed.

At the case level, the CAPS Work Group was able to design and utilize accountability forms which identified timelines, delegated responsibilities case coordinator, CAPS Coordinator, and tasks to be completed. Using this form and keeping it with the case record was a built-in accountability measure.

IV. CAPS Team Project Summary of Services

A. Number of Children Referred/Accepted

Thirty-five referral packets were received by CAPS between January 1, 1986 and June 30, 1986. Of the 35, 24 were formally accepted for CAPS services.

B. Distinguishing Characteristics of Cases Not Accepted

The following is a breakdown of the reasons that 11 cases did not participate in the project.

Eligibility Pending	4
Child Refused Treatment	1
Premature Referral	
Child Still in Hospital	1
Child Over Age Limit	1
Provider Agency Determined CAPS Services Are Not Needed	1
Remanded to Adult Court	1
No Documented Mental Health Need	1
No Need for Coordinated Services	1

— II

C. Summary of CAPS Services Provided

Of the 24 cases accepted for CAPS services, 14 were existing cases already receiving services from one of the four children's mental health service agencies. Of these 24 cases, ten are from out-of-home placements and one is living with a relative.

Of the 24 cases accepted by CAPS, only two cases have not had the initial review. Twenty-two cases have had the initial meeting and one review; ten have had the initial meeting and two reviews; and, three cases have had the initial meeting and three review meetings.

Case distribution by provider agencies is identified below:

<u>Provider Agency</u>	<u>Number of Cases</u>
Morrison Center	8
Center for Community Mental Health	8
Delaunay Mental Health Center	6
Mental Health Services West	0
Multnomah County School Mental Health Program	2
	<hr/> 24

Referral sources for all 35 cases are as follows:

<u>Referral Agency</u>	<u>Cases</u>
Morrison Center	8
Children's Services Division	5
Center for Community Mental Health	8
Riverside Hospital	1
Delaunay Mental Health Center	5
Oregon State Hospital	2
Multnomah County ESD	2
Renolds High School	2
Parkrose Special Education	1
School Mental Health	1
	<hr/> 35

D. Programmatic Summary

Perhaps the most significant accomplishments of the CAPS Project in FY 85-86 are not revealed numerically. A major task accomplished involved designing the model itself. This was done in concert with the CAPS Work Group and it was not easy to reach consensus or to develop compromises that were mutually acceptable. Thus, the CAPS Project, after a year of field development, has evolved into something more tangible and credible.

Proceduralization took place in FY 85-86 such that the CAPS Project has routinized and standardized how the CAPS Teams will operate. Further, the procedures established will greatly enhance the degree and facility of interagency collaboration and cooperation.

Perhaps the most important accomplishment has been the project's capacity to overcome a variety of barriers. The ability of the CAPS Work Group to reach an impasse and go beyond is a major structural achievement. As a result, CAPS has developed a method of structurally responding to issues and problems facing the project participants (i.e., CAPS staff, provider agencies, and MED Program Office). When considering the interagency aspect

of the project, CAPS appears well able to surmount any previous, current or emergent barriers.

V. Recommendations

This section will present some primary recommendations for enhancing the CAPS Team Project. The recommendations are from two key individuals: (1) the Multnomah County Social Services Division MED Program Developer, who initiated the concept and participated in the implementation; and (2) the Program Supervisor of the Multnomah County School Mental Health Program, who was responsible for the administration of the CAPS Team Project.

A. Comments of the Program Developer

The Program Developer was generally pleased with the development of CAPS over its first year of operation. She felt, however, that the project staff may need to mount an aggressive public awareness effort. It is possible that, with the production of printed materials such as brochures or pamphlets and through an outreach campaign to agencies and community based organizations, CAPS would be increasing its support base considerably.

Such a public awareness approach could have some valuable results. It may be valued for presenting to the general public some of the problems faced by SED youth and families and how both formal and informal resources can be utilized to establish a continuum of care. Also, public awareness from an agency perspective can acquaint external or autonomous agencies with CAPS criteria, services, and team processes.

Both the printed materials and outreach aspects of public awareness can expand the continuum of care network. Agencies such as the Private Industry Council, the Juvenile Court, the Park Bureau, Health Services, Youth Service Centers and other youth serving agencies can potentially play a vital role in providing service and participating on a CAPS Team for a given case. Informal resources and supports such as extended family, religious organizations, philanthropic organizations, fraternal groups, self-help and advocacy networks can give the CAPS Team, as well as the service plan, a more community based perspective.

The details of the CAPS Coordinators' role may need to be reconsidered. The Program Developer felt that the Coordinator assumes a posture of neutrality or objectivity by not being a direct service provider who may have a vested interest in a CAPS case. Further, this neutrality seems to disarm agency representatives and staff, making the process of accessing services or soliciting support from them less vulnerable to interagency conflict or unpleasant histories between certain agencies. The concern is that as the Coordinator assumes direct service responsibilities s/he may compromise her/his ability to network with autonomous agencies. When assembling and facilitating the CAPS Teams, neutrality is an important aspect of coordinating the activities of diverse individuals and the various agencies they represent.

It was suggested that CAPS Teams should perform termination planning to assure that client progress made during CAPS' involvement has a greater chance at being sustained. In addition, termination planning will present an opportunity to evaluate the success or drawbacks to interagency service delivery to this SED population.

Several issues remain unclear to date. For example, the CAPS' "saturation point" has failed to be identified. In the first year, CAPS appeared as the vacuum that fills itself. However, as CAPS continues for another year, the question becomes, "How many SED youth and children can the project effectively serve?" It is still unclear as to what degree of interagency

collaboration can occur until the process becomes too unwieldy or rife with conflict, such that the dissonance created is unmanageable.

B. Comments of the School Mental Health Program Supervisor

The CAPS Project was administered by the Multnomah County School Mental Health Program Supervisor.

The administration of CAPS was the responsibility of the Multnomah County School Mental Health Program Supervisor. Although the Program Supervisor was encouraged by the project's accomplishments in its first year, he feels the next major step in the evolution of CAPS will involve establishing written interagency agreements. Based on the service objectives of various agencies, these agreements could be developed through negotiations with the MED Program Office to satisfy service goals held in common among prospective service providers. Among other benefits, these agreements can serve to reduce barriers between and to services, refine and expedite referral and feedback processes, and generally assure the involvement of and support by relevant agencies and organizations.

There was concern expressed regarding the role of the CAPS Coordinators. In the future, it may not be possible for two CAPS Coordinators to attend initial meetings or review meetings given the lack of additional staff. This situation becomes even more acute if CAPS Coordinators conduct a public awareness or community outreach campaign--which are activities envisioned by the Program Supervisor.

The issue of CAPS Coordinator as case coordinator may also re-emerge. Case coordination closely resembles case management which is a time intensive activity that may compromise the CAPS Coordinator's ability to manage the CAPS Team. Thus the concern is that as case coordination becomes the responsibility of the CAPS Coordinators, the systems level duties that the project hinges upon may suffer.

The definition of the target population may require more work. The Program Supervisor would like to see the CAPS Work Group and the MED Program Office consider revising the current definition. He feels the current definition is weighted in favor of enhancing services for children returning to community placements from residential treatment programs and would prefer at least an equal emphasis be placed on children at risk of placement in residential treatment facilities.