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PB ²Performance Report

No. 98-43 **January 1999**

Children's Mental Health Measures Need Refinements, Additions to More Effectively Assess Program's Efforts

This report assesses the performance of the Department of Children and Families Alcohol, Drug Abuse, and Mental Health (ADM) Program, Children's Mental Health sub-program on 1997-98 measures and comments on measures proposed for 1999-2000 under performance-based program budgeting (PB²).

Summary

- **Past Performance, Fiscal Year 1997-98.** Because of questions about data reliability and performance standards, the Legislature should not use the approved PB² measures to assess the performance of the Children's Mental Health (CMH) sub-program for the 1997-98 fiscal year. These questions relate to the accuracy of the data. The performance standards were based on an insufficient sample of the target client populations and subsequent increases were not related to reliable performance criteria. Although changes have been implemented to improve data reliability, the impact of these changes has not been assessed. (See Appendix A for further discussion.)
- **Proposed Performance Measures, Fiscal Year 1999-2000.** We suggest further refinements and additions of performance measures to develop a more comprehensive accountability system. While the existing measures are good indicators of the program's performance in general, they need to be modified. For example, the sub-program needs to increase the response rate of surveys of family satisfaction with services and include the measurement of the change in clients' functioning while receiving services. Also, new measures should include a method for assessing whether clients live in the least restrictive setting and the reason for clients' discharge from treatment. Further, we recommend that the department include an output measure that links costs of services to clients served. (See Appendix B for more detailed discussion.)
- **Rating of Program Accountability.** The sub-program's accountability system needs to be improved. It needs some modification in its definition of program purpose, performance measures, and use of performance data by management. The sub-program needs major modification in its efforts to ensure data reliability.

Background

Sub-Program Purpose: This sub-program provides services to children and adolescents with mental health problems to enable them to live with their families or in the least restrictive setting, and to function in school at a level consistent with their abilities**.**

Sub-Program Summary: The provision of children's mental health services will change as a result of legislative action during the 1998 legislative session. The "Comprehensive Child and Adolescent Mental Health Services Act" became law in the 1998 legislative session (Chapter 98-5, Laws of Florida). It provides a statutory framework for the system of Children's Mental Health that focuses on the client, involves the family, and is community based. In addition, it defines the target populations to be served and provides performance outcome measures that specify stabilization or improvement of the emotional condition or behavior of the child.

The sub-program is administered by the Department of Children and Families, and all children's mental health services are delivered either through contract, rate agreements, or fee for service purchase from private for profit and non-profit service providers. The department purchases children's mental health services from 211 private service providers. Providers include community mental health centers, private psychiatric hospitals, and private mental health professionals.

Client Services

The sub-program provides two types of services.

Non-residential mental health services include case management, assessment, outpatient therapy, intervention, and day treatment.

Residential mental health services include crisis stabilization services, case management, mental health treatment, and transitional services for children being discharged from residential treatment programs. Services are provided in hospitals, residential treatment centers, therapeutic foster homes, group homes, and wilderness camps.

(See Appendix C for Description of Services.)

Clients Served

In Fiscal Year 1997-98, the CMH sub-program served 45,595 children in the following categories:

- children and adolescents with a serious emotional disturbance (SED) {22,104 clients};
- children and adolescents with an emotional disturbance (ED) {13,101 clients}; and

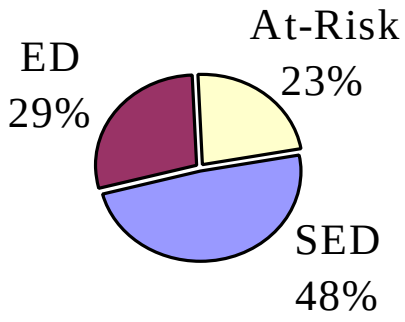
- children and adolescents at risk of developing an emotional disturbance {10,390 clients}.

The severity of emotional disturbance is determined by several factors, related to the degree that it interferes with functioning in the family, school, or community. (See Appendix D for definitions of these client groups.)

According to the department, children in the custody of the state through the child welfare and the juvenile justice system are given priority for service.

Approximately one-half of the client population served were children and adolescents with severe emotional disturbance.

Client Population Served
Fiscal Year 1997-98
(n = 45,595)



Source: Department of Children and Families' 1999-00 D-2 Budget Form

Sub-Program Resources

Program Allocations, Medicaid, and Local Match Expenditures, Fiscal Year 1997-98

Funding Source	Administration (Districts and Central Office)	Children's Mental Health Services	Total
General Revenue	$1,140,045	$ 63,542,981	$ 64,683,025
Trust Funds		14,779,240	14,779,240
Medicaid		143,700,000	143,700,000
Total	$1,140,045	$222,022,221	$223,162,266[1]

[1] Section 394.76(3)(b), Florida Statutes, requires Alcohol, Drug Abuse, and Mental Health funds to be matched by local funds. These funds may be cash or "in-kind" contributions, such as salaries, office space, and facilities maintenance. For Fiscal Year 1997-98, DCF reported the total amount of local match for the Children's Mental Health Sub-Program was $25,846,333. This figure had not been audited as of December 1, 1998.

Source: Department of Children and Families

The department reports that there are 26 FTEs allocated to the Children's Mental Health Sub-Program in the districts and 10 FTEs at the Program Office level.

Children Incompetent to Proceed to Juvenile Justice, a New Target Population for PB^2 Performance Measures for Fiscal Year 1999-00

For the 1999-00 fiscal year, a new target population, children incompetent to proceed to juvenile justice, is included in the department's performance budget. The administrative responsibility for this target population is the Forensic Division of the ADM Program Office who contracts with one provider that is responsible for ensuring that services are provided throughout the state. The goal is to restore children to competency and to enable them to proceed with their judicial hearing. For the 1998-99 fiscal year, the Legislature appropriated $2.7 million to serve 453 children in this target population.

Performance

1997-98 Fiscal Year

The Legislature should not use the sub-programs PB^2 data to evaluate its Fiscal Year 1997-98 performance, because the standards and performance reporting were based on data of questionable reliability. Also, the department has neither verified the adequacy of data collection and reporting procedures used by providers, nor the reliability (completeness and accuracy) of the data. (For further discussion of data reliability, see Rating of Program Accountability.)

For Fiscal Year 1997-98, there was only one target population identified for PB^2 purposes, severely emotionally disturbed (SED) children and adolescents. The program goal specified that children will live with their family, or in a least restrictive setting, and their schoolwork will be consistent with their abilities. For OPPAGA's analysis of the sub-program's performance measures, see Appendix A.

Proposed Performance Measures

Since the Children's Mental Health sub-program was included in PB^2 for the 1997-98 fiscal year, several target groups and sub-groups have been added, more performance measures have been added and revised, and performance levels have been increased. In Fiscal Year 1998-99, two new sub-groups (children with emotional disturbance and children at-risk of developing an emotional disturbance) were added. For Fiscal Year 1999-2000, the department is proposing one additional target group (Children Incompetent to Proceed to Juvenile Justice) and six new measures for this group. While some of the measures need to be modified, other measures should be added to better capture the program's intent. For OPPAGA's analysis of the sub-program's performance measures for the Fiscal Year 1999-2000, see Appendix B.

Rating of Program Accountability

A key factor in PB^2 is that agencies need to develop strong accountability systems that enable the Legislature and the public to assess program performance. An *accountability*

system consists of these key elements: program purpose or goals, performance measures, a process for valid and reliable data, and credible reports of performance that can be used to manage the program. OPPAGA's rating tells decision-makers whether they can rely on the program's performance information. We compared the components of the Children's Mental Health Sub-Program accountability system against our established criteria to determine its rating.

Accountability System Component	Meets Expectations	Needs Some Modifications	Needs Major Modifications
Program Purpose and Goals		X	
Performance Measures		X	
Data Reliability			X
Reporting Information and Use by Management		X	

Source: OPPAGA analysis

Accountability Rating System Summary

Program Purpose and Goals. The sub-program's purpose and goals need some modification. They should incorporate the goal of stabilization or improvement of the emotional condition or behavior of the child, as specified in Chapter 98-5, Laws of Florida. Also, specific objectives relating to the child's functioning in the community, the family and at school should be included. The sub-program needs to clarify its goal statement to specify whether its intent for clients' school functioning is to stabilize or improve students' behavior as opposed to their academic performance.

Performance Measures. The program's performance measures are good performance indicators of their statutory purpose and goals in general. However, there are some limitations in the completeness of measures to fully capture the goals of the program, as well as in the methodology of assuring a high return of the data.

- There needs to be a measure addressing the impact or effects of treatment on the functioning of clients served. We recommend that the program use a "change" score instead of an average in order to compare clients' functional levels before and after initiation of services. An average does not provide this information since it combines scores of individuals without consideration of their individual differences in scores and changes in functionality while receiving treatment.
- There is no performance measure to assess whether clients live in the "least restrictive setting." We propose a measure to address this goal.
- The completion of clients' treatment plans is an important indicator of service effectiveness. In order to provide this information, we propose a measure specifying the reason for discharge, including a criterion on treatment plan completion.

- The methodology for collecting family satisfaction information yields very low return rates and needs to be modified.

(For additional discussion, see Additional Measures, p.16.)

The introduction of performance measures in the 1997-98 fiscal year for children's mental health was intended to provide meaningful information for the evaluation of services that was not available previously. Since the development of initial measures, there have been modifications both in target populations and sub-groups, in measures and in performance standards that will assist in evaluating the impact of the sub-program.

Data Reliability: The department's inspector general has not assessed the accuracy of the program data as required by Sections 11.513, and 20.055, Florida Statutes. Consequently, the reliability of the 1997-98 fiscal year client record data has not been validated and thus cannot be assessed.

Also, in the beginning of the 1997-98 fiscal year, program staff reported low submission rates of performance data by providers and high error rates in this data. As a result, the program office initiated efforts to improve the collection, processing, and analysis of data during the 1997-98 fiscal year.

- Error rates for provider reported data declined from 27% in July 1997 to 8% by the last quarter of Fiscal Year 1997-98. This is an indication of data being submitted in the correct form by providers, however, not on the accuracy of the data itself.

- The program introduced a new software package for the Fiscal Year 1998-99 that contains required entries in specified fields to assure complete client and provider performance data that should improve the accuracy of the data. The Program Office has not evaluated the impact of these efforts on obtaining complete and accurate data from providers.

However, until OPPAGA obtains results from the department's efforts, assessing whether changes in reporting methods and software have resulted in the collection of complete and accurate data, we believe the rating on this component reflects the need for major modification.

Reporting Information and Use by Management. Performance information is reported to the Legislature and the general public through various publications, including the Legislative Budget Request, the Agency Performance Report, and the department's web site. Further, performance outcome data have been made available through its data warehouse (electronically stored client data files and various software applications) to the department's district managers. Performance measures have been included in all provider contracts. In addition, the department’s secretary monitors each district’s performance. However, performance data have not yet been used in a systematic manner to improve services, redirect resources, identify "best practices," or make changes to the types or mix of services purchased by the state. Improving data reliability in Fiscal Year 1998-99 may enable district staff to receive more accurate and timely feedback on performance, which should help to improve services.

For More Information

See FGAR profile at *http://www.oppaga.state.fl.us/profiles/5018/* or call Sibylle Allendorff (850) 487-9269 or Richard Dolan at (850) 487-0872. Information from the department is available on its web site at *http://www.state.fl.us/cf_web/adm/* or by calling (850) 487-2920.

Appendix A

Analysis of the DCF Alcohol, Drug Abuse, and Mental Health Program, Children's Mental Health Sub-Program for Each of Its Performance Measures

Outcome Measures

Performance 1997-98	1997-98 Standard	Met Standard?	Comments
Average number of days per year SED children spent in the community (not in detention, homeless, runaway or other facility)			
312	293	Unable to Assess	The sub-program's performance should not be evaluated based on the reported data because the department has not validated its accuracy.
Percent of families satisfied with the services received as measured by the Family Centered Behavior Scale			
83%	79%	Unable to Assess	We are unable to evaluate performance against the standard due to a low response rate (17%), and questions of whether these responses can be generalized to the client population as a whole.
Average functional level score SED children will have achieved on the Children's Global Assessment of Functioning Scale (C-GAS)			
49	54	Unable to Assess	The sub-program's performance should not be evaluated based on the reported data because the department has not validated its accuracy.

Output Measures

Performance 1997-98	1997-98 Standard	Met Standard?	Comments
SED children served			
22,104	9,301	Unable to assess	The method used to project these standards was based on limited data that produced unreliable projections.

Output Measures

Performance 1997-98	1997-98 Standard	Met Standard?	Comments
ED children served			
13,101	46,777	Unable to Assess	The method used to project these standards was based on limited data that produced unreliable projections.

Source: DCF Fiscal Year 1999-2000 Legislative Budget Request Exhibit D-2 and OPPAGA analysis

Appendix B

OPPAGA Recommendations for the DCF Alcohol, Drug Abuse, and Mental Health Program, Children's Mental Health Sub-Program $ Fiscal Year 1999-2000 Measures

Outcome Measures

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
Measures 1 through 7 apply for the Severely Emotionally Disturbed and Emotionally Disturbed Sub-groups.		
1. Average number of days per year SED/ED (respectively) children spent in the community (not in detention, homeless, runaway or other facility)	For SED: 338 For ED: 350	**We recommend modifying this measure and methodology.** This is a good measure of program effectiveness; however, it could be improved. We recommend changing the wording of the measure to omit "annual" or "per year" and replace it with "projected annual days" SED/ED children spend in the community. The current wording does not reflect the actual measurement, which is a projection from 30 days prior to assessment, to an annualized basis. The department should develop guidelines specifying the protocol for obtaining this information from parents or providers through the client's case worker, or other person most knowledgeable about the client's status. We agree with the department's proposal to remove clients in juvenile justice facilities from this measure for the 1999-2000 fiscal year and to increase the standards accordingly. The determination for placement out of the community for these clients is based on their legal status and not on mental health treatment considerations. Since this group is still included in other performance measures and in the measure that assesses commitments and recommitments to Juvenile Justice (Measure No. 6), the impact of mental health services on these clients will be assessed.

Outcome Measures

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
2. Percent of families satisfied with the services received as measured by the Family Centered Behavior Scale (FCBS)	For SED: 83% For ED: 85%	**We recommend modifying this measure.** We recommend modification of the FCBS instrument to enhance recipient response rates. This includes reducing the number of questions and assuring that the readability level is appropriate to the target population. Relevant results of the survey should be sent to providers to allow them to make any needed adjustments in their services. The Program Office reports that the FCBS instrument has yielded low response rates (approximately 17% of families of clients served) and generalization of the resulting data to the statewide population is questionable. Once modified, the Program Office should monitor the response rate and if it does not increase, consideration should be given to developing other strategies to assess family satisfaction. Alternative strategies could include interviews with families on a sample basis, the use of evaluation results from contract monitoring, or the use of provider quality improvement assessments by their accrediting entities.
3. Average functional level score SED/ED children will have achieved on the Children's Global Assessment of Functioning Scale (C-GAS)	For SED: 49 For ED: 55	**We recommend modifying this measure and methodology**. We recommend that the department revise this measure and develop an appropriate methodology to assess its impact. An average of clients' scores does not reflect changes in improvement or deterioration of functional levels of clients resulting from treatment services. Also, it does not represent the typical scores of the client population if there are several clients with extreme scores included in the computation. Change scores between admission and discharge allow the focus on individual clients' change in functionality while receiving services from providers. This method is already being used for adults in mental health crisis. The measure should be "Percentage of children and adolescents receiving services whose functional level score on the Children's Global Assessment of Functioning Scale (a) increased, (b) decreased, or (c) remained the same."

Outcome Measures

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
		In addition, there may be variability in the C-GAS scores based on who assigns the scores and their level of training, which is an issue of inter-rater reliability. The program may need to offer more frequent training sessions to staff administering the C-GAS instrument to assure consistency in scoring. This is especially important if staff turnover is high.
Measures 4 through 7 have been added since Fiscal Year 1997-98		
4. Percent of available school days SED/ED children attended during the last 30 days	For SED: 80% For ED: 87%	**We recommend clarifying this goal and modifying the methodology.** While this is an appropriate measure, the department needs to clarify its goal relating to clients' school performance. They should determine whether their intent is to stabilize or improve students' behavior as opposed to their academic performance. If the focus is on behavior, measure number seven should capture data to assess this goal. However, if the focus is to improve academic performance, the sub-program should develop a measure to assess that goal. (See also "Program Purpose and Goal," page 15, for additional comments). There is no standardized procedure that specifies the source of data providers should use to obtain "available school days" from the respective school districts of their clients. Providers may obtain this information from the school superintendent, a school principal, or a teacher. Obtaining data on the number of days a client attends school can come from either the parent, a teacher, or school attendance official. Sub-program staff reports that this information is difficult to obtain. We recommend that the department develop a standardized procedure for determining the number of available school days and the source that should be used to obtain the number of days attended by clients. A regularly updated timesheet for district specific available school days should be compiled by districts and disseminated to providers. Caseworkers should be responsible for obtaining information on their clients' attendance records, considering excused absences as well.
5. Percent of community partners satisfied based	For SED: 80%	**We recommend retaining this measure.** The community satisfaction survey results reflect the

Outcome Measures

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
on a survey	For ED: 80%	satisfaction of community partners (i.e., law enforcement, judiciary) using specific concepts (timeliness, cooperation, etc.), as well as overall satisfaction with Department of Children and Families services. The survey was designed to produce reliable results only at the state level. Satisfaction survey results are most useful for improving program services when the results apply to specific districts and client groups. The department should make the community partner satisfaction survey more useful to districts by identifying program-specific services that need to be improved and by disseminating these results to the districts.
6. Percent of commitments or recommitments to Juvenile Justice	Standard for 1999-2000 has not been set. Baseline data being collected in Fiscal Year 1998-99.	**We recommend retaining this measure.** This measure provides partial information about the juvenile justice involvement of clients while they are receiving mental health services. However, clients' juvenile justice involvement that does not result in commitment is not captured. Also, the informations accuracy depends on the ability of providers to ascertain this information from a reliable source. Unless these concerns are resolved, this data cannot be relied upon.
7. Percent of improvement of the emotional condition or behavior of the child or adolescent evidenced by resolving the presented problem and symptoms of the serious emotional disturbance recorded in the initial assessment	Standard for 1999-2000 has not been set. Baseline data being collected in Fiscal Year 1998-99.	**Methodology is being determined.** This has the potential to be an effective measure, depending on the accuracy of the instrument and method used to assess client performance. Information on this measure could provide a meaningful assessment of provider and program performance.
Sub-Group 3: Children at Risk of ED. (New sub-group since FY 1997-98.)		
Percent of families satisfied with the services received as measured by the Family Centered Behavior Scale	For At Risk: 90%	**We recommend adding these measures.** All performance measures that apply to SED/ED should apply to this sub-group. (Also, see comments under measure number 2.)

Output Measures, Fiscal Year 1999-2000

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
SED children to be served in 1998-99	22,104	These standards are based on 1997-98 fiscal year data and may be a more realistic number of clients to be served in the sub-groups than the standard set for the previous year.
ED children to be served in 1998-99	13,101	
At-risk children to be served in 1998-99	10,390	
Target Population 2: Children Incompetent to proceed to Juvenile Justice **Comments: This is a new target population for the 1999-2000 fiscal year. The goal is to restore children to competency and enable them to proceed with their judicial hearing. The Forensic Division of the ADM Program Office contracts with one provider who is responsible for ensuring services on a statewide basis.**		
Percent of community partners satisfied with program based upon a survey	70%	**We recommend retaining this measure**. The community satisfaction survey results reflect the satisfaction of community partners (i.e., law enforcement, judiciary, et al) using specific concepts (timeliness, cooperation, etc.), as well as overall satisfaction with Department of Children and Families' services. The survey was designed to produce reliable results only at the state level. Satisfaction survey results are most useful for improving program services when the results apply to specific districts and client groups. The department should make the community partner satisfaction survey more useful to districts by identifying program-specific services that need to be improved and by disseminating these results to the districts.
Percent of children restored to competency and recommended to proceed with a judicial hearing **a) with mental illness** **b) with mental retardation**	 90% 54%	**We recommend retaining this measure**. This is a good measure because it assesses the level of success of efforts to achieve the program goal. The standard is not based on historical or representative data and may need to be readjusted based on further collection of data. Clients can be served in up to three different settings (in-home, staff-secure residential placement, and facility-secure residential placements). The sub-program office should collect data by type of placement to determine the need for setting different standards by type of placement.

Output Measures, Fiscal Year 1999-2000

Measures Proposed by Agency	Proposed Standards	OPPAGA Recommendations/Comments
Percent of children returned to court for competency hearing, and the court concurs with the recommendation of the provider	95%	**We recommend retaining this measure**. This is a good measure because it assesses the level of success of efforts to achieve the program goal. The standards are not based on historical or representative data and may need to be readjusted based on further collection of data. Clients can be served in up to three different settings (in-home, staff-secure residential placement and facility-secure residential placements). The sub-program office should collect data by type of placement to determine the need for setting different standards by type of placement.
Percent of children with mental illness either restored to competency or determined unrestorable in less than 180 days	63%	**We recommend retaining this measure**. This is a good measure because it assesses the level of success of efforts to achieve the program goal. The standards are not based on historical or representative data and may need to be readjusted based on further collection of data.
Percent of children with mental retardation either restored to competency or determined unrestorable in less than 365 days	90%	**We recommend retaining this measure**. This is a good measure because it assesses the level of success of efforts to achieve the program goal. The standards are not based on historical or representative data and may need to be readjusted based on further collection of data.
Output: **Number of clients served**	224	This is a new program and once more information about it becomes available, the number of clients may increase, depending on available funding. The sub-program should maintain data on costs, by type of placement to effectively manage resources.

OPPAGA Recommendations for Additional Measures, Fiscal Year 1999-2000

Measures	Client Group	Comments
Total average expenditures for services per client (includes Medicaid services)	All	We recommend this new output measure to link expenditures for services to the clients served.
Percent of clients who are placed in the least restrictive setting available	All	We recommend that the department develop a methodology to assess whether providers or districts place clients in the least restrictive residential placement available. This will assess whether objectives in treatment plans are being met.
The percent of clients discharged by type of discharge		We recommend that the department office develop a measure, methodology and standard that reflects reasons for clients' discharge. This measure addresses the need for information on the outcome of services provided to clients. This is important to assess whether clients successfully complete their treatment program. This information will assist in identifying effective services and in developing and implementing appropriate treatment plans for specific sub-groups.
The number of days from CMH's determination of restoration of competency /unrestorability to the date of the court hearing on the determination	Incompetent to Proceed in the Juvenile Justice system	We recommend that the department develop a performance measure, methodology and standard to assess the number of days from the time the CMH sub-program determines either the competency or unrestorability of competency of these clients to the time of the court competency hearing. This measure should allow managers to assess whether these clients are moved through the system in a timely manner.

Recommendations for Additional Information

Measures	Client Group	Comments
The number of CMH children who return for additional services after discharge. **The number of clients served by the CMH sub-program who subsequently obtain services from the Adult Mental Health sub-Program.** **The number of Family Preservation, Economic Independence and Juvenile Justice clients served by CMH, by target population and services provided.**	All	We recommend that the department evaluate which services have the most impact on clients' functioning, by target group, so decision-makers can use this information to allocate resources. This analysis should identify those services and providers that are most closely associated with successful performance measure outcomes. Currently, there is no data to assess the impact of services on clients, by target sub-group, in regard to length of time services are provided and the frequency at which they may or may not return to CMH for additional services. The program office has no analytical data to assess the cost benefit of serving more clients in one target sub-group compared to those in others. By collecting this information, the program office can estimate anticipated costs and the number of new clients versus those clients who return for additional services. Information on the types of clients who return frequently for additional services will be valuable in planning and managing program services and resources.
For Incompetent to Proceed clients who are determined unrestorable, the type of disposition and placement for these clients	**Incompetent to Proceed in the Juvenile Justice System**	We recommend that the department develop a method to collect data that captures the judicial disposition of these clients and whether they receive services from other sub-programs of the department.

Source: OPPAGA analysis

Appendix C
Description of Community Mental Health Services - Cost Centers

Assessment assess, evaluate, and provide assistance to individuals and families to determine level of care, motivation, and the need for services and support.

Case management services consist of activities aimed at identifying the recipient's needs, planning services, linking the service system with the person, coordinating the various system components, monitoring service delivery, and evaluating the effect of the services received.

Intensive case management consists of the above-mentioned activities; but these are typically offered to persons discharged from a hospital or crisis stabilization unit, who are in need of more professional care, and who will have contingency needs to remain in a less restrictive setting.

Crisis stabilization provides residential acute care service on a 24-hour, 7-days-a-week basis, consisting of brief, intensive mental health care treatment services to individuals who, in the absence of a suitable alternative, would require hospitalization.

Crisis support/emergency service is a non-residential care service available on a 24-hour, 7-days-a week basis, or some other specific time period, to intervene in a crisis or provide emergency care.

Day-Night provides activities to children designed to assist their attainment of skills and behaviors needed to function successfully, in general, three or more times a week.

In-Home and on-site services overlay provides therapeutic services and support in a non-provider setting.

Inpatient services are acute care services designed to provide intensive treatment to person exhibiting violent behaviors, suicidal behaviors or other severe disturbances due to mental illness. This service provides 24-hour supervision and one-to-one therapy with limited interaction with the community, in a hospital or intensive residential treatment program licensed as specialty hospitals.

Intervention focuses on reducing risk factors generally associated with the progression of mental health problems, including early identification, individual assessment, providing supportive services that emphasize short-term counseling and referral.

Outpatient services provide a therapeutic environment that is designed to improve the functioning or prevent further deterioration of persons with mental health problems.

Outpatient medical services provide primary medical care, therapy and medication administration to improve the functioning or prevent further deterioration.

Outreach provides a formal outreach program to community at large and to individuals, including education, identification and linkage with high risk groups, planning and linking with other service providers, risk reduction, intervention, case management for non-clients, screening, and referral.

Prevention involves strategies that preclude, forestall, or impede the development of mental health problems, including strategies to improve public awareness.

Prevention/intervention day includes school-based mental health services for four or more consecutive hours per day for children identified by the school as having, or being at risk of developing mental health problems.

Residential services provide structured and supervised non-hospital settings at four levels. Services in **Level 1** provide the most restrictive and intensive level of residential therapeutic intervention. They are offered in a structured non-hospital setting with 24-hour supervision with a nurse on duty at all times for children with serious emotional disturbances. **Level 2** residential services for seriously emotionally disturbed (SED) children provide intensive therapeutic behavioral and treatment interventions, including therapeutic group homes, specialized therapeutic foster homes-level 2, and individualized residential treatment homes. **Level 3** residential services for SED children are programs specifically designed for the purpose of providing sparse therapeutic behavioral and treatment interventions including therapeutic group homes, specialized therapeutic foster homes-level 1, and individualized residential treatment homes.

Residential level 4 services for children with SED are the least intensive and restrictive level of residential care provided in group or foster home settings, therapeutic foster homes, and group care with treatment.

Respite care is an organized program designed to sustain the family or other primary care giver by providing time limited, temporary relief from the ongoing responsibility of care giving.

Supported housing/living assists adolescents in arranging for housing and providing services to assure successful transition to living on their own or with roommates; it includes training in independent living skills.

Source: Department of Children and Families, ADAMH Measures Manual, p.II, 21-24

Appendix D
Criteria for Enrollment in Client Sub-Groups

I. Children and Adolescents with serious emotional disturbance (ED)

This group includes children under the age of 18 years who meet one of the criteria listed below.

- Diagnosis of schizophrenia or other psychotic disorder, major depression, mood disorder or personality disorder
- Diagnosis of another allowable* Diagnostic and Statistical Manual diagnosis and a Children's Global Assessment Scale of 50 or below
- Currently classification as student with serious emotional disturbance by a local school district
- Current recipient of Supplemental Security Income benefits for a psychiatric disability

II. Children and adolescents with emotional disturbance (ED)

This group includes children under the age of 18 years who meet one of the two criteria.

- Diagnosis of another allowable* Diagnostic and Statistical Manual diagnosis and a Children's Global Assessment Scale of 51 to 60.
- Current classification as a student with an emotional handicap by a local school district

III. Children and adolescents at-risk of emotional disturbance (ED)

This group includes children under the age of 18 years who meet one of the two criteria.

- Current referral for placement in a program for students with emotional handicaps in accordance with Individuals with Disabilities Education Act
- Verified maltreatment per Family Safety and Preservation or similar agency in another state

*Note allowable diagnoses are mental retardation, pervasive developmental disorder (including autism), substance abuse, communication disorders, learning disorder, and V-codes.

Source: State of Florida, Children's Mental Health Plan, Fiscal Year 1999, p. 96-97

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FLORIDA DEPARTMENT OF

CHILDREN & FAMILIES

Jeb Bush
Governor

Kathleen A. Kearney
Secretary

January 15,1999

Mr. John W. Turcotte, Director
Office of Program Policy Analysis and
Government accountability
111 West Madison Street
Room 312, Claude Pepper Building
Tallahassee, FL 32301

Dear Mr. Turcotte:

This letter responds to your revised preliminary performance-based program budgeting standards report for *The Department of Children and Families' Alcoho/, Drug Abuse, and Mental Health (ADM) Program, Children's Mental Health Sub-program.* The report has encouraged us to evaluate objectively our system, and we are working diligently on improvements. The following are our specific comments on program data, the department's data improvement initiatives and our plans to implement your recommendations.

Program Data: One of the major conclusions of the OPPAGA report is that the Legislature should not use the FY 1997-98 PB^2 data to assess the performance of the Children's Mental Health Program because of questionable data reliability and weak performance standards. OPPAGA's basis for this statistical conclusion is that: (a) the department did not sufficiently validate its FY 1997-98 data, (b) the data are not accurate or complete, and (c) the performance standards were based on an insufficient sample of the target populations. The dismissal of the entire 1997-98 performance data as invalid for assessing statewide performance outcomes in the Children's Mental Health Program is statistically and programmatically misleading for the following reasons:

1. **Data validation and accuracy**: Although the department's inspector general and Office of Standards and Evaluation did not validate FY 1997-98 performance data, they validated FY 1998-99 first quarter data from District 10. The accuracy for demographic data ranged from 94 percent to 99 percent, compared to 100 percent accuracy for performance measure data.

Since the core data requirements did not change from FY 1997-98 to FY 1998-99, and since the same checker program was used for validation edits in both fiscal years, there is no reason to conclude that the data validity and accuracy are lower in FY 1997-98 than in FY 1998-99.

We request that the following statement in the accountability rating system summary be more accurately worded. The report states ". . . the department's inspector general has not validated the data submitted by providers to the source data as required by Sections 11.513, and 20.055, Florida Statutes." The inspector general met the requirements of §11.513, Florida Statutes. This section requires that no later than July 1 of the year in which the department begins operating under a performance-based program budget, the inspector general develop a plan for monitoring and reviewing the department's major programs to ensure performance data are maintained and supported by agency records.

On July 1, 1997, the inspector general submitted the *Monitoring Plan for Validating Outputs and Outcomes for Performance Based Budgeting FY 1997-98* to the Office of Program Policy Analysis and Government Accountability. Regarding §20.055, Florida Statutes, reliability and validity assessments are in process and have been since November 1998.

OPPAGA Response

The department's inspector general's recent reviews of data validity and reliability of client records of six providers in two DC & F districts indicate high accuracy rates of data reporting. However, the, the department's assertion that the data validity and reliability at the provider level as determined for the 1998-99 fiscal year can be generalized to a previous year, especially since the reporting procedures were changed, is not methodologically sound. Therefore, OPPAGA continues to assert that we cannot assess the sub-program's performance for the 1997-98 fiscal year, and urges caution using the data to assess program performance for that fiscal year. Once the inspector general's review is complete, and the program office has received and analyzed 1998-99 data submitted by providers, OPPAGA will review its program accountability rating in reference to data reliability.

2. **Data completeness**: The OPPAGA report indicates that the performance data are based on insufficient numbers of clients in the target populations, implying that the FY 1997-98 database is incomplete and not representative of the children's mental health population. This conclusion is incorrect and misleading for two major reasons.

   First, it is important to note that outcome data includes results from post admission data only. During fiscal year 1997-98, information was collected on children at the following points in time: admission, six months following admission, annually thereafter, and at discharge. Therefore, the outcome data reported for performance-based program budgeting purposes does not include children served less than six months.

   Second, the client enrollment records were not used during fiscal year 1997-98 to determine the number of clients served per target population, as was suggested in the OPPAGA report. Instead, fiscal year 1997-98 performance measures are based on both the Children's Functional Assessment Rating Scale and Children's Mental Health Outcome Scoring Sheet data from the Florida Mental Health Institute. Both of these data collection forms require the reporter to indicate the target population in which the child has been enrolled.

In addition, according to these data, at least 11,000 children were served in each target population group during the fiscal year. To evaluate either group, a random sample of 1,200 cases would be needed to achieve a confidence level of 99 percent. Since (1) the number of records used for performance measures is nearly ten times the required statistical sample size, (2) the report pertains to statewide performance, rather than to district or provider performance, and (3) there are no known biases in the sample of children who were reported on, our end-of-year data shows that there is no reason to suggest the number of records analyzed is too small to draw any conclusion.

In view of the above information, the department respectfully requests that:

1. Any reference to “the Legislature should not use the approved PB2 measures to assess the performance . . . “ be replaced with the following language: “Since the department's validations began with FY 1998-99 data, the Legislature should use the approved PB2 measures with caution to assess the performance . . .“
2. In the Past Performance section, under the heading “Met Standard?," replace “Unable to assess” with “Yes” or “No" as needed.
3. In the Past Performance section, under the heading “Comments," replace the language “The sub-program's performance should not be evaluated . . . " with the language “The sub-program's performance should be evaluated with caution . . .”

OPPAGA Response

The OPPAGA report does not focus on incomplete or insufficient outcome or enrollment performance data but rather refers to performance standards and the data used to establish these standards for Fiscal Year 1997-98. For example, the differences in the projected standard of seriously emotionally disturbed (SED) clients to be served for Fiscal Year 1997-98 (9,301) and the actual number of clients served (22,104) is so great that it makes assessment of the achievement of this standard questionable. We recognize that the department has used more reliable data to establish meaningful performance standards for the 1998-99 fiscal year.

Data Improvement Initiatives: Four data improvement workgroups met during March and April 1998 in an effort to improve various aspects of data collection and reporting for adult and children's mental health programs. These workgroups were well represented by staff from provider agencies, the Florida Council for Community Mental Health, district and central office mental health program offices, and the Florida Mental Health Institute. Following are major data improvement initiatives which have been implemented in fiscal year 1998-99 as a result of recommendations made by the Data Improvement Workgroups:

- **Simplification of the mental health performance outcome data**, to reduce the reporting requirements in fiscal year 1998-99 compared to previous years.
- **Implementation of software for electronic submission of the data**, to reduce the processing time and to improve the quality of the data by eliminating errors associated with scannable forms.

- **Development of the software checker program**, including data validation edits for providers who use their own database software, to further reduce errors in data reported.

- **Designation of at least one staff per district to serve as a data liaison**, to close the communication and planning loops between the ADM Central Program Offices and the providers.

  Direct access (by district liaisons) to both the ADM Home Page and the ADM Data Warehouse, to allow timely feedback of critical information to their respective providers, including the monthly submission of erroneous records that need corrective actions from providers.

- **Data validation by the inspector general and Office of Standards and Evaluation staff** to check the accuracy and validity of the data submitted by providers to ADM Central Program Offices.

- **Reinstatement of the statewide data workgroups** to address various data and performance measure issues, including the concerns outlined in the OPPAGA report.

- **Creation of the Mental Health and Substance Abuse Steering Committee** to serve as a forum for discussion of critical ADM performance monitoring issues, a vehicle for dialogue about these issues among diverse stakeholders, and policy recommendation and oversight body.

- **Provider and district training**: In preparation for fiscal year 1998-99, the training workgroup developed a “train the trainer” program. All district children's mental health staff were trained on outcome collection and data submission procedures. District staff were provided comprehensive training materials, and all districts subsequently held training sessions with their providers with assistance from central office staff. District staff are now able to accurately answer questions and provide training for new provider staff in the district throughout the year. This robust training effort, coupled with the publication and statewide dissemination of the *ADM Measures Manual* must be acknowledged as major sources of improved reliability.

- **Increasing the frequency of outcome data collection to admission and every quarter post admission,** in an effort to increase the number of children being served who are in the post admission performance data set and to increase the validity of our reported results due to more frequent observations.

The Data Improvement Workgroups will reconvene in January 1999 to continue efforts to further improve data collection, reporting, and analysis procedures for the coming fiscal year.

Implementation plans. The department plans to fully implement many of the recommendations listed in the report:

- **Average number of days per year spent in the community**: The department concurs with the suggestion to change the wording of the measure to omit “annual” or “per year” and replace it with “projected annual days.”

- **Family satisfaction**: The department has contracted with the Florida Mental Health Institute to research different methods of collecting family satisfaction data. We are planning to make substantial revisions to the Family Centered Behavior Scale (FCBS) to shorten it and make it more user friendly for the family members of the children we serve. These combined efforts should result in an increase in the FCBS return rate.

- **The average functional level score** on the Children's Global Assessment Scale (C-GAS) will be reported as “Percentage of children and adolescents receiving services whose functional level score on the Children's Global Assessment Scale (a) increased, (b) decreased, or (c) remained the same.”

The department will work through the collaborative Data Improvement Workgroups to address other concerns and recommendations listed in the report, including:

- Further strengthening of our training program for staff who administer all data reporting instruments and procedures.

- Standardization of the procedure for determining and reporting on the percent of school days attended and Juvenile Justice commitment status.

- Determining the relative cost benefit of creating and obtaining data on the numerous additional process and performance measures which are recommended.

The department appreciates the following elements of the report that clearly support our very considerable five-year investment in developing, administering and continuously improving our program's performance based accountability:

- The existing measures are good indicators of the program's performance.

- Agreement with the department's proposal to remove children in Juvenile Justice facilities from the community days measure.

- Acknowledgement that there have been modifications in target populations, measures and performance standards that will assist in evaluating the impact of the children's mental health program.

- New software and data submission edits and correction procedures should improve the accuracy of the data.

We appreciate the opportunity to comment on this revised draft report. The issues it addresses are very complex and challenging, and we are committed to making continuous improvements in the accountability and effectiveness of our children's mental health service delivery system.

Sincerely,

Melissa C. Jacoby
Executive Staff Director

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