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Task Order #18
Usefulness of Automated Information Management
System Data
and Other Data Sources in Kansas Children's
Community Based Services
FY 2006-2007

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Executive Summary

Purpose of the Study

This project explores data utilization within Kansas Community Based Services (CBS). There is a CBS within each Kansas Community Mental Health Center (CMHC) that provides services to children and youth. In this phase of the project researchers accumulated and analyzed CBS directors' input about what data sources they found useful, the purposes for which their data were useful, and how data utilization could be further supported.

One of the data sources available to CBS is the Children's Client Status Report (CSR) which is a quarterly report of Automated Information Management System (AIMS). CBS use of CSR/AIMS is of particular interest to the Kansas Department of Social and Rehabilitation Services (SRS). The AIMS V3.0 Manual states that CSR/AIMS inform local CMHC quality improvement efforts (Kansas SRS, 2005a, p. 2). This study includes an exploration of the extent to which AIMS data are actually useful to CBS, and the supports that could enhance CBS use of CSR/AIMS.

Implementation

A review of social work and related literature indicated that data use is integral to the practice process. Shaw and Gould recognized that qualitative research provides salient information about practice processes and outcomes (2001, p. 3). Researchers determined that a qualitative study would shed light on the processes of data utilization in mental health administration and practice.

Approval for implementation of this project was granted in January 2006, by the Human Subject's Committee Lawrence Campus (HSCL), the University of Kansas (KU) Institutional Review Board (IRB).

The research team conducted preliminary telephone or face-to-face interviews with four CBS directors, who indicated the types of data that are available for informing decision-making. The research team subsequently attended the April 2006 Kansas CBS directors meeting to invite their collaboration in the study and their participation in the survey. Development of the *Knowledge Building and Decision-Making in Kansas' CBS Survey* was informed by the literature review, the preliminary interviews, and the CBS directors' meeting.

CBS directors were contacted by the research team via telephone or e-mail. Surveys were conducted throughout May and June of 2006. The data for this study consisted of interviewer notes from 11 telephone surveys and participant responses from 14 SurveyMonkey.com (2006) surveys. Each set of responses was entered as a primary document into the qualitative data analysis software program Atlas.ti (Muhr, 2004). A constant comparative analysis was used to detect themes between and within documents.

Study Challenges

The apparent complexities of data utilization indicated that the task order for this study should be expanded from simply observing for CBS uses of AIMS data. Directors' working definitions of data exceeded the boundaries of statistical output and included whatever feedback, outcomes, or information they use to draw conclusions or make decisions. Therefore, an exploratory study about the many derivations of data use by CBS directors seemed more relevant to social work practice, social work management and to Kansas CBS. Uses and non-uses of the AIMS became but one component in this larger study of the ways directors use what they know to inform what they do.

Findings

Data sources used by Kansas CBS directors' include agency personnel, client records, community stakeholders, consumers, financial reports, goal measures, mental best practices, CSR/AIMS, and working knowledge. Directors use data to initiate services; make treatment decisions; make program decisions; support consumer voice; supervise staff; and track client status.

Directors experience supports for data utilization including a culture of trust and creativity; technology; resources allocated for data use; time to use and think about data; and funding to act on needed changes as indicated by data. Conversely, several of the supports that some directors indicate they already enjoy, are the same that other directors indicated that they need, including a culture of trust and creativity, technology and resources. Additionally, directors indicated that they need support in making and implementing targeted surveys that answer questions asked locally and changes in the CSR/AIMS.

Recommendations

In response to this study, it is recommended that the State of Kansas and local CMHCs further support data utilization. This would include improved accessibility of AIMS data, CMHC management support of data utilization, support for development and implementation of locally relevant surveys, expansion of CBS directors' framework for outcome data utilization and support for AIMS data utilization.

Future Steps

The subsequent phase of this study will be to develop innovations for supporting CBS data utilization in collaboration with children's CBS directors, the Department of Social and Rehabilitative Services Division of Health Care Policy (SRS/HCP) and the Children's Mental Health Research Team (CMHRT) at the KU School of Social Welfare.

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<p style="text-align: center;">Usefulness of Automated Information Management System Data and Other Data Sources in Kansas Children’s Community Based Services</p>

1. BACKGROUND

The Community Mental Health Center (CMHC) Act of 1963 called for a continuum of comprehensive community-based services to be coordinated by each state’s mental health authority (Schnapp, 2006). The Act established CMHCs in tandem with a movement to deinstitutionalize mental health treatment, but the CMHCs did not experience the level of support needed for a seamless transition. Some ex-patients were left feeling “isolated, neglected, untreated, and in some case abused” (Stroul, 1986, p. 2) as a result of inadequate federal appropriations for the CMHC service delivery model.

1.1 Background of Community Based Services (CBS)

The Kansas Mental Health Reform Act of 1990 formalized the principle that “services and supports are best provided in the community when possible” (Barfield, Corrigan & Chamberlain, 2005, p. 1). Community Based Services (CBS) for children and Community Support Services for adults, were subsequently developed within Kansas CMHCs. CBS may include Mental Health Case Management, Mental Health Attendant Care, Psychosocial Groups, Partial Hospitalization, Home Based Family Therapy, and Respite Care (Kansas Social and Rehabilitative Services [SRS], 2005c).

CBS exist to reduce the risk of state psychiatric hospitalization for children and youth with serious emotional disturbance (SED). Centers for Medicare and Medicaid Services waivers are available to purchase CBS for Kansas children and youth with low incomes who have an SED, as evidenced by substantial disruption to social, academic, or emotional functioning (Kansas SRS, 2005c). Clinical SED designations are determined by a Qualified Mental Health Professional (QMHP) within the CMHC, based upon a review of clinical V-Codes and standardized assessment instruments such as the Child Behavior Checklist (CBCL) and Child & Adolescent Functional Assessment Scale (CAFAS) (Kansas SRS, 2003).

1.2 Background of the Children’s Client Status Report

The Kansas Division of Mental Health requested the “development of a method for systematically capturing the effectiveness of community programs for persons with severe mental illness” (Rapp, Gowdy, Sullivan & Wintersteen, 1988, p. 123). Productivity measures had proven to be unsatisfactory determinants of treatment and program effectiveness, so a review of mental health practice and research literature, legislative and judicial mandates, and the National Institute of Mental Health’s Community Support Program Model helped to inform development of a new way to measure effectiveness. The new method followed the level of restriction in the living situations, or client status, for Community Support Services clients. Quarterly change within each CMHC and across the State of Kansas was indicated in Status Movement Tables.

The KU School of Social Welfare published the first Measuring Client Status Data Report in 1987. A pilot study indicated its usefulness as a program management tool within six Kansas CMHCs. Researchers observed that in most of the six settings, it was the first time there had been “solid evidence that their prodigious efforts were making a difference” (Rapp et al., 1988, p. 130). The pilot study indicated that early client status data reports were used by community services staff to identify need and take action. Quarterly reports tracked client status movement for adult mental health consumers.

Since 2002, alongside Consumer Status Reports for adults, the quarterly Children’s Client Status Report (CSR) has been generated from Automated Information Management System (AIMS) data provided by the CMHCs via the Mental Health Consortium (Kansas SRS, 2005b, p. 1). The CSR provides client status information about children and youth receiving community based mental health services in Kansas. Children’s status movement tables reflect changes in residential living status (institutional, substantially restrictive, surrogate home or permanent home) and changes in SRS custody status (out-of-home, in-home, supervision or no involvement). The CSR also provides statistics about clinically significant Child Behavior Checklist (CBCL) scores and schools, including academic performance, attendance and the percent of children and youth in CBS with an individualized education plan. Data are provided statewide and specific to each CMHC.

1.3 Background of the Automated Information Management System (AIMS)

Data management progressed from hand calculations in 1987 (Kansas SRS) to the AIMS computer information system (CIS) launched in 2002. The AIMS is a “succession of processes that result in a comprehensive data set comprised of 85 data fields that reflect demographic, client status, and encounter data for the mental health consumers served by local Community Mental Health Centers in Kansas” (Kansas SRS, 2005a, p. 2). AIMS meets and exceeds federal mental health outcome requirements of the Uniform Reporting System Basic and Developmental tables.

1.4 Study Purpose

Preliminary interviews with CBS directors indicated that the information held within CSR/AIMS, and the knowledge needed by managers for local decision-making, may have become disconnected. Yet, local CMHCs are among the three entities identified by the AIMS V3.0 Manual that utilize CSR/AIMS data. The entities and purposes for which they are believed to apply CSR/AIMS data are:

- **Kansas SRS** uses CSR/AIMS for federal and state quality improvement reports and to monitor CMHC Mental Health Reform Contracts, including the federal accountability requirements of the President’s New Freedom Commission (NFC) on Mental Health (2003).

- **The Association of CMHCs of Kansas** uses CSR/AIMS data for legislative reporting and lobbying.
- **Local CMHCs** purportedly use CSR/AIMS for their quality improvement efforts (Kansas SRS, 2005a, p. 2).

This study was undertaken to determine whether CSR/AIMS data are in fact useful to CBS directors' quality improvement efforts, as well as whether there is potential for additional usefulness of CSR/AIMS. The study was further developed to explore the additional sources of data currently accessed by Kansas CBS directors, and the current and potential usefulness of the data generated by those sources.

2. LITERATURE REVIEW: KNOWLEDGE BUILDING TO INFORM DECISION-MAKING

Social work grew out of the "organisation and management of charity on 'rational lines'" (Hearn, 2000, p.1). The profession emerged through the "laborious and learned seeking for truth" (Richmond, 1917, p. 51). Dr. Richard Cabot commended social workers to "measure, evaluate, estimate, appraise your results, in some form, in any terms that rest on something beyond faith" (Bloom & Fischer, 1982, p. ix; Cabot, 1931, p. 22). Social work managers and practitioners examine facts to develop mental health competencies. "We draw inferences from those facts, we diagnose, we view the individual against a frame of reference which is itself the product of informal research. We constantly alert ourselves to sources of error" (Hollis, 1963, p. 13). Demonstrations of effectiveness remain central to social work's mission and ethical responsibilities (National Association of Social Workers, 1999; Reid, 1980, 1994). Social work continues to evaluate the outcomes of its interventions with an eye toward planning future success.

Utilization of relevant data has been and remains integral to decision-making by social work managers and practitioners in mental health. Local agencies use data that inform their everyday decisions (Kirkhart & Attkisson, 1986, p. 324; Ryan, 1988, p. 27). Today's social work practitioners and managers apply existing knowledge "widely and effectively in social work education and practice" (Kirk, 1979, p. 3) when given the resources needed to interpret outcomes. Useful data are relevant to practice; have clear and practical applications; are effectively communicated; and are delivered along with skill sets and supports needed to apply the new knowledge within agency settings (p. 12).

2.1 Computer Information Systems (CIS)

Despite a long history of social work practice evaluations, data generated to satisfy external stakeholders may be detached from data utilization by local managers. Disengagement may have developed amidst a flurry of government social programs prompted by social unrest of the sixties, and the simultaneous surge of computer capability and accessibility. As federal and state spending on matters of public welfare multiplied, so did calls for evaluative accountability, at a time when it had become possible to quickly count so many aspects of so many social programs.

Increased specialization across all disciplines, including social work, was a third influence on the divide between data use for external purposes and data use by mental health managers. The convergence of increased government spending for social programs, the possibilities of generating a surfeit of data, and emergence of evaluation as a specialization within social sciences sometimes resulted in unintended and uncomfortable effects, as often happens when system change occurs. It seemed a natural progression for program evaluation using CIS to emerge as a distinct field of human service practice. Indeed, with the exponential increase in external calls for evaluative accountability, and the increased technological skill needed for answering those calls, it seemed that it might be no longer even be feasible for social work practitioners and managers to evaluate their own work.

Computerized program evaluation served to distance practitioners and managers from evaluation of their own programs, and from their voices being heard by funding sources and policy makers. Counters, not clinicians, became the specialists to whom policy makers turned for guidance in funding social programs (Carrilio, Packard & Clapp, 2003, p. 62). “Not so long ago,” observed pioneer program evaluator Carol Weiss in 1972, “innovative social action programming and its accompanying evaluation were small-scale enterprises. The greatest effect that evaluation could have would be to encourage further street work with gang youth” (Carrilio et al., p. 328). A new order of program evaluation evolved from that climate of ongoing and large-scale programs, of CIS, and of evaluation specializations.

There remains uncertainty by those who self-evaluate about the work of those whose practice is evaluating programs for external stakeholders. For those whose practice is evaluation, the “pathways from scientific effort to service excellence are tortuous” (Reid, 1980, p. 39). Uncertainty is reinforced when efficacy does not correlate with real world effectiveness (Berlin, 1982; Sperry, Brill, Howard & Grissom, 1996). The process is complicated because “we are dealing with a complex force field in which research is one of many forces” (Reid & Fortune, 1992, p. 108). Evaluators strive to curb the unintended effects of their evaluations, as evidenced by the theme of the 2006 Annual Conference of the American Evaluation Association, *The Consequences of Evaluation*. Yet caution persists regarding whether program evaluation answers the historical and ethical call for social work to evaluate, and whether CIS are in fact “alien to the core values and skills of practice. Knowing that numbers provide the rhetoric of our age, social workers often view research as . . . ‘data-mugging’ – the use of survey methods for media, commercial or political ends” (Shaw, 1996, p. 4). The question is not whether these newer order program evaluations have a place, but the question is how the newer order program evaluations can fit into the evaluation landscape to inform what practitioners and managers are doing.

Program evaluation using CIS is a mainstay in today’s burgeoning managed care environments (Howard, Moras, Brill, Martinovich & Lutz, 1996). Stakeholders continue to demand “outcome measures that demonstrate that programs work” (Darling, 2000, p. 259). Managers will continue attending to the expectations of those who evaluate their work

(Siddall, 2000). They will do so, cognizant that once targets have been established, standards set, and outcome indicators defined, there still exists the danger of creating distance between knowledge and knowing; a divide between meeting an outcome and actual effectiveness.

2.2 Defining Outcomes that Support Client Voice

Social work objects to any suggestion that clients come in broken and that social work interventions fix them. Rather, effective social work outcome management is guided by the understanding that client change is influenced by multiple causes. “The number of contextual (moderating) factors to be taken into account [are] too many and too difficult to specify for the field to yield definitive answers to an inquiry as crassly empirical as the ‘Who is likely to benefit?’ question” (Fonagy, Target, Cottrell, Phillips & Kurtz., 2002, p. 33). Both client betterment and decline may be influenced by many factors, social work interventions among them.

The challenges of defining outcomes in a way that considers all parties involved are magnified when the client is a child.

Ultimately, effective childhood interventions are those that set a child on a developmental path comparable in risk to those without significant childhood disturbance. Thus, it may be suggested that given the extremely limited time span covered by most treatment studies, the true effectiveness of most child mental health treatments is unknown. (Fonagy et al., 2002, p. 32)

Indicators of effectiveness cannot be established and interpreted in isolation, but only “as a set, in relation to each other, balancing considerations of cost, quantity, access, quality and client outcomes. Effectiveness and efficiency are not absolute” (Tilbury, 2004. p. 238). The dilemma is how to use the enormous capabilities of computerized systems for evaluating programs in ways that still attend to the voice of the client system (Grasso & Epstein, 1993b, p. 27).

When workers are aware of and have input into what is measured, they have the potential to influence the future evolution of those measurements. Despite the initial care with which domains may be developed, however, the nature of CIS is that once domains have been adopted they become less interactive, opening the door to unintended consequences. Collecting information generates activity around what is being measured (Rapp & Poertner, 1992, p. 138). This can be both the bane and the boon of large scale program evaluation. The more awareness workers have of outcome measures, the greater value those measures have for focusing agency energies toward mutual objectives. There is optimism that the potential for local agency utilization of CIS data is strong, that it “helps staff more clearly to understand the purposes of their work and encourages them to focus on achieving those objectives” (Hatry, Lampkin, Morley & Cowan, 2003, p.3). Unfortunately, there is also potential for generating

activity around the pursuit of identified outcomes rather than around support of actual improvement in client systems.

In client-centered practice, outcomes are agreed upon between the client, the practitioner, and the agency. How can outside entities define the outcomes of interest? What if an evaluation indicated that a program was successful in attaining agency goals, but if the program did not address client need? What if closing cases too soon improved outcome measures by reducing opportunity for problem recurrence? (Tilbury, 2004). What if evaluating distorted the human exchanges (Saleebey, 1979, p. 269)? “What if the outcomes diverge – if what is optimal for the child is less favorable to other members of the family or to the service provider? . . . Good outcome might sometimes be an increase rather than a decrease in symptomatology” (Fonagy et al., 2002, pp. 4-5). Misgivings persist about program evaluation for external stakeholders, because the one who defines the situation determines the desired outcome, and might very well control what gets done.

Outcomes are the “specific results that service organizations seek” (Hatry et al., 2003, p. 2). Evaluators truly want to measure actual outcomes rather than to simply produce output. They understand that undue emphasis on simple outputs can result in “goal distortion and displacement” (Grasso & Epstein, 1988, p. 89). The program evaluator looks for indications that desired outcomes have been achieved by defining “specific measurements of the desired results, such as ‘number, and percent, of clients whose condition improved after receiving services’” (Hatry et al., p. 2). Identifying which indicators should be measured to provide salient outcome information to agencies, workers, clients and client/systems has proven to be one of the most difficult tasks of evaluating. Program evaluators are challenged to conceptualize and operationalize indicators that capture outcomes of importance to all parties, so that the counting does not inadvertently mute client voices rather than support them, so that it does not actually depersonalize rather than empower clients.

2.3 Working Knowledge

Data have no meaning of their own. Evaluation is about assigning meaning to the events that occur between agencies and the lives of clients (Rein & Tanenbaum, 1979, p. 215).

- 1234567.89 and 8087% are **data**.
- “Your bank balance has jumped 8087% to \$1234567.89” is **information**.
- “Nobody owes me that much money” is **knowledge** (emphasis added). (The Free On-line Dictionary of Computing, n.d., data)

Research and evaluation are salient when data yield information that workers can use to know what to do in practice (Kirkhart & Attkisson, 1986, p. 324; Ryan, 1988, p. 27). Research and evaluation are useful when their data adds something to the “ordinary knowledge [that] provides the basis for decision and action” (Cousins and Leithwood, 1986, p. 331). Many reviews of research

utilization “neglect the realities of how knowledge – research or otherwise – get incorporated in what social workers and social agencies actually do” (Reid & Fortune, 1992, p.111). Data that are useful within local mental health settings are those that help practitioners and managers broaden what they know in a way that informs what they do.

Working knowledge is the ever-evolving base of understanding from which human service practitioners and managers make decisions. Practice wisdom is informed by theory and subjective clinical experience (Krill, 1990), and it is a component of working knowledge. Working knowledge surpasses practice wisdom, however, by continually layering new data atop previously held understanding.

It includes the entire array of beliefs, assumptions, interests, and experiences that influence the behavior of individuals at work. . . . The knowledge itself is tentative, subject to change as the worker encounters new situations or new evidence. . . . Working knowledge often has a greater *cumulative* influence on policies and practices than does the evidence that is selectively brought to formal decision points (Kennedy, 1983, p. 193-194).

This is applicable to the practice of social work in mental health, where decision-making involves everything that workers and clients bring to situations, including “intentions, meanings, uncertainty, intersubjectivity, values, personal knowledge and ethics” (Shaw, 1996, p. 180). Any new feedback supplements but does not supplant the working knowledge that is already in place.

The essence of previously held knowledge is perceptible in the meaning derived from new outcomes. Likewise, new knowledge flavors but does not overpower previously held understanding. Meaning is assigned to data within the context of what managers and practitioners already know. Movement toward utilization of outcome data occurs not as a deluge but as a creep, as new information impacts previously held understanding. Outcome data seldom provides a single “answer” to a particular policy or practice problem, but provides a “background of empirical generalizations and ideas that *creep* into [decision making]. . . . Its influence is exercised in more subtle ways than the word “utilization” – with its overtone of tools and implements – can capture” (Weiss, 1980, p. 381). The difficult task befalls mental health administrators and practitioners to discern whether patterns within the data point to relationships between specific interventions and specific results. When such patterns are determined they can indicate solutions to agency problems, yield meaningful answers to managers’ questions, and demonstrate client successes.

3. METHODS

This study was developed in cooperation between CBS directors, Kansas SRS, and the KU School of Social Welfare. HSCL reviews and approves the study's protocols and processes to ensure that all considerations related to protection of human subjects are appropriately addressed according to IRB standards. HSCL granted approval to implement this project on January 24, 2006 (Appendix A). The approved information statement was available to each participant (Appendix B). Identifying information was removed from CBS directors' quotes for the report of findings.

3.1 Research Questions

A review of literature indicated that data utilization in social welfare predates and exceeds the boundaries of CIS. Both the literature review and preliminary interviews with directors demonstrated a definition of data that is broader than CIS output.

3.1.1 Definition of Data

For the purposes of this study, **data are whatever feedback, outcomes, or information CBS directors use to draw conclusions and make decisions.**

3.1.2 Questions

- 3.1.2.1 What data do CBS directors find useful for helping them know what to do and what works? What are their sources for that data?
- 3.1.2.2 In what ways are CMHCs supportive of the use of knowledge derived from outcome data for decision-making?
- 3.1.2.3 How are data useful to CBS clients and workers?
- 3.1.2.4 What suggestions do CBS directors have about ways the use of data could be supported for improving provision of services in their local setting?

3.2 Research Design and Instrumentation

A qualitative design was developed to garner information about data use processes (Shaw & Gould, 2001, p. 3) within Kansas CBS. The qualitative inquiry explored the current and potential uses of multiple data sources, including CSR/AIMS. The purpose of this study was to provide information about data utilization for Kansas SRS, the Association of CMHCs of Kansas, and Kansas CBS and CMHCs.

A review of program evaluation literature for the social sciences indicated that social work managers and practitioners base program and practice decisions upon the meaning they extract from available data. Preliminary interview questions for use with four Kansas CBS directors were informed by the literature review (Appendix C). A preliminary face-to-face

interview with one CBS director and preliminary phone interviews with three CBS directors provided researchers with an understanding of issues surrounding use and nonuse of CSR/AIMS in Kansas CBS. Preliminary interviews also provided an indication of other types of data and their applications within each of their four settings.

The research team attended the April 2006 Kansas CBS directors' meeting to inform attendees of the study, explain its purposes, and invite directors' collaboration and participation. Directors who were not at the meeting were subsequently contacted by the research team via phone or e-mail.

Based upon input from the literature review, preliminary surveys, and the directors' meeting, the Knowledge Building and Decision-Making in Kansas' CBS Survey was developed for completion by all directors (Appendix D&E). The 24-question survey consisted of four sections. Section A was about the information upon which directors rely to inform them about what to do. Section B was designed to elicit directors' perceptions of the ways their agencies both support and obstruct data use. Questions in Section C were about additional supports that might improve directors' data utilization. The final section of the survey was included as a result of input from the directors at the April CBS meeting who indicated interest in an AIMS Workbench for CBS. Section D was developed to determine what benefit directors anticipated from a tool such as Workbench.

Directors at the April 2006 meeting were polled for their survey format preferences. Per directors' preferences, surveys were made available in two formats, as phone interviews to be completed with a researcher, and as internet-accessed surveys to be completed through SurveyMonkey.com (2006). Surveys were designed to take about half an hour to complete. Surveys were administered in May and June of 2006.

Phone participants received an e-mail attachment of the survey so they could have the questions before them during the interview. Interviewers called each phone participant, read each question aloud, and recorded detailed notes on directors' responses. A follow-up copy of researcher notes was available via email for perusal and editing by respective directors.

Internet participants received a link to the survey via e-mail. Directors completed and submitted their confidential response to SurveyMonkey.com (2006). A follow-up email was not sent to online participants, as they could review their own responses prior to submitting.

3.3 Sample & Data Collection

Twenty-eight CBS serve children and youth in the State of Kansas, each affiliated with a CMHC for their regional catchment area (see Appendix F). After preliminary interviews, it became apparent that each setting was unique, and that relying on a subgroup of directors would risk losing the "locally relevant" stories (Shaw & Gould, 2001, p. 194). Researchers invited and encouraged all of the directors to participate in the study. This approach

was intended to engage directors in the study process and to heighten potential for the study's applicability and usefulness within each CBS.

A total of 25 directors responded, for an 89% response rate. Eleven directors participated in phone interviews, and 14 participated through internet-accessed surveys. Interviewer notes from the phone surveys and CBS director responses to the internet-based surveys constituted the data for this study.

There were advantages and disadvantages of each survey methodology. The greatest advantage of the online survey methodology was its convenience. Six directors opened their surveys prior to 7 AM, before the busier parts of their days and earlier than they would have likely scheduled phone interviews. Four directors left their surveys open for several hours to work on them as time allowed. The online surveys were also less time consuming. Most of the phone interviews lasted more than an hour, whereas most online participants completed their surveys within 12 to 54 minutes, for a mean completion time of 26 minutes. Phone interviews offered the advantage of allowing participants to ask specific questions about the study's purposes immediately prior to entrusting their experiences with data use to the study. The phone interviews also supported mutual understanding between researchers and participants and precipitated a much larger volume of text than did the online interviews. Phone participants were able to think aloud, unhampered by recording their own thoughts. While taking notes on participant responses, researchers were able to immediately clarify their understanding of participant responses. The online surveys precipitated a much smaller volume of text, but they supported a broader base of feedback that maximized researcher understanding about data utilization within all centers.

3.4 Data Analysis

The research team consisted of a principal investigator and a research assistant. Each set of survey responses was entered as a primary document into the qualitative data analysis software program Atlas.ti (Muhr, 2004). The texts were analyzed through close reading and rereading, coding, and the development of themes and diagrams that supported a constant comparative analysis within and between the texts. A thematic analysis of content was developed from directors' responses to survey questions. Themes were coded from survey questions that had been developed from the literature review and the preliminary interviews. Unanticipated themes from survey responses were captured through open coding. Researchers met regularly to discuss patterns and themes, as they moved from specific observations to the phenomenon (Patton, 2000, p. 56), that is, the use of data by Kansas CBS directors. Researchers strove to achieve internal validity from the reflexive influence of anticipated themes on serendipitous themes and of serendipitous themes on anticipated themes (Boeije, 2002). Researchers were thus able to identify themes from the uniqueness and commonality of directors' responses.

4. FINDINGS

This study examined the usefulness of data for Kansas CBS directors. Findings are presented according to content themes about the purposes for which they use data. Each theme is introduced by a brief synopsis followed by corresponding passages from the text. In the spirit of capturing locally relevant stories, numerous quotes were included to elucidate perspectives and reflect variations within each theme. James Drisko similarly included lengthy passages of text “to allow readers to make their own judgments about the accuracy and usefulness of the researcher’s summaries and conclusions” in a 2001 constant comparative analysis of the ways clinical social workers evaluate their own practices.

Some passages were included in the findings because they reflect the observations of several directors, while others reflect unique observations of only one or a few directors. For instance, the report includes identification by only one director of the use of CSR for determining treatment effectiveness. Such unique utilizations were included because each director operates in a different context with unique personnel, clients, and communities. No two directors identified identical data sources or purposes for which they use data. Synopses within each theme indicate whether passages were included because they reflect common perspectives or because they reflect unique perspectives.

Director quotes have been de-identified in the report that follows. Each director was assigned a letter of the alphabet, which follows either a P indicating they were a phone respondent, or an S indicating they were a SurveyMonkey.com (2006) respondent. Directors’ words are indented and italicized throughout the report. Researcher edits for the purpose of de-identifying quotes are not italicized.

Data are useful to CBS directors across Kansas for building knowledge that informs decision-making. The findings of the survey are detailed in the four sections following. Section 4.1 presents an overview of CBS directors’ data sources and the purposes to which they are applied. Section 4.2 describes the purposes for which data are utilized. Section 4.3 presents supports that directors identified as useful within each CMHC for knowledge building to inform decision-making, as well as additional supports that they think would be useful. Section 4.4 reports ways in which CSR/AIMS data could be made more accessible and useful within the CBS.

4.1 CBS Directors’ Data Sources

Directors identified nine sources of data that are useful to them: Agency personnel, client records, community stakeholders, consumers, financial reports, goal measures, mental health best practices, CSR/AIMS, and working knowledge. Figure 4.1 provides an overview of the types of data available from each source.

Figure 4.1 Sources of Useful Data

<p>4.1.1 Agency Personnel provide feedback individually as well as collaboratively within teams. Agency personnel include:</p> <ul style="list-style-type: none"> ▪ staff: case managers, attendant care workers, psychosocial aids, coordinators, parent support specialists ▪ qualified mental health professionals (QMHPs) and clinical coordinators ▪ administrators and business office personnel <p>4.1.2 Client Records may be generated by the CBS, the CMHC, or by cooperating treatment agencies. Useful records include:</p> <ul style="list-style-type: none"> ▪ client histories ▪ intake assessments ▪ previous treatments and collateral contact with treatment providers ▪ medical records <p>4.1.3 Community Stakeholders, when proper information releases are secured, include schools, child welfare, JJA and law enforcement, and community councils. Types of community data include:</p> <ul style="list-style-type: none"> ▪ individualized education plans (IEP) ▪ school attendance reports ▪ standardized behavior forms, such as a Teacher's Report Form (TRF) ▪ child welfare charts ▪ verbal feedback in formal settings (e.g., court hearings) ▪ verbal feedback in informal settings (e.g., school hallways) <p>4.1.4 Consumers are the child or youth receiving CBS, and their parents or guardians who participate in the treatment process. Consumer data includes:</p> <ul style="list-style-type: none"> ▪ standardized behavior forms, such as a CBCL, CAFAS, and/or Preschool and Early Childhood Functional Assessment Scale (PECFAS) completed by parents and/or guardians, and a Youth Self-Report (YSR) completed by older youth ▪ locally developed surveys ▪ Kansas Consumer Satisfaction Surveys (CSS), ▪ verbal feedback in formal settings (e.g., team meetings) ▪ verbal feedback in informal settings (e.g., conversation during a lengthy van ride) <p>4.1.5 Financial Reports may be generated by electronic medical records (EMR), corporate compliance and financial officers, business office staff, and cancellations graphs kept by therapists and case managers. Financial reports provide data about:</p> <ul style="list-style-type: none"> ▪ cost un-reimbursed by Medicaid, SED waivers, or Cenpatico ▪ billable hours ▪ staff productivity <p>4.1.6 Goal Measures identify progress toward specific desired outcomes. They are developed within teams of agency personnel, consumers and/or community members. The measures are criteria for determining the extent to which each goals and objectives are met. They are rewritten as progress is made or as new issues become prominent. Useful goal measures generate data that determine:</p> <ul style="list-style-type: none"> ▪ treatment effectiveness ▪ program and grant effectiveness ▪ staff productivity ▪ agency mission <p>4.1.7 Mental Health Best Practices are accessed through:</p> <ul style="list-style-type: none"> ▪ social work and child mental health journals, websites and workshops ▪ networking with other CBS directors <p>4.1.8 CSR/AIMS provide data about:</p> <ul style="list-style-type: none"> ▪ residential status; SRS, JJA & school statistics, aggregated CMHC-wide and state-wide ▪ demographics <p>4.1.9 Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources. It is a compilation of the information that directors access to inform their decision-making.</p>

4.2 CBS Directors' Utilization of Data

CBS directors make decisions informed by the data at their disposal. In their surveys, the directors discussed six purposes for which data are utilized: Initiating interventions, making treatment decisions, making program decisions, supporting consumer voice, supervising staff (productivity and goal clarification), and tracking client status. This section will describe each of these purposes and discuss how the directors use these data sources to support their activities and the activities within their CMHC.

Table 4.2 presents the purposes for which CBS directors apply each data source. **Agency Personnel** and **Consumers** informed all of the six purposes for which directors use data. **Community Stakeholders** informed all purposes except staff supervision, and **Mental Health Best Practices** informed all purposes except tracking client status. **Goal Measures** informed treatment and program decisions, supported consumer voice, and clarified goals in the context of staff supervision. **CSR/AIMS** were useful for making treatment and program decisions, supervising staff by clarifying goals, and tracking client status. **Working Knowledge** was included as a unique type of data because directors indicated that they were informed by the interplay of multiple data sources for initiating services, for making treatment and program decisions, and for supporting consumer voice. **Client Records** were used for initiating services and for making treatment and program decisions. **Financial Reports** were useful for making treatment and program decisions and for supervising staff productivity.

Data Sources	Purposes for Which CBS Directors Use Data					
	<i>4.2.1 Initiate Services</i>	<i>4.2.2 Make Treatment Decisions</i>	<i>4.2.3 Make Program Decisions</i>	<i>4.2.4 Support Consumer Voice</i>	<i>4.2.5 Supervise Staff</i>	<i>4.2.6 Track Client Status</i>
Agency Person.	X	X	X	X	Productivity	X
Client Records	X	X	X			
Comm. Stake.	X	X	X	X		X
Consumers	X	X	X	X*	Clarify Goals	X
Financial reports		X	X		Productivity	
Goal Measures		X	X	X	Clarify Goals	
MH Best Practice	X	X	X	X	Clarify Goals	
CSR/AIMS		X	X		Clarify Goals	X
Work. Know.**	X	X	X	X		

*Consumer voice is not included in the report as a data source used to support consumer voice. Rather, it is incorporated into the role of agency personnel in eliciting and broadcasting consumer data.

**Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources.

4.2.1 Initiating Services. Determination of CBS eligibility and decisions about how to initiate services are reliant upon agency personnel, client records, community stakeholders, consumers, mental health best practices, and working knowledge. Data sources useful for initiating services are summarized in Table 4.2.1.

Table 4.2.1	Data Sources Used to Initiate Services
4.2.1.1 Agency Personnel	QMHPs (Clinicians)
	Psychiatrists
	Case managers
	Clinical directors
	Treatment coordinators
	Teams
4.2.1.2 Client Records	Referral documentation
	Intake and assessment documentation
	Records from collateral agencies
	CMHC charts: history; progress notes; medical records
4.2.1.3 Community Stakeholders	Schools – IEP, TRF, etc.
	Foster workers and foster parents
	Probation officers
	Child welfare workers
	Referral sources
4.2.1.4 Consumers	Parents and guardians
	Case managers
	Intake templates
	CBCL & CAFAS
4.2.1.5 Mental Health Best Practices	DX & TX modalities
	Provider specializations
	Client characteristics
	MH literature, e.g., Maldonado
4.2.1.6 Working Knowledge**	Compare data from different sources
	Pool data from different sources
	Consumer strengths and needs
	Resources available to CBS
	Family requests
	Case manager strengths
	Psychosocial issues: culture, gender, interests
Programmatic recommendations	

**Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources.

4.2.1.1 Agency Personnel inform initial services. QMHPs are responsible for initial assessments, the determination of whether a child or youth meets CBS diagnostic criteria, and initiating treatment. Their work is informed in part by input from other clinical professionals and by case managers. A flow of information occurs among personnel in team settings.

A team of clinicians who meet together make decisions together. They are headed by clinical director/ treatment coordinator. It is a team-based response to mental health presentation (PG).

Information may come to light through clinical staffings which include our psychiatrist. . . . The family is contacted by the case manager after a referral for CBS services is made. Parents provide ongoing information as it relates to their child and their child's history (SW).

4.2.1.2 Client Records inform initial services. Client records inform a QMHP's determination of whether diagnostic criteria are met and the CBS determination of what services are to be initiated. The process includes a chart review for children and youth who were previously established in treatment. Other records that may be available are referral documentation, intake and assessment documentation, collateral sources' documentation, and CMHC records

When a child is eligible for CBS services a formal intake and progress notes would be available for review. Medical records from treatment agencies outside the agency are requested (SW).

4.2.1.3 Community Stakeholders inform initial services. School, child welfare personnel, and referral sources are useful for gathering information about the history of current troubles across settings. Directors mentioned utilization of teacher reports and IEPs, foster worker reports and probation officer reports.

4.2.1.4 Consumers inform initial services. CBS rely heavily on parents and guardians to inform them of client histories and to inform decisions about initial interventions.

The family is contacted by the case manager after a referral for CBS services is made. Parents provide ongoing information as it relates to their child and their child's history (SW).

The problem as the parent sees it informs the CBS of a child's history (PY).

Client histories are transmitted to the CBS through consumer completion of intake and case management documentation, and behavior instruments such as the CBCL and CAFAS that are required for the SED waiver.

One director identified the CBCL and CAFAS as tools that can engender understanding.

These can be very useful, depending on how they're administered. Do they score in the clinical range? Do they provide key indicators? It is a useful tool in sitting down with the family and hearing from them (PE).

4.2.1.5 Mental Health Best Practices inform initial services.

Mental health best practices help CBS routinize initiation of services. Continual and intentional awareness of best practice likewise helps CBS determine what to do.

Children are matched with specific workers and programs based upon the diagnosis and best treatment modality for that diagnosis. Services are provided at the place where problems are occurring, for example at home or school, some of the services are provided in that setting. They are also matched based on interests and successes of workers, gender (especially for adolescents) and individual needs (PH).

Some directors identified one or more specific effects of the influence from mental health literature. For example:

For children under three, we use Dr. Maldonado's tools [Kansas Association for Infant Mental Health] (PD).

4.2.1.6 Working Knowledge informs initial services.**

CBS consider input from multiple data sources about the strengths and needs of a child or youth. Data from multiple sources can likewise be compared to determine data source reliability.

For example, a parent would not be considered reporting well if they reported no school absences for a child who has been truant (PE).

In addition to providing points of comparison between data sources, pooling data from multiple sources helps the CBS understand whether the concerns of community stakeholders and consumers are similar and provides a picture of clients' strengths and needs.

Decisions are made about initiating services based upon data comparisons and data pooled, alongside resources available to the CBS. Directors in centers with large geographical

catchment areas, for instance, expressed that they have fewer options for optimally matching clients with workers and programs than do directors in geographically smaller catchment areas. Working knowledge informs the best match of agency resources with indicators of what is called for, informing CBS about how to match children with specific workers and programs and how to coordinate client services and treatment.

How I match clients with workers and programs is difficult to answer. It is a mental process that I just do. We match services requested by the family with services available. We do a chart review. We decide which case manager would work with a child based on □cultural issues, and who can manage aggressiveness and physical violence tendencies, and location (PC).

We take into account gender, temperament, interests, worker strengths, the child's needs, the case manager's caseload, the match of personalities: Who works best with that child & that parent (PD)?

Programmatic recommendations, for example the attendant care or psychosocial programs, are made by recommendations and requests from the family, case manager, clinician, and/or from discussions with the director (PB).

4.2.2 Treatment Decisions. Directors across the state utilize data provided by agency personnel, client records, community stakeholders, consumers, goal measures, mental health best practices, CSR/AIMS, and working knowledge to inform treatment decisions. Data sources useful making treatment decisions are summarized in Table 4.2.2.

Table 4.2.2 Data Sources Used for Treatment Decisions	
4.2.2.1 Agency Personnel	Treatment teams and case staffings
	Case managers
	Therapists
	Supervisors
	Providers
4.2.2.2 Client Records	Chart reviews
4.2.2.3 Community Stakeholders	Schools: Teachers (TRF) and principals (discipline records)
	Law enforcement
4.2.2.4 Consumers	Parents
	Youth
	Case managers
	Clinicians
	CBCL & CAFAS
4.2.2.5 Goal Measures	Child or youth specific measures
	Program specific measures, e.g., PSEDRI
	Objectives (measurable outcomes)
	Action steps
	Team developed and regularly reviewed
4.2.2.6 Mental Health Best Practices	Mental Health literature, e.g., Evans
	Mental Health literature, e.g., Miller & Duncan
	Mental Health literature, e.g., Hodges
4.2.2.7 CSR/AIMS	Identifies regular home, law enforcement contacts, grades, school, JJA, foster care & parents
4.2.2.8 Working Knowledge**	Therapist's perceptions
	What case managers learn in kid's larger systems
	TX plans & adaptations from collateral source info
	Best practices
	Clinical experience; practice wisdom
	Youth, family and multi-disciplinary feedback
	Family assessments
	Parent management of child behavior

**Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources.

4.2.2.1 Agency Personnel inform treatment. Directors value feedback from agency personnel for building knowledge that informs treatment decisions. This is often a team process. It occurs informally as well as within the context of regularly scheduled interdisciplinary feedback.

Several directors found integrated treatment plans to be useful.

Treatment and services are coordinated by an integrated treatment plan that includes all members of the treatment team. . . . This occurs in regular case staffings, individual and group supervision, and coordination with additional providers (SX).

It should be noted, however, that one director believed strongly that the integrated treatment plans were a move in the wrong direction for data from agency personnel data to inform treatment.

The therapist turns the 'integrated' treatment plan over to the case manager with limited information so case managers frequently struggle to know what they're supposed to be working on. The therapist has to call the team meetings, but does not have a way of tracking whose plan is due to be updated. We used to have a collaborative plan on every child in the program with the family, therapist, school teacher, medical provider, etc. (similar to wrap around). It got done, because it was the case manager's responsibility to update that every quarter, either in a meeting or input from individual collateral sources.

4.2.2.2 Client Records inform treatment. The utilization review process provides an opportunity for systematic review of client records. One director identified this as useful for informing treatment decisions.

The utilization review holds four hour meetings on all charts twice monthly. This process is beginning to provide more clinical feedback (PD).

4.2.2.3 Community Stakeholders inform treatment. Community feedback about decreased symptoms and increased use of new skills in problem settings are indicators of treatment effectiveness. Directors gave several examples of the types of stakeholder feedback that is useful to them. SR and PF found the TRF to be helpful for informing treatment, and other directors relied on a broader range of stakeholder feedback.

If things are going better, you'll hear about it through better scores, fewer law enforcement contacts, fewer visits to the principal's office, fewer suspensions, detentions, truancies (PY).

4.2.2.4 Consumers inform treatment. Parents and youth provide ongoing feedback that informs treatment decisions. This occurs within the team setting.

Parent and client reports are a big measuring stick (SO).

We discuss intensity level with parents, and follow up with the case manager and clinician to finalize a treatment plan (PD).

Consumer feedback is also generated with behavior measures such as the CBCL and CAFAS.

CBCL and CAFAS are useful to help us see progress we may have overlooked, particularly over large time spans (PF).

4.2.2.5 Goal Measures inform treatment. Teams write goals and objectives specifically for each child and youth. Included in the goals and objectives are specific measures of success that will help the team track progress.

Treatment has been effective if the child has accomplished a goal that was supported by a specific treatment (SL).

Goals, objectives (measurable outcomes) and action steps can be followed to see if progress has been made. These treatment plans are assessed every quarter (SO).

Goals and objectives yield to changes in clients. They can be rewritten to accommodate needed adjustments.

Meeting a goal may not actually be progress in the child's life (PF).

They are revised at regularly scheduled intervals, such as monthly, every three months or biannually, but they can also be revisited more frequently when change occurs.

Progress notes provide information on a more short-term basis of when goals and objectives are being accomplished (SW).

In addition to goals and objectives written for specific children and youth, there also program goals and objectives by which progress may be measured.

In some psychosocial groups there are set criteria and when that is met psychosocial treatment is complete (SW).

Therapeutic preschool uses the Preschool Social and Emotional Development Readiness Index (PSEDRI) to answer requirements of grants. It's possible to see for a child on a given day where his behavior was, why things went right or wrong (PA).

4.2.2.6 Mental Health Best Practices inform treatment. Directors use mental health literature that informs treatment planning and assessment of treatment effectiveness.

For example, we recently received the Report on Emotional & Behavioral Disorders in Youth [Evans, 2006]. It reinforced the service integration we were implementing (PD).

At intake, every child 12 and above completes a norm-based inventory with 4 scores, cognition, behavior, emotion & relationship, based on Miller & Duncan [2007]. *When therapy ends, clients/families complete an end-of-therapy evaluation based on Miller & Duncan relationship outcomes -- how they were treated by the therapist, and whether they felt heard by therapist (PG).*

We are applying for a Technical Assistance Grant to bring Dr. Kay Hodges [2000] CAFAS Train the Trainers event and pursuing use of CAFAS in CBS programs for assessing individual progress as well as outcomes associated with various CBS services and delivery (SX).

4.2.2.7 CSR/AIMS inform treatment. One director identified the CSR as helpful for determining treatment effectiveness.

CSR on each child identifies regular home, law enforcement, grades, school, JJA, foster care contractors, foster parents, and parents (PY).

4.2.2.8 Working Knowledge informs treatment.** Directors described the importance of an interplay of data sources that informs their decision-making.

The idea is for the therapist to sit down with families and create a master treatment plan, but a therapist's perception may not match what a case manager learns in the kid's larger system. Case managers act based upon the master treatment plan, then add information from collateral sources, as authorized by the therapist and parent. These are ideally collaborative (PF).

Our knowledge base is built from models of best practices and clinical interventions and experience with clinical indications about what is needed, family assessments, multi-disciplinary feedback from within CBS, family/client feedback about what seems to be working and what does not seem to be working, that result in treatment plans built around clinical interventions (PE).

Look at how well the parent is able to manage the child and if there are skills that we can build with the parent that would help them manage the child better/easier [and listen for] parent and child verbalizing feeling better about how things are going (SU).

We primarily rely on oral feedback between parties involved. Best practice guidelines and practice wisdom are in there. We underutilize formal sources of data other than direct communication between children, families, providers, etc. Community feedback - schools, JJA, etc., - is very useful. We take some formal data into account, especially CBCL data. It is useful in some cases, but we can tell more from parent/school/ community agency reports, anecdotal observations from families, the child. When we close CBS services, I talk with case managers about a child's progress. Before coming to that decision the case manager has spoken with family, youth and the clinician. If everyone agrees there has been enough progress, we close. I cannot remember a time we've said, 'Let's look at the CBCL' to decide whether to close, though sometimes it is included in mix about what is considered (PB).

4.2.3 Program Decisions. Each of the nine data sources identified by Kansas CBS directors are used to inform program decisions, as indicated in Table 4.2.3.

Table 4.2.3	Data Sources Used for Program Decisions
4.2.3.1 Agency Personnel	Administrator reviews
	Clinical oversight teams
	Teams and team leaders
	Case managers
	CMHC staff
4.2.3.2 Client Records	Utilization review of medical records
	Random record reviews of service delivery, outcomes
4.2.3.3 Community Stakeholders	Community surveys
	Community roundtables; action committees
	Hospital administrators
	County health nurses
	Ministers
	Law enforcement
	Schools
	Judges
	SRS
4.2.3.4 Consumers	Case managers
	Parent support specialists
	Focus groups
	Parent meetings
	Family nights
	Parents & guardians
	Number of attendees
	CSS & locally developed surveys
4.2.3.5 Financial Reports	Electronic medical records
	Business reporting software
	Reports generated according to staff; program; billing code; client
4.2.3.6 Goal Measures	Program goals connected to grant requirements
	Agency-wide goals
	Agency mission
4.2.3.7 Mental Health Best Practices	Biopsychosocial model
	Mental health literature, e.g. Rhule
	Mental health literature, e.g. Gaskill & Perry
	State of Kansas library
	Continuing education
	Professional websites, e.g. SAMHSA & TAG
4.2.3.8 CSR/AIMS	Networking with & visiting similar CBS
	Comparing CSS & CSR scores with other CBS
4.2.3.9 Working Knowledge**	Assess trends
	Assess improvement & needed change
4.2.3.9 Working Knowledge**	Spend time listening to clients; family nights
	Read articles; anticipate trends; watch for useful models; discuss
	Processing & research alongside previous experiences
	Unique characteristics of local population
	Gaps in services – countywide & CBS
	Re-tool when something isn't working
	Re-tool when someone has a new idea; new staff
	Feedback from children & parents
	Community dialogue & relationships
	Attendance for programs
	Collateral reports
	Staff & parent surveys
	Agency goals
	Funding sources

**Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources.

4.2.3.1 Agency Personnel inform program decisions. The need for change may be indicated by periodic and regular reviews by teams and administrators. Indicators may likewise come from changes in the population and from front line staff.

We conduct regular reviews of programs and aspects of programs, so every area is reviewed and looked at every year. The team leader responsible for the program presents to the board and the clinical oversight team, about how the program is running, recommendations for change, things that are not going as well as hoped. If line staff want to suggest a change, they write a proposal for consideration. For instance, a case manager runs an independent living skills psychosocial group and wants to address more social skills related to relationships. They will write it up, review it, and take it to the weekly team leaders' meeting for programmatic issues, then it moves up to the clinical oversight meeting for approval (PA).

If CBS case managers identify services needed to meet the needs of their clients, we then proceed with a process for developing new programming (SM).

Often times these decisions are identified by the front line staff. They may see a need with a specific population, such as dual diagnosis of mental health and developmental disabilities. The CMHC also looks at the referral base and what the primary needs are related to that population. We may have more younger children versus older children or more youth at risk of out of home placement requiring more in home family services (SW).

4.2.3.2 Client Records inform program decisions. One director identified client records as useful for identifying trends and making recommendations.

All medical records go through a basic utilization review process. CBS has done random reviews of records as it relates to service delivery, outcomes, documentation, etc. (SW).

(See also 4.2.3.6. Goal Measures to inform program decisions become part of client records.)

4.2.3.3 Community Stakeholders inform program decisions.

Community feedback helps directors identify program outcomes and community need. Community feedback comes through community surveys, community council roundtables, and through other interactions of the CBS with the community.

We get input from the community action committee - hospital administrators, county health nurses, ministers, law enforcement, schools, and judges. They meet periodically to talk about what communities are doing, needs, resources, what we could be doing. . . . The committee meets every two months, and all participants give feedback about what is happening and what could be done for children in our area (PC).

We encourage community members to make referrals to programs, even if they don't know we have them. . . . Requests for presentations to schools, and SRS, and to the police, about for example, cutting behavior – we track the requested topics (PH).

4.2.3.4 Consumers inform program decisions.

Case managers and parent support specialists encourage and engage consumer input that occurs one-on-one, in focus groups, and in parent meetings.

We know when to develop new programs or retool existing programs based on how happy families are with what we're doing. On monthly family nights throughout the catchment area there's an educational presentation, but also a forum to hear from parents, and feedback from staff and children (PJ).

Consumer attendance helps managers gauge the value of programs and need for additional programs. A waiting list may be an indicator that a program is meeting a need and could be expanded.

Like our summer camp this summer we have 52 children, a sizable number more than we've had before - adding staff & hours to the camp. I guess we're always looking at when to develop new programs or retool existing programs (PC).

More than half of the directors discussed surveys they developed and implemented in-house that provided them with useful information about program effectiveness. Locally developed surveys targeted to provide specific program information provided useful information about program effectiveness. In-house evaluations completed by parents

helped confirm the importance of program and identify the need for change.

In contrast to locally developed surveys, only a third of directors identified the CSS as a useful data source.

CSS give feedback as to areas where we might be doing well, and where we might improve. We have done some surveys through the consortium that have been targeted, and those are more helpful because we know who we're getting feedback from and which staff the feedback is about (PY).

CSS comments are helpful in exploring specific strengths and areas for improvement, but our experience has been that survey participation is limited and biased. . . . The comments provided through the satisfaction surveys are more helpful than the overall scores (SM).

At the end of every summer parents fill out feedback forms. Therapeutic services preschool - parents and staff fill out surveys. CSS was not really useful. N was too small and we couldn't determine outcomes. Keys for Networking (2006) gave a more unbiased questionnaire (PD).

Supervisors do wellness checks. They call random samples of parents or guardians each month to learn their perceptions of services provided. They try to catch every family over a 6-month period (PE).

One director identified using CSS to inform community stakeholders of consumer satisfaction. It was a tool to both inform stakeholders and to elicit their additional feedback.

Results of CSS are presented to the community action committee every year. They give us feedback (PC).

4.2.3.5 Financial Reports inform program decisions. Financial reports accessed through Electronic Medical Records (EMR) help directors manage programs.

Reports can be run according to staff, program, billing code, and client (PE).

We utilize business reporting software that help us to see patterns, progress, and areas of improvement (SO).

4.2.3.6 Goal Measures inform program decisions. The degree to which program goals are met provides useful information. Two directors indicated that they have maintained program goals that were initially generated to satisfy grant requirements.

Outcomes are kept on preschool psychosocial program and school age psychosocial program. Outcomes are related to former grants. Outcomes tracked basic information, for example, 80% of preschoolers go into regular education Kindergarten. . . . After completion of the high school psychosocial group, disciplinary referrals were reduced by half. Outcomes are harder to track for attendant care and case management, which are on individual bases (PA).

In addition to goals with measurable outcomes that gauge program success, there are also agency-wide goals that help inform program development.

New services or program needs to include a system of care delivery that fits within our agency mission and biopsychosocial model (SX).

4.2.3.7 Mental Health Best Practices inform program decisions.

Outcomes reported in mental health literature help directors determine what to do locally. Directors access mental health literature through the State of Kansas Library, continuing education, and professional websites, such as the Substance Abuse and Mental Health Services Administration website and the Training Advisory Group website from Wichita State (Kids Training Team, 2007)

What works and doesn't work tells us what we should and should not use (PJ).

Group interventions are leading to worse outcomes for people with conduct disorders, at both the inpatient and outpatient levels (Rhule, 2005). That reinforces what we have been hearing. We are reconsidering both inpatient and outpatient groups. There are only a few groupwork models with that population that do not result in social contagion. None of our inpatient or outpatient groups approximate the rigor of those models (ST).

Rick Gaskill from Sumner County has been a tremendous help. He started therapeutic preschools. He works with Bruce Perry's training [ChildTraumaAcademy, 2006]. We've received a lot of assistance from them in making some changes (PI).

We do some reading on what practices are considered best, and attend workshops. In particular, Rick Gaskill is the early childhood guru around the state. He's developed some good early childhood programs and is up on national best practices for early childhood work. Our staff meets with him regularly (PG).

Networking with other CBS directors is also an important avenue for comparing what is happening locally to what is happening elsewhere. Networking occurs face-to-face at directors meetings and at visits to other CBS sites. Networking occurs online through email and professional websites. The CSS and the CSR facilitate networking as they help directors compare what is happening locally with what is happening in other CBS and against state averages.

We listen to others, particularly those in similar settings who are doing similar things that seem to be effective. When visiting other settings to develop psychosocial, day treatment, expectations for case managers, etc. I see what they are doing (PY).

4.2.3.8 CSR/AIMS inform program decisions. The CSR/AIMS may find its greatest usefulness in its informing program decisions. Several directors stated that it provided little or limited usefulness for their treatment decision-making, but nearly half identified its usefulness for informing program decisions.

The quarterly CSR information is reviewed for trends. We developed a morning CBS psychosocial breakfast group to address truancy and absenteeism of students. We also developed a psychosocial group to address school work needs when the trends were that youth continued to struggle academically (SW).

Each year the AIMS reporting results are sent to our CMHC and based on these numbers we can assess where more intervention is needed and where we have improved (SL).

4.2.3.9 Working Knowledge informs program decisions.** Decisions are based upon feedback about program effectiveness, resource availability and agency priorities.

I don't know what we know. We listen to clients we serve, spend time with them. I read articles and anticipate trends (PD).

We meet weekly to discuss trends and data from the various reports. From these meetings there are discussions about expansion and development of possible new programs (SO).

There are no standardized tools for evaluation of programs - I don't know of any. We use family nights, staff processing, and research about what works and doesn't work, what we should use and should not use, alongside our previous experiences (PJ).

We have to look at the population that we are serving as very different from those in other regions. We have to meet the needs of the local population here. Sometimes we are forced to do things because of the groups we serve (PI).

We look at family feedback, and what kinds of services are missing in our county, then try and develop new programs based on that. We re-tool when something isn't working or we have thought of a new and better way to do something. Sometimes staff turnover and new managers in certain departments will simply want to do things a different way (SQ).

There's not data to show that because we did, for example, a summer program those children have better grades at school or less contact with law enforcement. It's not very scientific. Decisions are based on feedback from children, parents, community, and impressions of personnel – good dialogue with the community and face-to-face relationship-building (PF).

Factors such as attendance, changes in staff, or emergence of a useful model can initial change or development of programs (SS).

Outcome trends are tracked by collateral reports, family reports, results of staff & parent surveys at end of the summer program, the number of intakes and /discharges on a monthly basis for annual trends. The CBS director does that informally (PH).

Agency goals are considered in tandem with funding sources to address gaps in services.

We know to develop new programs or retool existing programs when we become aware of a gap in appropriate services and are able to access a funding source (SX).

4.2.4 Supporting Consumer Voice. Consumers are a unique data source, in that they are the reason CBS exist. That places great import on identifying and capturing consumer data. The process of hearing consumer voice informs practice, in a manner that likewise encourages and motivates consumers.

That's where our information is coming from, client voices (PF).

The data that support consumer voice come from agency personnel, community stakeholders, goal measures, mental health best practices, and working knowledge. Data sources useful for supporting consumer voice are summarized in Table 4.2.4.

Table 4.2.4 Data Sources Used to Support Consumer Voice	
4.2.4.1	Staff consciousness-raising – advocate for families
Agency Personnel	Staff consciousness-raising – families feel heard
	Generate consumer data – CSS & local surveys
	Review CSS with each team & with parents
	Conduct consumer feedback forums
4.2.4.2	Communicate with other service providers: therapists, doctors, schools
Community Stakeholders	Communicate with family & identified friends
Consumer Voice*	<i>See how agency personnel support consumer voice.</i>
4.2.4.3 Goal Measures	Develop goals with consumers
	Keep family invested through treatment outcomes
	Ongoing feedback from client and family
	Meet with client and family in treatment plan meetings periodically
	Measure the therapeutic relationship
4.2.4.4 Mental Health Best Practices	An ADHD program for parents was based on mental health literature.
4.2.4.5 Working Knowledge**	Compare parent suggestions and other data, e.g., mental health literature, program outcomes, collateral sources

*Consumer voice is not included in the report as a data source used to support consumer voice. Rather, it is incorporated into the role of agency personnel in eliciting and broadcasting consumer data.

**Working Knowledge is an evolving base of understanding that is informed by the interplay of data sources.

4.2.4.1 Agency Personnel support consumer voice. Consumer voice is supported by attending to what consumers have to say. Ongoing consciousness-raising for staff provides a foundation to the process of supporting consumer voice.

Client voices are heard within our agency. Our staff are trained to advocate for clients both within and outside the agency. Our clients are our customers. We are constantly trying to improve service provision (SR).

It's important that families feel heard. Families give feedback, and we let them know that it's responded to (PY).

Agency personnel are intentional about generating and attending to consumer data. The CSS and surveys that are generated locally help keep CBS accountable to parents.

You don't like to hear the negative things, but when you hear them you can address them. If a family is having a particular concern, it can come to my attention through those surveys. We might think we're delivering great services, but if the clients aren't seeing that, then they help us to look again (PC).

Some settings review CSS results with parent groups. Directors report results and ask for consumer responses to those results.

I will meet with each of the teams and with parents to get their ideas of needs and improvements that need to be made (SU).

Consumer feedback forums and satisfaction surveys help identify strengths and needs of the program (SX).

4.2.4.2 Community Stakeholders support consumer voice. Consumer voice is supported by the community sources they identify as important to the child's or youth's progress.

Client treatments and services are coordinated by communicating with other service providers involved in the child's life - therapists, doctors, schools, family & friends that the family identifies as important (SU).

4.2.4.3 Goal Measures support consumer voice. Developing goals with consumers is a way to support consumer voice. This informs provision of services that consumers recognize as effective.

The individual services offered to the family and the outcomes of that process is what keeps families invested in the treatment process (SW).

Asking for ongoing feedback from client and family helps them see where they are at and where they want to go in terms of mental health goals (SX).

Meeting with the client and family periodically in treatment plan meetings helps them stay encouraged & motivated. . . . If they didn't feel like they had a voice, but there was only something done to them, it's not very fair way to do it, and they won't buy into it, and there won't be success (PC).

One director indicated that measuring therapeutic relationship goals with a locally developed standardized measure supports consumer voice in that setting.

If the relationship is not going well, we know that right away, and can perhaps make a change in approach or match the client with a new clinician (PG).

4.2.4.4 Mental Health Best Practices support consumer voice.

Mental health literature supports consumer voice. Based upon ADHD research, one CBS developed a program for parents whose children were in the ADHD psychosocial program.

4.2.4.5 Working Knowledge supports consumer voice.** Directors reported listening to consumers in face-to-face contacts, in teams, through surveys, in family councils and family nights, and in treatment and support groups. Consumer feedback provides a context for information from other sources.

Some parents really get on board with the ADHD psychosocial group based upon recent mental health research, but for some it is not useful. We try to use that for encouragement and motivation, but it is not a source of encouragement to everyone (PA).

Although parental suggestions initiated the examining of [parent support services, other] data supported the expansion of those services (SM).

Consumer input is also supported by corroboration from other data.

If a parent reports something, and other sources are consistent with that, it gives validity to what the parents say. If parents and collateral sources are consistent, that is useful (PH).

4.2.5 Supervising Staff. Director discussions of supervising staff took two divergent tacks. They are reported here according to use of data for monitoring staff productivity and clarifying goals for staff.

4.2.5.1 Monitoring Staff Productivity. Staff productivity is the time staff spent “with teachers, children, parents, and other collateral contacts” (PY). The two data sources useful for monitoring staff productivity are presented in Table 4.2.5.1. Data from agency personnel and financial reports assist directors’ supervision of staff productivity.

Table 4.2.5.1 Data Sources Used to Monitor Staff Productivity	
4.2.5.1.1	Corporate compliance data person
Agency	Business offices
Personnel	Case management supervisors
4.2.5.1.2	Production quota
Financial	Caseload reports - approximately 15 clients
reports	Reports about payer sources & un-reimbursed cost
	Billable hours & minimum expectations printouts

4.2.5.1.1 Agency Personnel support staff productivity monitoring. Business offices and case management supervisors provide data that help directors track productivity.

There are more streams of information now than ever before. We have to pay closer attention to the business side of mental health. The corporate compliance data person is on the management team now, which is helpful (PD).

Productivity information is provided by the business office. They helped us realize that new case managers were spending time in psychosocial group, not very productive in terms of revenue or client services. I monitor caseloads, and keep track on a week-to-week basis about who is full and who has openings (PB).

4.2.5.1.2 Financial Reports support staff productivity monitoring. EMR and spreadsheets are used to supervise staff productivity and accountability to payer sources.

Each individual provider has a production quota based on their assignment. Progress toward that annual quota is routinely reviewed in supervision. Caseloads are usually based on the CBS guideline of 15 kids per case manager, but other assignments are factored in (SS).

We get a lot of reports about payer sources and un-reimbursed cost generated internally. We send a strong message to staff that we have to understand payer sources and provide services in collaboration with payer source or self-pay. Un-reimbursed costs are written off. We receive weekly reports on expectations and caseload. We have capacity to run caseload on a daily basis – it is probably run weekly. We have a paperless chart system that allows us to pull staff performance from the computer (PA).

Staff get a monthly printout on their billable hours and they have minimum expectations. If they don't meet those, it will effect their evaluations, their raises, and will lead to disciplinary action (SQ).

4.2.5.2 Clarifying Goals for Staff. Data from consumers, agency-wide goals measures, mental health best practices and CSR/AIMS assist directors in clarifying goals for staff. Data sources useful for monitoring staff productivity are presented in Table 4.2.5.2.

Table 4.2.5.2 Data Sources Used to Clarify Goals for Staff	
4.2.5.2.1 Community Stakeholders	School-based teams, including families and IEPs
4.2.5.2.2 Consumers	Locally developed parent surveys provide useful program feedback CSS clarify state goals
4.2.5.2.3 Goal Measures (Agency-Wide)	Mission statements and values statements
4.2.5.2.4 Mental Health Best Practices	Clinical coordinators Information nationally & regionally, e.g., Kids Training Team Child treatment planning guide
4.2.5.2.5 CSR/AIMS	Communicate state goals Problem solving Staff create reports

4.2.5.2.1 Community Stakeholders help clarify goals for staff. School data was identified as useful for clarifying staff goals.

Information from school-based teams, IEP meetings, families - the local data are very helpful (PG).

4.2.5.2.2 Consumers help clarify goals for staff. Consumer surveys, particularly surveys developed locally, are useful for helping directors clarify goals for staff. Goals can be reviewed and modifications planned based upon that feedback.

We have an extensive parent support education program. . . . At the end of it, parents fill out in-house evaluations. We have a one day divorce workshop - referrals from divorce court or attorneys - parents who have filed go through the one-day Saturday workshop on how to avoid screwing up your kids while you go through the divorce. Parents fill out in-house evaluations. The same for summer camp program evaluations. Staff look at those evaluations and try to make modifications for the next year. It's local, immediately useful, and further clarification is possible from the sample (PF).

CSS . . . make the goals very clear. When goals are not met, performance improvement plans are written and focus our attention (PE).

4.2.5.2.3 Goal Measures (Agency-Wide) help clarify goals for staff. Agency goals are a criterion for staff evaluation.

Staff know goals through mission statements and values statements, about what's important in doing their job here. When people don't meet the expectations, they don't stay here (PY).

4.2.5.2.4 Mental Health Best Practices help clarify goals for staff. Several directors indicated that they access mental health literature and resources with information about what is happening nationally and regionally, that provide a basis for developing and clarifying goals for staff. For example:

The Kids Training Team [2007] has developed a toolbox that is most useful for clarifying CBS goals for my staff. I can also refer my staff to their clinical coordinator in their office who will provide them great resources. Each staff member also has access to the child treatment planning guide which gives them ideas on how to word client goals (SL).

4.2.5.2.5 CSR/AIMS help clarify goals for staff. The CSR helps directors communicate state goals for their local staff. In one setting, the director indicated that communicating state goals was the only application for CSR/AIMS.

The data I can provide through AIMS is only useful as a supervision piece of keeping goals clarified (PG).

Three directors indicated that they use the CSR to help staff problem solve and to plan for future successes.

AIMS outcomes are useful with staff to guide them when they feel like they've hit a dead end, or are ready change services (PJ).

AIMS . . . make the goals very clear. When goals are not met, performance improvement plans are written and focus our attention (PE).

PA reviews CSR/AIMS with case managers quarterly so that they see their data compiled. Another director similarly involves staff, in this instance for development of reports based upon CSR/AIMS.

The staff have helped us create these reports and way of tracking things. So it's useful for them, and useful for the organization (SV).

4.2.6 Tracking Client Status. Tracking client status begins with identification by consumers of the relevant settings. Directors track client status movement through feedback from agency personnel, community stakeholders, consumers and CSR/AIMS. Data sources useful for tracking client status are summarized in Table 4.2.6.

Table 4.2.6	Data Sources used to Track Client Status
4.2.6.1 Agency Personnel	Case managers
	Parent support specialists
	QMHPs
	School social workers
4.2.6.2 Community Stakeholders	JJA, including courts, DA's office, probation officers
	Schools
	Child welfare
	The Farm
	KAW Valley
	DCCCA
	Kansas Children's Service League
	Head Start & birth to three programs
	MR/DD
	Sexual offending behavior programs
4.2.6.3 Consumers	Primary source of status information for youth not involved with the legal system.
4.2.6.4 CSR/AIMS	Data obtained through case managers' contact with client systems and entered by case managers
	Useful in conjunction with other data

4.2.6.1 Agency Personnel provide client status information. Case managers are key agency personnel for following youths' community statuses. They relay status information based upon their involvement in the home, the school, with child welfare and with law enforcement. Parent support specialists can likewise provide important status information. QMHPs also provide feedback based on their contact with involved systems. They may attend meetings such as school multidisciplinary conferences, or they may be assigned within the school setting as school social workers. If a child exits CBS temporarily for inpatient psychiatric or group home services, they can be followed by a QMHP who helps transition the youth back into the community.

Sometimes the information is funneled through the case manager and sometimes through the therapist (SS).

Case managers live with these kids (PF).

Our school social workers and case managers provide many services in the schools. Our foster care diversion program, juvenile intake services, juvenile programs, and emergency services support living situations and law enforcement involvement. Our therapists and case managers also support living situations (SR).

4.2.6.2 Community Stakeholders provide client status information. Some directors indicated that it is difficult to track client status through community stakeholders. Other settings, however, could rely upon JJA, child welfare and other outside agencies to notify them when there is a change of status.

School information is acquired directly from the schools. Law enforcement feedback for children referred through JJA is provided through the courts or the DA's office. For children without previous JJA involvement, we rely on family reports. CBS relies on the child welfare worker's input regarding changes in foster placements (PE).

We make efforts to include all the relevant parties in the treatment process, including contact with probation officers. We are in every school in the county at some point in the school year (PA).

Our community relationships are really good. These include schools, □ SRS, The Farm, DCCCA, KAW Valley, Kansas Children's Service League, □ JJA, court services, Head Start, DD, MR, sexual offending behavior programs, the birth to 3 program. Our home-based coalition meets monthly. We talk to each of these there and informally throughout the month (PB).

4.2.6.3 Consumers provide client status information. Consumers are the primary source of status information.

If a child isn't directly involved with the legal system then that information is obtained from the parent and youth report (SW).

4.2.6.4 CSR/AIMS provide client status information. Many directors look at their CSR/AIMS status information, yet each of the ten who identified CSR/AIMS as useful mentioned it in conjunction with other data sources. Directors particularly identified the case managers who input the AIMS data as being their useful source for client status.

Case managers do a great job in keeping the center up on this type of data. There is a lot of communication between the center and the schools. . . . This data will be recorded on AIMS at the end of the month. This is also a way of tracking this data (SO).

CSR -- we would get that anyway without the CSR (PD).

The child's community status is reviewed by the case manager. All of this information is incorporated in the CSR/AIMS data monthly report (SM).

4.3 Supporting Knowledge Building for Informed Decision-Making

On a four point Likert-type scale, participants indicated that their CMHCs are supportive of knowledge building for informed decision-making. CMHCs were rated as extremely supportive of informed decision-making by 62% of directors, and as supportive of informed decision-making by 21% of directors. No directors indicated on the Likert-type scale that their CMHC obstructed informed decision-making.

Follow-up questions asked directors to elaborate on the ways their agencies were supportive and the ways their agencies seemed to obstruct the use of information. It is interesting to note that more than one fourth of the directors who had indicated that their CMHC did not obstruct the use of information nonetheless answered the question about ways their CMHCs obstructed their use of information. Responses to this qualitative question provided much more in-depth feedback than was captured by the Likert-type scale. CMHC supports for the use of data to inform decision-making are presented in section 4.3.1. Additional supports that directors indicated needing for data use are presented in section 4.3.2.

- 4.3.1 Current CMHC Supports for Use of Data to Inform Decision-Making.** CMHCs that support knowledge building for informed decision-making have a culture of trust and creativity, use technology effectively, and allocate resources needed for data to inform decision-making. CMHC supports are summarized in Table 4.3.1.

Table 4.3.1.	CMHC Supports for the Use of Data to Inform Decision-Making
	4.3.1.1 CMHC Culture of Trust and Creativity
	4.3.1.2 Technology
	4.3.1.3 Resource Allocation
	4.3.1.3.1 Personnel Who Research and Communicate Best Practices
	4.3.1.3.2 Access to Best Practice Materials
	4.3.1.3.3 Time to Collaboratively Consider Data and Make Decisions
	4.3.1.3.4 Funding to Support Interventions Suggested by Data

- 4.3.1.1 CMHC Culture of Trust and Creativity.** In agencies with cultures of trust and creativity, administrators encourage the use of data for developing new ideas and interventions.

If someone has an idea that seems logical, follows a standard line of treatment, they are open to that (PA).

We are encouraged to seek grants to bring new programs when need is identified (SX).

The CMHC encourages reports and recommendations made by a variety of staff, from provider to administrative levels, with demonstrable support for making changes or adding services” (SS).

Supportive CMHCs disseminate useful information to the CBS and share information with CBS personnel.

They provide information that gives the staff a framework for understanding policy and the need for policy changes that occur. Understanding the “why” behind policy certainly helps reduce resistance (SM).

Information is shared in clinical directors’ meetings (PE).

Collaboration is important in CMHC cultures that support building knowledge to inform decision-making.

The CMHC trusts the clinical judgment and practices within the treatment team. They are supportive of staff training and improving current practices. The business, clinical and administrative teams function and work together well (SR).

The executive director is very visionary. There is a permissive leadership style regarding trying new things, delegating responsibility and authority. CBS are considered as independent mental health centers. The executive director is not disconnected, and is ready to go out on a limb. Do it, and figure it out as you go (PD).

4.3.1.2 Technology. Several directors identified EMR as a support for data use. Two directors reported the use of business reporting software that captures AIMS data that are submitted to the Mental Health Consortium.

One director spoke of an agency where EMR was used both to reduce paperwork and to support a best practice ideology.

They are incorporating the strengths based perspective into our newly developed EMR, which would have been much easier to write just from the medical model. They are working hard to move all paper medical records onto the computer (PG).

4.3.1.3 Resource Allocation. Supportive CMHCs provide resources that support the use of data. Useful resources include personnel who research and communicate best practice information, direct access to best practice materials, time for making decisions based upon data, and funding to support interventions suggested by data.

4.3.1.3.1 Personnel who research and communicate best practices. Intentional allocation of personnel to seek out best practices for the CBS was mentioned by two directors. The identified personnel had a clinical title in one setting and an administrative title in the other.

We have a clinical director here that mainly works on reviewing data and evidence based practices to help our center head in the right direction (SO).

The associate executive director is constantly challenging us and providing us with new data (PE).

4.3.1.3.2 Access to best practice materials. Supportive agencies place best practice materials within the reach of their personnel.

We send people to current, relevant training. The center pays for State of Kansas library card so we can research. Many staff like to do research, and they will go do it (PA).

We are supported through workshops, articles, sharing among clinicians (SQ).

We have created tools for our staff, supervisors and directors use to guide our practice. We have dedicated resources to utilizing evidenced based practice (SV).

There is an expectation in these agencies that best practices will inform decision-making in the local setting.

We make decisions based on broader based studies and national research more than on studies done in this local setting. We have to look at the population that we are serving as very different from those in other regions. We have to meet the needs of the local population here (PI).

4.3.1.3.3 Time to Collaboratively Consider Data and Make Decisions.

Supportive CMHCs have consistent and planned forums to support utilization.

We are allowed the time and staff to devote to improving gaps in programming (PG).

We share at monthly leadership meetings for CBS and at Administrative Council. Then the teams take the information to their teams (SN).

They are supportive of regular team meetings on a number of levels to stay informed. We are able to access good data for making program and staffing decisions. We have regular client feedback surveys, budget reports, caseload and direct service hour reports (SX).

One director identified agency support for gathering information for community stakeholders.

We are heavily invested in having good community relationships and those sources help provide immediate and honest feedback and input. The CMHC encourages that, gives me the time to do it. Those relationships are used throughout the agency, not just in CBS (PF).

4.3.1.3.4 Funding to Support Interventions Suggested by Data. One director spoke of working in a CMHC that helps find funding for services that data indicate to be necessary, but that are unreimbursable through Medicaid, private insurance, SED waivers, Cenpatico, grants, and other sources.

4.3.2 Supports Needed for Use of Data to Inform Decision-Making.

CBS directors recognize that there are ways in which the culture of their CMHC could better support data use. There are technology and resource supports that could be useful. Several directors requested access to survey data with more locally relevant information. Directors also have several suggestions for the support of CSR/AIMS.

Some of the directors' comments about the surveys and about CSR/AIMS are more about the need for state supports than CMHC supports. The observation that one director would like to expand the role of CAFAS data is likewise directed to the state level. These observations are also included within this section. Needed supports are summarized in Table 4.3.2.

Table 4.3.2.	Supports Needed for Use of Data to Inform Decision-Making
	4.3.2.1 CMHC Culture
	4.3.2.2 Technology
	4.3.2.3 Resource Allocation
	4.3.2.3.1 Access to Best Practice Materials
	4.3.2.3.2 Time to Collaboratively Consider Data and Make Decisions
	4.3.2.4 Surveys
	4.3.2.5 CSR/AIMS
	4.3.2.5.1 Disaggregated Data
	4.3.2.5.2 Timely Data
	4.3.2.5.3 Help with Understanding Data
	4.3.2.5.4 Help Explaining Data
	4.3.2.5.5 Workbench

4.3.2.1 Need: CMHC Culture of Trust and Creativity. Directors want to be part of a CMHC culture where decisions are informed by data, but that does not always occur.

We are part of county government that is political in nature and decisions are not always based on data (ST).

Funding approval seems sometimes attached to executive director whim (PH).

Directors want to be part of a CMHC culture that protects the time needed for work with clients, but that is not always the case.

The CMHC brings a lot of paperwork, hoops to jump through. It can seem overwhelming to some clinicians. Paperwork is burdensome (PG).

4.3.2.2 Need: Technology. One director identified a way that technology could expedite recording data while at the same time decreasing time spent apart from client encounters.

Access to EMR for field staff so they do not have to duplicate record keeping. Our CMHC has come a long ways, but it would be good to know what information, what data, is out there and potentially accessible. We need tools you can use, such as Excel and Pivot Tables, and technology training to use them (PE).

4.3.2.3 Need: Resource Allocation. Needed resources include access to best practice materials and time for looking at and collaborating about data.

4.3.2.3.1 Need: Access to Best Practice. Several directors called for state supports in researching and applying best practices within their local settings.

Don't just tell me I have a problem, but offer some solutions. . . . Things like the kids' training team website [Kids Training Team, 2007] let me communicate with others about what they're doing. There's a ton of expertise & knowledge in the state that we don't access, often because we don't know it's there (PF).

It would be most helpful, rather than each CMHC having to develop their own programming for, for example, anger management or parent training, if someone would develop a really good program across the board. . . . It's quite time consuming to sit down and discover those programs for ourselves. We feel like we reinvent the wheel (PI).

We need more workshop opportunities, more evidenced based practice articles from the State, so they can do the research since I don't have a lot of time for that (SQ).

Two directors indicated additional measures that they would like to have collected by the state, to improve collaboration with other CBS.

It would be useful to include statewide use of CAFAS for data collection on CBS clients, to look at which services are bringing about favorable results, track outcome measures and use that to make policy/funding decisions (SX).

Other evidence-based outcome instruments, like what I'm hearing nationally that treatment is about the relationship, not about the model. Then we want to go to the state with that when we report outcomes (PG).

4.3.2.3.2 Need: Time to Collaboratively Look at Data and Make Decisions. The process of developing data sources, building expertise in discerning outcome information, and thinking about available data is time consuming. Lest the pages of research documentation find their best use as a "doorstop," it is important to have a forum for data to bring about understanding. CBS directors do not want to wade through streams of information alone. They want regular, planned forums for discussing CSR/AIMS and other outcome information.

Time is not provided for thinking about the information we received. There should be time in the management meeting every three months to look at and review AIMS and other data, but that does not happen. We have management meetings, sometimes without an agenda. That could generate some momentum around the use of AIMS data. If I knew more, understood the categories, I would be more likely to use it (PB).

We need more time at the administrative level to think about what we're doing. That's a luxury. Necessity isn't the mother of invention, luxury - time to contemplate & plan instead of just reacting - is the mother of invention. Time is a luxury we don't have (PF).

One director requested the time necessary to provide consistent wraparound services for every client.

When we do wraparound team processing, we accomplish things and the family feels heard. Our families stay encouraged. It would help if this were more systematic and we hit every family at least annually with an actual wraparound. . . . I would like routinely scheduled wraparound types of meetings. These need to happen without my specifically requesting them (PB).

Another director identified the CSS as an underutilized data source, because time does not allow requested the time necessary to provide consistent wraparound services for every client.

We get the CSS that are supposed to evaluate programs and practices, but I don't ever use them. It goes in the trash because I don't have time to dig through fifty pages of material (PF).

4.3.2.4 Need: Surveys. More than half of the directors requested either changes to the CSS or discussed the value there could be from having surveys that would supplement what they currently receive from the CSS. The CSS could provide more useful insights for local agencies if it supported the voice of all consumers and provided timely and targeted feedback.

The consumer satisfaction survey only supports the Medicaid recipient's voice. We have families that receive CBS services that are not Medicaid eligible (SW).

CSS could be very helpful in terms of shaping programs and their accessibility if it were more timely (PG).

We don't know who's contacted with the CSS, if they reach people without phones, if they reach people who are non-English speaking. Some people are reluctant to answer a survey, because they don't know how they've been contacted, how someone got their name (PI).

The CSS information is difficult to sort out, and it is unreliable. . . . We want family feedback, but for a parent to evaluate a program they don't understand is not helpful. They contact parents only involved in CBS, but talk to them about psychiatric services, out-patient therapy, crisis management, things that are not related to CBS. If they wanted to know about the other services, they should contact representative samples of recipients of the other services. . . . Formal data is not useful, at least I don't know how to use it well. A grade of 2.5 on a psychosocial program from the Consumer Satisfaction Survey might tell me I have a problem, but doesn't tell me what the problem is. We can have parent meetings to follow up but the parents who are willing to come and contribute are those with a high commitment to the program, and therefore, generally are well satisfied with the services they get (PF).

Directors want information that is easily understood and applicable to their work, to supplement information that comes from CSS.

We developed a survey for the school based program, but it does not get completed as it should because of staff shortages. It's supposed to be done at the beginning and end of each semester. We survey both parents and teachers about changes in the child's behavior (PI).

It would be helpful for us to create our own survey, asking the questions we need the answers to (PF).

4.3.2.5 Need: CSR/AIMS. CBS directors want more information about how well their programs and teams are addressing the needs of individual clients and groups of clients. They believe that existing data hold evidence of program functionality, but that the data do not readily surrender that evidence.

4.3.2.5.1 Need: Disaggregated Data. There was wide consensus among directors that they want data that identifies local outcomes, disaggregated by youth and by timeframe.

To look at individual client data, staff specific data and team related data to look for problems as well as successes (ST).

It needs to be available on an individual basis, or divided into meaningful dimensions - the program the kid is in; the case manager; how the child is doing compared to last month, last six months, last year. It's not so useful to find out we have three more kids who've been truant in the past six months, but it would help if you knew who they were (PB).

4.3.2.5.2 Need: Timely Data. Directors want to receive their CSR/AIMS while the things that were occurring during data collection are still relevant, so it could be applied to local decision-making. It seems that at a minimum this includes being able to access the data that they submit to the Mental Health Consortium.

Timeliness. CSR information comes too late. When field staff asks about it, we can't remember what happened. It ceases to be valid about anything pinpointed. It needs to provide more accessibility for local trends, not just to be about compliance (PH).

We need *timely feedback about goal-based performance* -
- preferably a "real-time" process (SS).

AIMS monthly rather than quarterly would inform the program in a time frame that allows me to do something about a problem if it is apparent. It can be relevant to what parents and families are telling us, only if we can get it in a timely fashion. . . . We want to see it monthly, to inform treatment teams and families on the work they do with kids right now (PG).

4.3.2.5.3 Need: Help with Understanding Data. There were directors who expressed regret about the waste of resources. For these, the CSR joins the off-putting mound of potentially useful outcome information, that limited training in the uses of the data, and time to comprehend the data, prevent them from accessing.

I do not know enough about the data we have. . . . It is frustrating to advocate for anything that takes more time, but meaningful training would be helpful to teach us how to read the CSR, what we can and can't get out of it. . . . It probably wouldn't take longer than a training session, but the CSR seems daunting. This training would need to be for those who create, develop, implement, supervise and administer programs. It is not just teaching nuts and bolts of the categories that would be helpful (PB).

Through a lot of education about the power of the available information and how to use it to develop programs/services (ST).

4.3.2.5.4 Need: Help with Explaining Data. One director requested support in communicating the purpose of collecting AIMS data to community stakeholders.

It would be helpful for the agencies that we collect information from to understand the State's effort in collecting data, school attendance records for example. Maybe a brochure for schools, court services, special education, parents, because these are goals that we have to work on in conjunction with other agencies (SW).

4.3.2.5.5 Need: Workbench. Adult community-based services in Kansas have the AIMS Workbench, a tool for accessing and applying AIMS data in the local setting. Seventy-six percent of the children's directors who responded to the Workbench questions indicated that they had heard of the Workbench for the adult Community Support Services. Of those familiar with the adult Workbench, 81% indicated that they expect the development of a similar tool for CBS could be of use to them.

Of the directors who were familiar with the Workbench, researchers asked, “What usefulness do you anticipate the workbench might have for your CBS?”

A workbench-like tool gives the ability to look at data in more specific detail in terms of teams, practitioners, and individual clients; but this is only useful if data is accurate and timely (SX).

Help us drill down individually to look at teams, case manager performance, section it out to look at timeframes (PA).

Instead of aggregated data, we would receive find-tuned data, structurally narrowed down to provide information about particular teams or staff members. When I get AIMS data, I have figure out what questions I need to be asking based on that data. The workbench would sort it out and point to areas for improvement and change (PE).

Pull reports for productivity of individual case managers. Why is this case manager able to provide more services than another? How could we help the others? □Is there one case manager who has most of the children who don't go to school? (PC).

Workbench might provide an easier way to manipulate the data applicable to particular settings and people, tailored to what we need to know (PH).

5. 5. DISCUSSION

Each respondent in this study indicated that informal feedback from parents, schools, and community supports was useful for planning and action in behalf of the client, despite the anecdotal nature of that information. The immediacy and direct applicability of information gleaned from “listening to clients we serve and spending time with them” (PD) make it valuable for ongoing understanding about what is and is not functioning well for the child or youth. Information that was valuable to CBS directors was evidence accessed within the context of decisions they were making. This echoes what Stuart Kirk observed in 1979, that useful data are relevant to practice.

5.1 Limitations

The research teams asked CBS Directors to recall what data they have used to inform decisions. Reid & Fortune (1992) suggest that it is difficult to recall data use after the fact. A follow-up study in which directors record the types of decisions they make, and the data on which they rely to make those decisions, would provide a more accurate picture of data utilization. It would likewise be useful for an observer to spend time with directors to catalog their data utilization, as observations are considered more reliable than self-reports.

This study provides in-depth information about data utilization in 25 Kansas CBS. The findings present categories of data sources and utilization, with the caveat that knowledge about the sources and uses of data in one setting may not be transferable. Findings may, however, be applicable to other children's community mental health services settings with contextual similarity (Lincoln & Guba, 1985, p. 298).

Survey questions asked by researchers defined the data utilization categories, based upon the literature review and preliminary interviews. There may have been additional categories of data utilization not included in the survey questions. It is possible that there are internal uses of outcome information that were not captured by this study.

5.2 Implications

There were CBS directors in this study whose immediate answer to the question, "How do you use data?" was, "We don't!" Upon closer examination, however, the use of data to inform decision-making was so fully integrated into practice that directors did not think about what they are doing as 'data utilization.' CBS directors gather data based upon its availability and its applicability. The directors in this study were good information stewards, with the ability to uncover consumer-focused information that answers program and practice questions from the sources at their disposal and to inform their next decisions.

Outcomes indicating the effectiveness of prior programs and practices are important to Kansas CBS, but directors face new sets of dilemmas and resources each day. Factors that culminated in successes and impasses of six months prior are no longer in place, which leads to uncertainty about whether yesterday's interventions will produce yesterday's outcomes. Michael Patton suggested that "if one had to choose between implementation information and outcomes information because of limited evaluation resources, there are many instances in which implementation information would be of greater value" (2002, p. 161). Directors identified staff turnover, policy changes, community resource and need changes and client changes as reasons why outcome data lose their local relevance.

A 2001 study of the use of empirical evidence in mental health settings similarly concluded that social workers use "direct statements from their clients and/or observations of new client skills to evaluate their practice efforts" (Drisko, p.420). While data use is integrated into practice and program decision-making, technology is not fully incorporated. While the CSR was developed to provide useful outcome information, its expansion to meet state and federal information demands has not enhanced its availability or its applicability to inform decision-making. The results of this study are consistent with Grasso & Epstein's observation that it is "fair to say that information system designers have yet to demonstrate the full compatibility of computerization and clinical treatments" (1993a, p. 374-5). CBS directors' decision-making is far more influenced by meanings derived from client interactions than by formal outcome information.

Separating data from their time context limits their usefulness. The problems of children and youth do not wait for statewide data to be aggregated. Rather, children's issues flux as they grow, as friends move in or out, as school demands vary, and as their home and community supports change. Computerized information loses its local relevance by separation from the time context. AIMS has the capacity to collect and aggregate large amounts of data from multiple sources, but the process of collecting data from each of the children's CBS remains time-consuming, distancing data from its context.

5.3 Recommendations

Support for data utilization within CBS is consistent with the President's NFC goal of accelerating excellent consumer and family driven mental health care delivery and research (2003). The recommendations of this study are to support data utilization by supporting the work that is already occurring, and by restoring a connection between technology and data utilization.

- 5.3.1 Provide AIMS Data in More Useful Packages.** Directors want to receive CSR/AIMS data in a timely fashion, while the things that were occurring during data collection are relevant to current decision-making. They want read-only access to their data after they submit it to the Consortium; a more rapid turnaround time for CSR; and CSR data disaggregated by team and timeframe.
- 5.3.2 CMHC Administrator Meetings with Time for Data.** This was already occurring in many settings, but other directors expressed that this would be meeting time well spent. Directors need time to process the information at their disposal.
- 5.3.3 Support Development and Implementation of Locally Relevant Surveys.** Directors know the questions that they would like to ask of their constituents, but do not have all the resources at their disposal for the surveys they would like to conduct.
- 5.3.4 Expand Directors' Orientation toward Outcome Data Utilization.** Directors use data primarily to inform week-to-week decision-making. It may be further useful to help directors develop the ways statistical and evaluative outcome data might be applied to program development.
- 5.3.5 Support Utilization of AIMS Data.** Nobody really wanted yet another training session, but some directors who were not using AIMS data wanted to know whether there are applications of CSR/AIMS to their own practice and planning. AIMS support could involve directors attending workshops. It could also include non-traditional supports, such as having a person familiar with AIMS person spend an afternoon with a CBS director in their CBS, to help them make connections between the questions they are asking and components of CSR/AIMS that could help answer those questions.

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Appendix A
IRB Project Approval Letter

Appendix B
Information Statement

Information Statement

The Department of Social Welfare at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

We are conducting this study to better understand utilization of Automated Information System (AIMS) Data in Kansas Community Mental Health Centers (CMHCs). This will entail your completion of a questionnaire. The questionnaire packet is expected to take approximately 30 minutes to complete.

Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of not only how AIMS Data are currently utilized, but also how it may further be utilized in order to better serve our consumer population. Your participation is solicited, although strictly voluntary. Your name will not be associated in any way with the research findings. You may drop out of the investigation at any time. If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail.

Completion of the survey indicates your willingness to participate in this project and that you are over the age of eighteen. If you have any additional questions about your rights as a research participant, you may call (785) 864-2269 or (785) 864-8972 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email dhann@ku.edu or mdenning@ku.edu.

Sincerely,

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Appendix C

CBS Directors' Preliminary Interview Guide

Assessment in CMHC Management

This questionnaire is being conducted to learn how managers build knowledge that helps them make decisions in Kansas Community Mental Health Centers. The questionnaire is designed to be completed in about fifteen minutes. Of course, your responses will be kept confidential, and your questionnaire will not be available to other CMHC personnel.

There are three questions:

- Question One asks about how you make decisions.
- Question Two asks about the usefulness of the CSR in decision-making.
- Question Three asks for your input in making the CSR more useful in the management of your CMHC.

Thank you for the help!

1. What influences do you consider when making decisions about modifying services at your CMHC?
 - a. Fiscal & funding constraints
 - b. Input from practitioners
 - c. Input from clients and their families
 - d. Input from regulatory bodies
 - e. Client attendance at the programs offered
 - f. Outcomes of single system design studies
 - g. Outcomes of other evaluation studies at your CMHC
 - h. Current literature/research
 - i. Information provided by the Children's Client Status Reports
 - j. Other
-

2. In which of the following ways do Children’s Client Status Reports provide knowledge that is useful to you as decision maker?

- a. Problem and goal formulation
- b. Progress monitoring
- c. Outcome evaluation
- d. Decision-making
- e. Increasing the knowledge of your staff
- f. Planning
- g. Teasing apart complex evidence
- h. Acquiring external funding
- i. Quality improvement
- j. Staff evaluation
- k. Other

l. CSRs do not provide knowledge that is useful to me as a decision maker

3. Finally, please take a moment to consider and talk about what supports could be put in place that might help the CSR become more useful to your CMHC.

Appendix D
CBS Directors' Phone Survey

Knowledge Building and Decision-making in Kansas' CBS
Survey

The child and family systems who present at your CBS carry a complex mixture of strengths and adversities. Your responses to the following questions may be as multifaceted as the children you serve. While we work through these questions, if you have an idea that applies to a previous question, we can go back to that for a moment. The complexities of the use of knowledge for decision-making are what we want to know about.*

A. How do you know what to do? How do you know what works? What information do you use?

A-1) In your CBS, how do you learn about a child's history?

A-2) How do you match a child with specific workers and programs?

A-3) How are client treatments and services coordinated?

A-4) How are clinical treatment decisions made with and for the child?

A-5) How do you know whether a treatment has been effective?

A-6) How are a child's community statuses followed, including educational placement/progress, living situations, law enforcement involvement, and the like?

A-7) How do you identify aspects of your CBS that generate desired results, and aspects of your CBS that need improvement?

A-8) How do you keep track of outcome trends within your CBS?

A-9) How do you know when to develop new programs or retool existing programs?

A-10) How do you manage payer sources, unreimbursed cost, monitor staff 'minimum expectations' and caseloads?

A-11) How do you compare what you are doing to what is happening in other CBS settings?

A-12) Are there other ways that programs and practices are evaluated?

- B. To respond to these questions, please think about the support you experience within your CMHC for the use of knowledge for informed decision-making.

B-1) Indicate how supportive of knowledge building and informed decision-making you experience your CMHC to be:

- Extremely supportive of informed decision-making
- Supportive of informed decision-making to some extent
- Obstructive of informed decision-making to some extent
- Extremely obstructive of informed decision-making

B-2) If you think the climate of your CMHC seems to support the use of information for knowledge building and decision-making, please tell us ways they do that.

B-3) If you think the climate of your CMHC seems to obstruct the use of information for knowledge building and decision-making, please tell us ways they do that.

B-4) Is the information you access useful for clarifying CBS goals for staff? If so, could you say more about that?

B-5) Is the information you access useful for supporting client voices? If so, could you say more about that?

B-6) Is the information you access useful for helping clients stay encouraged and motivated? If so, could you say more about that?

- C. To respond to questions for this section, please think about additional ways information could become more useful within your CBS for knowledge building and decision-making.

C-1) How might the information sources that you identified previously be supported or enhanced, to provide information that is more useful to you?

C-2) What are some ways your CMHC could improve their support of knowledge building and informed decision-making?

C-3) Is there anything else that could be made available to you for knowledge building and informed decision-making within your CBS?

D. There has been some consideration of implementing the AIMS workbench for children's CBS.

- | | |
|--|--------|
| 1. Are you familiar with AIMS workbench? | Yes/No |
| 2. Do you think the workbench would be useful to your CBS? | Yes/No |

3. What usefulness do you anticipate the workbench might have for your CBS?

*Listed in the box below is a short list of information sources that are useful to some CBS Directors for knowledge building and decision-making. This list is provided here for your convenience. As you read through the list, you may want to make a note of other information sources that you have found useful.

- ❖ CSR/AIMS data
- ❖ Electronic medical record data
- ❖ Financial reports
- ❖ Community partnerships, including but not limited to: Schools, juvenile justice/courts, child welfare, community councils/coalitions, and wraparound
- ❖ Formal assessments, including but not limited to: CBCL, CAFAS, and intake information
- ❖ Parent/guardian feedback, including but not limited to: Parent councils, and family nights, and informal contacts, and consumer satisfaction surveys
- ❖ Multi-disciplinary feedback within the CBS, including but not limited to: Information exchanged in case management teams and supervision
- ❖ Practice wisdom: Experience with clinical indications about what is needed
- ❖ Best practices guidelines & clinical models, including but not limited to those gleaned from: Continuing education, literature, and CBS directors' collaboration

Appendix E

CBS Directors' Internet-Based Survey Accessed on Surveymonkey.com (2006)

Top of Form

Respondent Type: Tracked [Edit](#) / [Delete](#) this respondent

Email:

Name:

Custom Data:

IP Address:

Started Survey:

Ended Survey:

1. Informational Statement

1. In your CBS, how do you learn about a child's history?

2. How do you match a child with specific workers and programs?

3. How are client treatments and services coordinated?

4. How are clinical treatment decisions made with and for the child?

5. How do you know whether a treatment has been effective?

6. How are a child's community statuses followed, including educational placement/progress, living situations, law enforcement involvement, and the like?

7. How do you identify aspects of your CBS that generate desired results, and aspects of your CBS that need improvement?

8. How do you keep track of outcome trends within your CBS?

9. How do you know when to develop new programs or retool existing programs?

10. How do you manage payer sources, unreimbursed cost, monitor staff 'minimum expectations' and caseloads?

11. How do you compare what you are doing to what is happening in other CBS settings?

12. Are there other ways that programs and practices are evaluated?

2. Within your CMHC

13. Indicate how supportive of knowledge building and informed decision-making you experience your CMHC to be.

14. If you think the climate of your CMHC seems to support the use of information for knowledge building and decision-making, please tell us the ways they do that.

15. If you think the climate of your CMHC seems to obstruct the use of information for knowledge building and decision-making, please tell us ways they do that.

16. Is the information you access useful for clarifying CBS goals for staff? If so, please tell us more about that?

17. Is the information you access useful for supporting client voices? If so, could you please tell us more about that?

18. Is the information you access useful for helping clients stay encouraged and motivated? If so, please tell us more about that.

3. Additional uses of information

19. How might the information sources that you identified previously be supported or enhanced, to provide information that is more useful to you?

20. What are some ways your CMHC could improve their support of knowledge building and informed decision-making?

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21. Is there anything else that could be made available to you for knowledge building and informed decision-making within your CBS?

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22. There has been some consideration of implementing the AIMS workbench for children's CBS.

Are you familiar with AIMS workbench?

Do you think the workbench would be useful to your CBS?

23. What usefulness do you anticipate a workbench might have for your CBS?

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4. Thank you!

24. Name and Contact number (Again, all information will be kept strictly confidential):

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Appendix F

CMHC/CBS Local Catchment Areas

Community Mental Health Centers

1. Area Mental Health Center
1111 E. Spruce St.
Garden City, KS 67846
620-275-0625
2. Bert Nash Community Mental Health Center
200 Maine St., Suite A
Lawrence, KS 66044
785-843-9192
3. Center for Counseling and Consultation Services
5815 Broadway
Great Bend, KS 67530
620-792-2544
4. Central Kansas Mental Health Center
809 Elmhurst
Salina, KS 67401
785-823-6322
5. COMCARE of Sedgwick County
635 N. Main
Wichita, KS 67203
316-660-7540
6. Community Mental Health Center of Crawford County
911 E. Centennial
Pittsburg, KS 66762
620-231-5130
7. Cowley County Mental Health & Counseling Center
22214 D St.
Winfield, KS 67156
620-442-4540
8. Family Consultation Service
560 N. Exposition
Wichita, KS 67203
316-264-8317
9. Family Life Center, Inc.
6610 SE Quakervale Rd., P.O. Box 550
Riverton, KS 66770
620-848-2300
10. Family Service & Guidance Center of Topeka, Inc.
325 S.W. Frazier
Topeka, KS 66606
785-232-5005
11. Four County Mental Health Center
3751 W. Main
Independence, KS 67301

620-331-1748

12. Franklin County Mental Health Center
204 E. 15th St.
Ottawa, KS 66067
785-242-3780
13. The Guidance Center
J. David Kaaz Memorial Campus
500 Limit Street
Leavenworth, KS 66048
913-682-5118
14. High Plains Mental Health Center
208 E. 7th St.
Hays, KS 67601
785-628-2871
15. Horizons Mental Health Center
1715 E. 23rd St.
Hutchinson, KS 67502
620-665-2240
16. Iroquois Center for Human Development
610 E. Grant
Greensburg, KS 67054
620-723-2272
17. Johnson County Mental Health Center
6000 Lamar, Suite 130
Mission, KS 66202
913-831-2550
18. Kanza Mental Health and Guidance Center
909 S. Second Street, P.O. Box 319
Hiawatha, KS 66434
785-742-7113
19. Labette Center for Mental Health Services
1730 Belmont, P.O. Box 258
Parsons, KS 67357
620-421-3770
20. Mental Health Center of East Central Kansas
1000 Lincoln
Emporia, KS 66801
620-343-2211
21. Pawnee Mental Health Services
P.O. Box 747
Manhattan, KS 66505
785-587-4346
22. Prairie View, Inc.

1901 E. First St., P.O. Box 467
Newton, KS 67114
316-284-6310

23. South Central Mental Health &
Counseling Center, Inc.
2365 W. Central
El Dorado, KS 67042
316-321-6036

24. Southeast Kansas Mental Health Center
304 N. Jefferson, P.O. Box 807
Iola, KS 66749
620-365-8641

25. Southwest Guidance Center
P.O. Box 2945
Liberal, KS 67905
620-624-8171

26. Sumner Mental Health Center
1601 W. 16th Street, P.O. Box 607
Wellington, KS 67152
316-326-7448

27. Sunflower Centers of Kansas, Inc.

28. Wyandot Center for Community
Behavioral Healthcare, Inc.
757 Armstrong, P.O. Box 171578
Kansas City, KS 66101
913-233-3300

(Kansas SRS, 2005d, pp. 60-61).