

**STATE OF TEXAS  
STATE OFFICE OF CRCG**

**EVALUATION OF THE  
COMMUNITY RESOURCE COORDINATION GROUPS (CRCGs)  
OF TEXAS: PHASES I & II**



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## Executive Summary: Phases I & II

### Introduction<sup>1</sup>

In 1995, the largest proportion (29%) of Texas' population was under age 18 with 5.3 million youth (Texas Kids Count Project, 1998). Furthermore, one in four children in Texas live in poverty. Over the past two decades the economic security of families with children has severely declined, thereby increasing the risks for these children. Social services are a vital part of ensuring the physical, emotional and mental well being as well as the safety and success of this at-risk population (Texas Kids Count News Release, 1997), placing health and social service providers in great demand.

In response to these and other concerns, the Children and Youth Services State Coordinating Committee was created by the 70<sup>th</sup> Legislature in Texas in 1987 to assist state and local agencies with the coordination of their local service delivery for children with problems that could be addressed only with the participation of more than one agency. *Texas Family Code* 264.003 (formerly *Texas Human Resources Code* 41.0011), enacted at the time, requires state agencies to maintain a Memorandum of Understanding (MOU) to provide service to Texas children who "fall through the cracks." The primary purpose of the memorandum is to establish a system for interagency coordination of services to children and youths. The agencies are asked to recognize the importance of the family in the life of each youth whom the agencies serve and to provide services in the most normal and least restrictive environments possible. Currently, 151 local Community Resource Coordination Groups (CRCGs) serve all 254 counties of Texas.

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<sup>1</sup> Portions of this section excerpted from the Community Resource Coordination Groups (CRCG) of Texas Fiscal Year 1996/97 Annual Report, *Making a Difference One at a Time*.

## **Research Methodology**

### **Phase I**

The main objectives of Phase I of this two-year study were essentially two-fold: to determine to what extent selected Community Resource Coordination Groups (CRCGs) were meeting the stated goals of the Memorandum of Understanding (MOU), and to learn about the best practices of CRCGs in relation to the charge of the MOU. The research team of The University of Texas at Austin, School of Social Work, Center for Social Work Research (CSWR) conducted a focus group with CRCG members, visited four (4) CRCG sites covering 11 Texas counties to observe the process of CRCG meetings, conducted semi-structured face-to-face interviews with CRCG members, and mailed out questionnaires to CRCG members.

### **Phase II**

The main objective of Phase II was to determine the extent to which families that were staffed by CRCGs were satisfied with the process. During Phase II, the research team selected 52 CRCGs across the State of Texas to participate in this part of the study. Potential subjects included the parents/guardians of all children/adolescents served by the 52 selected CRCGs and who attended a CRCG meeting or case staffing from January through July 1999. [A case staffing is a meeting where representatives from various agencies collaborate under the direction of a CRCG chair to discuss how to best meet multiple needs of individual clients (youth and their families), often with the youth and his/her family present]. Subjects had to be at least 18 years of age to participate in the study. Questionnaire packets (Client Satisfaction Questionnaires [CSQ-8]), cover letters/consent forms, and demographic face sheets) were mailed in bulk to each CRCG

selected for participation in the study. The CRCG chair or coordinator handed out the packet to parents or guardians that had just been served by the CRCG, and the parents or guardians at that time determined whether or not they wished to participate in this study. All forms were available in English and Spanish. Subjects that agreed to participate, and mailed in their completed forms, were also contacted two months later to complete a 2<sup>nd</sup> (follow-up) CSQ-8, and to answer some open-ended questions, to determine if their perceptions about the CRCG process changed over time.

Client Satisfaction Questionnaire (CSQ-8). The Client Satisfaction Questionnaire (CSQ-8) is an eight-item pencil-and-paper instrument, measured on a four-point Likert scale, which has been used successfully in numerous settings to assess client satisfaction with services provided. *The CSQ-8 is not necessarily a measure of a client's perception of gain from intervention, or outcome, but rather elicits the client's perspective on the value of services received.*

### **Major Findings: Phase I**

#### **Memorandum of Understanding (MOU)**

*Overall, the Community Resource Coordination Groups (CRCGs) that participated in this study appear to be meeting the stated objectives of the Memorandum of Understanding (MOU).* This is evidenced by the following findings as it corresponds to the objectives of the MOU.

- Most respondents agreed that family participation is important to the CRCG process, and expressed a desire for an increase in the amount of family participation. Some respondents felt that more could be done to prepare the families for staffings.

- The CRCGs appear to be serving children/youth and their families with multi-agency needs.
- While CRCGs accept referrals openly, there is at times confusion over what the specific criteria are for referrals (e.g., cutoff age of youth served). The referral process is at times loosely structured with unclear guidelines.
- There does not appear to be a duplication of services, and there are no identified laws or regulations that cause duplication.
- With regard to interagency cost sharing, most CRCGs seem to be effectively meeting the charge of the MOU by offering the services and funds available. However, there are often restrained resources and limited members with the proper decision-making authority to donate services or funds (especially in rural areas), in which case a handful of select agencies end up carrying the load.
- Dispute resolution was typically handled competently and this was not cited as a major problem for most sites.
- It appeared that most mandated agencies were attending staffings, but a greater variety of participants were desired. Non-attendance by mandated agencies was more of a problem in rural areas.
- Respondents were overwhelmingly satisfied with how often their CRCG met. Many CRCGs hold mini-staffings as needed that allow them to convene in between regular monthly staffings.
- Most respondents had no knowledge about permissible non-attendance, but in several cases it was reported that the chair contacted representatives from mandated agencies that did not attend a staffing.

- The CRCGs that were observed all used a confidentiality form that members had to sign, and handled confidential information of clients in a professional, ethical manner.

### **Best Practices**

In addition to the above findings relating to the Memorandum of Understanding, several “best practices” were identified among CRCGs, some of which are outlined below.

- Creating new resources (e.g., respite care), especially in rural communities where resources are limited.
- Continuing to meet every month, even when there is no child or youth to serve. This time could be used to familiarize each other on resources and to work on other projects.
- Combining CRCGs and Community Management Teams (CMTs) together in order to work on both micro and macro issues. [CMTs are the local operating mechanism for the Texas Children’s Mental Health Plan, which is an integrating initiative targeting mental health needs of children and youth.]
- Inviting a variety of agencies and participants, such as judges, to offer their expertise, if not resources and money, was highlighted.
- The collaborative effort of parents and agencies getting together, laying their resources out on the table, and allowing parents to have some input in the plans was identified as an essential part of CRCG practice.
- Immediate implementation of service plans (e.g., making relevant phone calls while interagency service planning is still on-going at the meeting).

- CRCG coordinators have been known to make a difference in the CRCG process by acting as case managers, facilitating meetings, and helping capture data.

Additional recommended best practices are explored at greater length below.

## **Major Findings: Phase II**

### **Client Satisfaction**

Fifty-two (52) respondents (parents/guardians of children served by a CRCG) completed and returned the Client Satisfaction Questionnaire (CSQ-8) immediately following a CRCG staffing, and thirty-five (35) of these 52 were available for contact two months later to complete the CSQ-8 again. With a range of scores between 8 and 32 on the CSQ-8, higher scores reflect greater levels of satisfaction.

- Initially, scores ranged from 9 to 32, with an average score of 28. Two-thirds (66%) of respondents scored between 29 and 32, indicating that overall respondents were satisfied with the CRCG process.
- For the two-month follow-up, total scores on the CSQ-8 ranged from 10 to 32, with an average score of 26. Just under half (45%) of respondents scored between 29 and 32, and almost one-fifth (17%) scored a 24 at the two-month follow-up.
- The average total score on the CSQ-8 lowered by two points over the two-month period following the staffing. While slight, this two point difference was enough to produce statistically significant differences ( $\alpha = .05$ ,  $p = .02$ ) between the first and second administration of the CSQ-8 when comparing mean scores.

Thus, there was a general trend toward slight degeneration of satisfaction with the CRCG process as time passed. One possible explanation for this trend is that immediately after

the initial staffing parents/guardians feel some relief from having their concerns addressed and they have hope for the future resolution of their child's problem.

### **Recommendations**

The operation of interdisciplinary efforts has the potential to bring many benefits, but also brings stress and complications. Both strengths and areas needing improvement are discussed below, and recommendations are made when appropriate.

There are many strengths of the CRCG process, which tends to be flexible. Many resources are brought to the table, and it appears that representatives are able and willing to share their expertise and available resources as needed. The teamwork and collaboration within each CRCG is dynamic, yet members respect and trust one another enough that healthy confrontation and challenging takes place between members, which is always in the best interest of the child/youth and his or her family. The chairs appear to possess the needed skills to facilitate the meetings. Importantly, the CRCG process lends itself to fostering an enhanced sense of community among helping professionals within a geographical area, which in and of itself creates increased seamless services.

While many CRCG staff complained of not having enough resources (in-cash and in-kind) in this study, data compiled by the State Office of CRCG from 1996 to 1998 examining barriers to service reveals that approximately 75% of CRCGs reported "no barriers" in 1998 to providing services, and that less than 10% of CRCGs reported "service unavailable" as a problem for the same year. Thus, even though many respondents noted anecdotally in face-to-face interviews in this study that they needed additional resources, more comprehensive data collected by the state indicates that barriers to service provision are relatively minimal. However, the State Office of CRCG has also compiled data that indicates a need for specific services (e.g., residential care,

respite care) in many communities. Based on our interviews with respondents, it is probably safe to assume that each community has different and unique needs.

This leads one to the conclusion that it may be necessary to utilize additional resources by building community action structures in each community. Most communities do not have a structure that allows local citizens to identify health care/mental health needs and to make decisions relevant to these issues. Planning and decision making are often governed by federal and state policy officials, by health professionals, and by local social service providers. For a community to become organized, action structures must be developed or revitalized (Poole, 1997). Action structures provide channels through which responsible citizens can take part in community health and mental health decision making through local planning and voluntary social action. Typically, these channels are called councils, commissions, and task forces. According to Poole (1997), “to qualify as *action* structures, they must include the top political, economic, and social welfare leadership of the community” (p. 82). For instance, a reformed Texas service delivery system known as “Safeguarding Our Future” links state and communities in the planning and delivery of services by making decisions at the local level. This program enables state government and individual communities to work towards common goals, to increase knowledge, and to identify and utilize resources in order to help families.

While such an effort may be beyond the charge of the MOU for CRCGs, they certainly have in place some of the needed infrastructure to actively participate in (and maybe spearhead!) community action structures. For example, CRCGs with a paid

coordinator could assume such a charge. However, due to the time and energy of such an effort, we recommend that a paid position (at least half-time if not full-time) is required. Getting at top-level issues in each community requires top-level leadership involvement, especially from the business community and key elected officials (Poole, 1997). One CRCG (Travis County) that we know of is already participating in a similar network by actively participating in the Children's Mental Health Partnership, which actively involves parents and community leaders to drive the delivery of community-based wraparound services to children and their families. (Note: The Travis County CRCG has a full-time paid coordinator.)

It may be helpful to provide additional training for the chairs and coordinators around issues such as theoretical frameworks or practice models used in interagency service planning, as their personal biases and frameworks for viewing clients can certainly shape the facilitation and focus of the CRCG process. Chairs and coordinators might also benefit from training on burnout prevention. (The State Office of CRCG would be responsible for providing such training.) As indicated above, there is a need for paid coordinators (full-time or part-time) whenever feasible, with the expectation that the coordinator possesses a certain skill level to deal with different treatment providers and increasingly challenging cases. In addition to the need for building the type of community coalitions described above, the added benefits that a paid coordinator brings to the CRCG include the flexibility to: follow up on multi-agency service plans, clean up complex client histories for presentation to the local decision-makers at the CRCG, prioritize the referrals of children and youth to be staffed, maximize decision-makers'

time and make the process more efficient, and hold frequent mini-staffings (pre-meetings or post-meetings) as needed.

The cases being staffed are often challenging in a variety of ways. Typically, it seems that there are enough sophisticated treatment providers at CRCG staffings to adequately address treatment issues. However, there seems to be a dearth of medical and legal expertise at the staffings. CRCGs might consider including medical doctors, nurses, and attorneys to fill this lacuna. One added benefit of having medical and legal professionals sitting on CRCGs is that these professions often bring resources (in-cash and in-kind) to the table. It is important to emphasize, however, that the CRCG process should not be hindered while waiting for medical or legal professionals to attend (whether for scheduling conflicts or other reasons).

Having co-chairs, especially at larger CRCGs in urban or metropolitan areas, is suggested. Responsibilities, such as group facilitation and securing resources, could be shared. This, in turn, might prevent burnout.

An important part of the success of a CRCG is an energetic, hard-working, and competent leader. Additionally, each CRCG should have a paid coordinator. This person should have strong interpersonal and facilitation skills. Having the right leader is a key ingredient to the success of any collaborative community network (Poole, 1997; Springer, Shader, & McNeece, in press). Because the leader is a key ingredient, each CRCG would benefit by having a leader who is compensated so that he/she will be able to devote the necessary time and energy to the tasks at hand.

The State Office of CRCG gathers local CRCG data in order to report service needs and groups to state level policy and decision-makers. This reporting process is

voluntary by local CRCGs and there is little to no incentives or penalties. Having support staff or co-chairs may help in this area.

Additional support for chairs could come in the way of a grant writer. A few respondents noted the need for such a position to secure external funding. How many grant writers are needed remains unclear at this point, but one possible suggestion is to hire one or two grant writers per region as needed.

Respondents identified lack of participation from certain agencies as a problem. (Non-participating agencies varied by site.) Some agencies appear to not have a representative at the CRCG staffings on a regular basis. One possible solution is to require that each mandated agency have a regular back-up representative that can serve as an alternate if the primary representative cannot attend. Additionally, attrition might decrease if mandated agency representatives are required to call the CRCG chair or the State Office of CRCG if they are unable to attend a meeting. If placing the responsibility on the individual representative is problematic, an alternative solution is to have the CRCG chair call the representative's immediate supervisor following missed meetings. Finally, an additional solution is that CRCG participation becomes a part of the representative's job description, which would provide representatives with needed support from their employer as well as the responsibility to participate as part of their duties. Employers would then have the option of including the representative's CRCG participation in his or her performance evaluation.

It is highly plausible that the mission of CRCGs would be better supported by the community of citizens and helping professionals if there was an increased awareness of what CRCGs do in a given community. It is recommended that public service

announcements (PSAs) and other forms of media coverage (newspapers, radio, and television) be utilized. The majority of respondents echoed this concern. Of course, this ties in to the discussion above about the importance of developing community action networks.

The State Office of CRCG produces a newsletter and maintains a website page. These are vital resources that can be used to share information (e.g., best practices) among the 151 CRCGs around the state. However, many respondents recommended that either a newsletter or a website be created, indicating that the CRCG members are unaware of the State Office's efforts in this area. Therefore, it is recommended that the CRCG members be made aware of these efforts, which will allow for the dissemination of information, and will also promote a greater sense of community among CRCG members across sites.

A concern for one rural CRCG regarding confidentiality and parent representatives was that in a small community most people know one another and have contact with each other on a regular basis and it may therefore be more challenging to maintain a client's right to privacy. However, with proper training on confidentiality, a parent representative can certainly maintain a client's right to privacy regardless of the size of the city or town. Based on information gathered, the inclusion of a parent representative on the CRCG should support overall family participation and level of comfort of families to participate in this collaborative process.

Overall, respondents were concerned about family attendance and expressed concern that it needs to improve. Additionally, once families do attend, there was an overwhelming concern that the families need to be better prepared for the staffing, as it

can be a rather intimidating process. For example, the contact person should be responsible for obtaining background information (conducting an assessment) on the child/youth and his or her family, clarifying the expectations of the family, and exploring how this fits with the CRCG mission. In addition, it would be helpful to explain beforehand how the CRCG process works and how a typical meeting proceeds.

Respondents (parents/guardians of children served by a CRCG) from Phase II of the study appeared generally satisfied with the CRCG process and with the type of services received. Even though in some cases the child's/family's problems had not been resolved entirely, parents/guardians still had positive perceptions of the CRCG process and personnel after a period of time had passed since the initial staffing. There was a general trend toward slight degeneration of satisfaction with the CRCG process as time passed. One possible explanation for this trend is that immediately after the initial staffing parents/guardians feel some relief from having their concerns addressed and they have hope for the future resolution of their child's problem. Very few children that come to the attention of CRCGs will have a complete resolution of their problem in a short period of time (although some did). Over time, parents/guardians may become disillusioned with the process when they continue to experience difficulty. This disillusionment with their life situation may carryover to their assessment of the CRCG process itself. In fact, Roberts, Pascoe and Attkisson (1983) found that there might be a relationship between service satisfaction and level of well-being overall in a respondent's life.

### *Considerations for Future Research*

The following suggestions for future researchers to consider in their efforts are based on the experiences that the research team gained over a two-year period of evaluating different aspects of Community Resource Coordination Groups (CRCGs).

- Examine to what extent CRCGs are involved in community action structures in their local community, as well as the impact that such efforts have on the community and the children and families that CRCGs serve.
- In the event that some CRCG chairs receive specialized training (e.g., using the strengths perspective as a guiding theoretical framework, how to facilitate task groups, community organizing), examine the impact that the trained chairs' leadership and facilitation skills have on the CRCG process when compared to chairs with no specialized training.
- Explore the best ways to utilize CRCG parent representatives in serving children/youth and their families.
- When implementing a mail survey with CRCG service recipients, follow-up phone contact (on evenings and weekends) will maximize the response rate.
- Attend local CRCG staffings, as they provide a setting with rich resources for data collection (e.g., CRCG chairs, staff and service recipients).

Overall, the CRCGs that participated in this two-year evaluation appear to be meeting the stated objectives of the MOU and effectively meeting the needs of a difficult population to serve. As with any collaborative interdisciplinary effort, there is room for enhanced delivery of services. Nevertheless, the CRCGs should be commended on their continued progress.

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## **Final Report. Evaluation of the Community Resource Coordination Groups (CRCGs) of Texas: Phases I & II**

### **Introduction**

The Republic of Texas was formed in 1836 and continued as such until December of 1845 when Texas became the 28th state in the Union. Covering 800 miles of seacoast, mountains, forests, and deserts, Texas has the second largest population among the states with over nineteen million residents spread over 254 counties. It is estimated that by the year 2025, Texas will be home to 8% of the nation's population ([www.census.gov/search97cgi/s97.cgi](http://www.census.gov/search97cgi/s97.cgi)). Texas residents come from a variety of ethnic backgrounds with 55.9% Anglo, 29.8% Hispanic and 11.5% African American ([http://txsdc.tamu.edu/abt\\_sdc.html](http://txsdc.tamu.edu/abt_sdc.html)). From big cities to border towns, Texans experience a variety of lifestyles.

In 1995, the largest proportion (29%) of Texas' population was under age 18 with 5.3 million youth (Texas Kids Count Project, 1998). Furthermore, one in four children in Texas live in poverty. Over the past two decades the economic security of families with children has severely declined, thereby increasing the risks for these children. Social services are a vital part of ensuring the physical, emotional and mental well-being as well as the safety and success of this at-risk population (Texas Kids Count News Release, 1997). Health and social service providers are in great demand as they attempt to successfully meet the growing needs of these families (Texas Kids Count Project, 1997). While urban communities may be more likely to have sufficient resources to address some of the needs of the children and families in their area, there are many border towns and rural communities that are simply not equipped with the needed resources.

### **The Establishment of Community Resource Coordinating Groups (CRCGs)<sup>1</sup>**

In response to these and other concerns, the Children and Youth Services State Coordinating Committee was created by the 70<sup>th</sup> Legislature in Texas in 1987 to assist state and local agencies with the coordination of their local service delivery for children with problems that could be addressed only with the participation of more than one agency. *Texas Family Code* 264.003 (formerly *Texas Human Resources Code* 41.0011), enacted at the time, requires state agencies to maintain a Memorandum of Understanding (MOU) (see Appendix A), with the advice of private sector service providers and children's advocates, to provide service to Texas children who "fall through the cracks." This MOU was adopted as a rule by the Texas Department of Human Services, Texas Commission for the Blind, Texas Rehabilitation Commission, Texas Department of Health, Texas Department of Mental Health and Mental Retardation, Texas Education Agency, Texas Juvenile Probation Commission, and the Texas Youth Commission, and published in the *Texas Register*. The most current MOU also includes the Texas Department of Protective and Regulatory Services, and the Texas Interagency Council on Early Childhood Intervention.

The primary purpose of the memorandum is to establish a system for interagency coordination of services to children and youths. The agencies are asked to recognize the importance of the family in the life of each child and youth whom the agencies serve and to provide services in the most normal and least restrictive environments possible.

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<sup>1</sup>This section excerpted from the Community Resource Coordination Groups (CRCG) of Texas Fiscal Year 1996/97 Annual Report, *Making a Difference One at a Time*.

Typically, a child or youth served at a local CRCG is a person who: (1) is less than 22 years old, (2) meets an agency's statutory age-limitations for eligibility, (3) is now receiving services or has received them in the past, and (4) needs services that require interagency coordination. Each coordination group should include one appointed representative from each participating state agency, and as many as five local representatives from the private sector. If there is more than one private sector representative, the second should be a member from substance abuse services. The private sector representatives must be selected by their peers from private sector agencies serving youths in the geographical area the coordination groups serve. The private sector representatives have the same status as state agency representatives. The organizations they represent are considered member agencies of the coordination group, and they are encouraged to present from the private sector. Local CRCGs are strongly encouraged to include a parent representative to be part of the team, as this component has proven effective in many successful CRCGs.

Currently, one hundred and fifty-one (151) local Community Resource Coordination Groups exist serving all 254 counties over 11 regions of Texas (see Appendix B). Each local CRCG serves either one single county or multiple counties covering urban, suburban, rural, or border communities. Each group has a designated CRCG chairperson (volunteer), and possibly a coordinator (paid), who is the group's lead contact and the point of contact for the State Office. The Director for the State CRCG Office assumes responsibility for local CRCG implementation, and reports to the State CRCG Team, which is responsible for implementing the MOU at the state level (see Appendix C).

## Literature Review

As recent trends have shown, a great number of agencies and organizations have banded together in an attempt to better serve children and adolescents across the country. By coordinating resources, these groups are able to offer a wider range of services, increase accessibility to services, and manage service delivery more effectively. Bilchik (1998) states “effective rehabilitation requires maximum use of a broad range of public and community resources, including health and mental health care, social services, recreation, education, and employment and training services” (p. 95). Ohlin (1998) supports this idea, stating that in order to address the problems of juvenile delinquency “one useful possibility would involve the establishment of several centers that would pull together already assembled data, undertake carefully designed longitudinal studies and critical short-term studies, and analyze the results systematically for their policy and theoretical implications” (p. 152). Such efforts are critical at a time when juvenile delinquency is on the rise.

The increasingly violent nature of juvenile crime and the escalating number of youth involved with the juvenile justice system have challenged established thought guiding policy and practice with this population (Jenson & Howard, 1998). While property crime (burglary, larceny, theft and motor vehicle theft) arrest rates have remained constant since 1992, the rate of violent crime (murder, nonnegligent manslaughter, forcible rape, robbery, and aggravated assault) arrest rates among juveniles remain at an all time high despite declines from 1994 to 1997 (Snyder, 1998). The recent tragic shootings at Columbine High School in Littleton, Colorado has amplified this trend. The National Institute of Justice (1995) predicts a significant increase in the

number of youth referred to the juvenile justice system by the turn of the century. This should raise concerns, as historically, there has existed a lack of adequate resources nationwide to provide treatment for such youth.

In addition to the increase in violent crime among juveniles and the increased likelihood that youth have multiple needs, there are a number of other reasons why collaboration has increasingly become the organizational structure of choice. Federal funding for social services, particularly those targeting children and youth, have diminished steadily over the last ten years resulting in increased need in communities (Ozawa & Kirk, 1996). There has also been a marked shift in responsibility from the federal to the state government and to the private non-profit and for-profit sectors (Ewalt, Freeman, Kirk, & Poole, 1997). Competition for limited funding between community organizations, and among and within state agencies, has increased as well (Roberts-DeGennero, 1997). Interagency collaborations provide possibilities for meeting the individualized needs of children in communities, coordinating the activities of various providers, and maximizing limited resources. Indeed, this has been acknowledged by leadership in government at all levels and is reflected in the mandating of collaboration and community involvement by funding sources (Bailey & Koney, 1997). Vice President Al Gore (1993), in his report on reinventing government states, "Time and again, agencies find it impossible to meet their customer's needs because organizational boundaries stand in the way.... In a rapidly changing world, the best solution is not to keep redesigning the organizational chart; it is to melt the rigid boundaries between organizations" (p. 48). And yet, melting these boundaries requires a shift in both conceptualization and operation on the part of professionals in the human services.

Organizations create boundaries in order to define themselves and reinforce those boundaries in their competition for members, funding or market share (Radin, 1996; Stein, 1988). These boundaries can be defined in terms of an organization's "turf", the exclusive domain of activities and resources over which an agency has the right, or prerogative, to exercise operational and/or policy responsibility (Bardach, 1996). The boundary definition of organizations changes as technology and other environmental forces affect it. For instance, the emergence of the World Wide Web has helped redefine the concept of community (Mooney, 1996). Developments in information technology have radically increased speed and access to information used in decision-making (Edwards, Cooke, & Reid, 1996). Having a more flexible definition of how people can work together and share information has helped create an atmosphere of collaboration for individuals and agencies alike (Hogue, 1994). Flexibility is also required in thinking about the structure of collaborations.

There are several models for interagency collaboration proposed by different authors (Hasenfeld & Gidron, 1993; Roberts-DeGennero, 1997; Thompson & Ingraham, 1996). For instance, Hasenfeld and Gidron (1993) use a model that compares collaborations to self-help groups and looks at the ways in which either competition or collaboration develops. Thompson (1996) describes corporate reengineering as applied to the public sector, using the Internal Revenue Service as a case study in order to broaden a concept used in the for-profit sector to this context. Roberts-DeGennero (1997) uses a political-economy perspective to analyze youth services networks, with case vignettes used to illustrate coalition models. There appears to be no general consensus on an appropriate model for all settings.

One model that is particularly relevant to this study is that of Alter and Hage (1993), entitled Organizations Working Together. In this work, Alter and Hage describe collaborations as networks with different forms, including “obligational networks (informal, loosely linked groups of organizations having relationships of preferred exchanges), promotional networks (quasi-formal clusters of organizations sharing and pooling resources to accomplish concerted action), and systemic production networks (formal interorganizational units jointly producing a product or service in pursuit of a supraorganizational goal)” (p.73).

An interagency collaboration can take one form or the other, or move fluidly from one structure to another, as need and circumstances change. Regardless of the form taken at any particular moment or location, there are common principles that apply to effective implementation.

A review of available literature reveals an apparent trend in many states to establish systems that are conceptually similar to CRCGs (reflecting various organizational structures as described above), yet none that truly resemble CRCGs. It is also apparent that coalitions of a variety of sources are continuing to surface all across the United States. Some of these efforts are reviewed below.

The Center for Mental Health Policy, located in Nashville, Tennessee is one of many examples of creative coalitions. The center’s focus is on research rather than services, yet the idea of coordinating resources is the same. Focusing on children, adolescents, and family services, the researchers work in multidisciplinary teams bringing their fields of expertise together, including psychiatry, psychology, economics, and pediatrics to gain valuable information on the mental health service needs for their area.

A second example comes from the Community Service Boards (CSBs) in Virginia. Also established through law, CSBs are “the local government agencies responsible for mental health, mental retardation and substance abuse services for citizens in their communities.” Using available community resources, as well as “natural support systems (family, friends, work)” CSBs are able to offer integrated, individual, effective services to individuals in need ([www.dmhmrzas.state.va.us/csb.htm](http://www.dmhmrzas.state.va.us/csb.htm)).

Maryland’s State Coordinating Council (SCC) housed in the Office for Children, Youth and Families offers interagency case management to “children with disabilities who are at risk of residential placement.” Due in part to this collaborative effort, Maryland has reduced its reliance on other states for residential services ([www.ocyf.state.md.us/](http://www.ocyf.state.md.us/)).

The Protection and Safety System in Nebraska is another organization focusing on juvenile services. An outgrowth of the Nebraska Health and Human Services System, the mission is “to ensure that the abused, neglected, dependent, or delinquent populations that it serves are safe from harm or maltreatment; in a permanent healthy nurturing and caring environment; with a stable family; that the effects of harm to the child or youth are diminished or improved, and that communities are safe from harm by these children or youth.” Not only is the Protection and Safety System itself a collaborative effort mandated by the state, but the Nebraska HHS System is as well. The Protection and Safety System is a combination of the Nebraska Department of Social Service, Child Welfare Office, and the Office of Juvenile Services. Members from a number of agencies work together to accomplish specific objectives. Members include representatives from HHS, law enforcement, judges, medical personnel, foster parents,

and schools. There is also a focus on including the families, youth and children as much as possible in the process. Thus, in some ways, Nebraska's program is very similar to the CRCG model.

New Mexico has a unique program called Futures for Children that focuses on Latin America and the American Southwest. The program aspires to "establish stable foundations for the continued growth of local communities", and conducts leadership training programs for youth as well as organizational and management skills training to tribal groups to help them use their resources more effectively. "School retention and excellence in education through cross-cultural friendships" are additional aspects of the program ([www.futurechild.org/home.html](http://www.futurechild.org/home.html)).

The state of Missouri developed the Interdepartmental Initiative for Children with Severe Needs and their Families to try to improve care for children with serious mental health needs. The Department of Social Services, Department of Mental Health, Department of Health, and Elementary and Secondary Education work together to address concerns and meet the needs of these children and their families. The Initiative is targeted at children in the Central and Eastern regions of the state, and is comprised of Multiple Care Management Organizations (CMOs) around the state that are responsible for enrolling 100-400 children and families and working with participating child-serving agencies to establish service plans of care for each child ([www.modmh.state.mo.us](http://www.modmh.state.mo.us)).

Missouri has another collaborative program in Jackson County designed to identify unmet needs of youth and establish agencies to meet those needs. The program is called YouthNet, and it is a non-profit agency run by a board of directors. "YouthNet's long-term vision is to open 40 schools year-round in Jackson County by the year 2003

and offer young people access to academic, career-building and recreational activities.” These activities complement schools’ established curricula and strengthen existing efforts to ensure that area youth are succeeding in school and are ready to enter the work force and become productive citizens. Additionally, YouthNet is developing a highly skilled work force of youth-worker professionals ([www.ecodev.state.mo.us/ded/press/REGIS.html](http://www.ecodev.state.mo.us/ded/press/REGIS.html)).

The Washington County Commission on Children and Families in Oregon created the Community Advisory Committees “to provide broad based community input into the work of the Commission.” Further, any resident or person working in Washington County is invited to participate. The goals are to “support, promote, and enhance the effectiveness of services provided” to the children, youth, and families of Washington county. Members from the Youth Advisory Council, the Teen Pregnancy Prevention Advisory Committee, and the Student Retention Advisory Committee are just some of the many participants ([www.co.washington.or.us/deptmts/hhs/chld\\_fam/srvc\\_fon.htm](http://www.co.washington.or.us/deptmts/hhs/chld_fam/srvc_fon.htm)).

Washington’s Youth Initiative is a program focusing on juvenile justice issues in Clark County. The Human Services Council serves as the host agency for the 40 plus groups and individuals dedicated to Washington’s youth. Their objectives are: implementing the provisions of the Juvenile Justice and Delinquency Prevention Act; acting as a resource for the Governor’s Juvenile Justice Advisory Council (GJJAC); and planning and coordinating local programs, and meeting monthly to collaborate and plan a variety of projects and programs to help meet the needs of Clark County youth.

Iowa’s Commission on Children Youth and Families, as mandated by the Iowa legislature, works to “promote coordination of federal, state, and local services by

developing a plan to streamline delivery of services and making recommendations to the governor and general assembly.” They are also asked to identify unmet resources/needs, as well as recommend ways to improve current services. Furthermore, they are encouraged to “identify state and federal resources that can be used in local areas” and are required to “provide information to parents and assist and support them in their parenting roles.” The Commission itself includes the directors of the Iowa department of public health, education, corrections, and human rights, as well as a member of the board of directors of a school, one from a county board of supervisors, and a professional family counselor ([www.legis.state.ia.us/IACODE/1997/217/9A.html](http://www.legis.state.ia.us/IACODE/1997/217/9A.html)).

On the federal level, a few more examples of collaborative efforts were identified. As part of the Safe Futures Partnerships to Reduce Youth Violence and Delinquency, grants are given to “help communities implement a comprehensive and coordinated delinquency prevention and intervention treatment program for at-risk and delinquent juveniles.” Partnerships are to be made between public and private agencies, community-based organizations, community residents, and youth. Family Preservation and Family Support Services “help state child welfare agencies and eligible Indian tribes establish and operate integrated, preventive family preservation services and community-based family support services for families at risk or in crisis.” Again, community organizations, residents and parents are part of the planning and follow-through. Finally, the Human Services Coordinating Council, a legislatively-mandated organization of state agencies including Division of Veteran’s Affairs, DHHS, School for the Deaf and the Blind, and the Department of Juvenile Justice, meets regularly to address issues of case

management, the state health and human services plan, and ways to coordinate services ([www.leginfo.state.sc.us/man97/stategov/state87.html](http://www.leginfo.state.sc.us/man97/stategov/state87.html)).

In Texas, “Families are Valued” (FAV) supports the creation of policies and practices directed toward keeping families and their kids with disabilities together. Guided by the philosophy of permanency planning, FAV believes that children belong in families and need permanent family relationships. This can be achieved by permanency planning through state level and local level activities ([www.hhsc.state.tx.us](http://www.hhsc.state.tx.us)).

It is apparent that agencies and systems around the country are seeing the benefits of interagency collaborative efforts. New partnerships are emerging from a variety of sources to deal with the issues of mental health, substance abuse, juvenile justice, and family support. While some act in response to a particular need, others work to prevent problems from arising in the first place. Realizing that many of the problems and issues children and adolescents face are interdependent with one another, often centering around issues of poverty, these collaborative efforts help families deal with coinciding issues simultaneously, rather than shuffling families from one agency to another. This is proving to be a more comprehensive approach.

For example, “Communities Can” is a growing network of communities dedicated to ensuring comprehensive service and support systems for children and their families. In particular, this organization brings resources to children who are with or at risk for disabilities. This collaborative community effort is geared toward commitment to family-centered services, culturally-competent services, and community-based services.

Additionally, the Texas Integrated Funding Initiative develops community-based systems of care for children with severe emotional problems by using available funding

in innovative ways. These community-based systems of care are family focused, and are accountable for outcomes while maximizing all funding sources (state, local and federal).

### **Research Methodology**

The main objectives of this two-year study were essentially three-fold. The main objectives of Phase I (year 1) were to determine to what extent selected Community Resource Coordination Groups (CRCGs) were meeting the stated goals of the Memorandum of Understanding (MOU), and to learn about the best practices of CRCGs in relation to the charge of the MOU. The main objective of Phase II (year 2) was to gather data from families served by CRCGs in Texas to determine the extent to which they were satisfied with the CRCG process.

#### **Phase I**

During Phase I, the research team of the University of Texas at Austin, School of Social Work, Center for Social Work Research (CSWR) visited four (4) CRCGs covering 11 counties in Texas: Bastrop/Fayette/Lee Counties; Bexar County; Tom Green, Coke, Sterling, Reagan, Irion, Crockett, Concho Counties; and Travis County. During these field visits, the researchers observed the process of the meeting, took field notes, and conducted semi-structured face-to-face interviews with CRCG members. In addition, questionnaires identical in format to the semi-structured interviews were mailed to four (4) other CRCG sites: Burnet, Gilmore-Upshur, Laredo, and Seguin. This was done to obtain a more representative sample of CRCG respondents.

Prior to these visits, however, the research team conducted a focus group with selected CRCG members at the Regional Conference in Dallas in April 1998. The purpose of conducting the focus group was to identify issues of CRCG operation that

needed to be explored further in the subsequent field visits and interviews. Thus, the focus group process guided the development of the format and content for the interview/questionnaire.

The field visits to the individual CRCGs were conducted from May to August 1998. The research team visited the Travis County CRCG on three different occasions (due to geographical proximity), and the three other sites were each visited once. On each of the field visits, the research team typically made a brief introduction regarding their purpose for visiting and of the study. The researchers took field notes during the course of the meeting. Either before or after the meeting, the researchers interviewed as many CRCG members as possible in the time allotted.

During the face-to-face interviews, a semi-structured format was used (see Appendix D). This allowed for consistency across interviews and sites so that meaningful conclusions could be drawn from interviewee responses. The purpose of the interviews was to gather information about several areas of CRCG functioning, such as to what extent CRCGs are meeting the charge of the MOU; what the best practices are for CRCGs; what the major obstacles are facing CRCGs; and so on.

The purpose and format of the questionnaire (see Appendix E) was the same. However, the questionnaire was mailed to the chair or coordinator at each of those three sites, who then distributed the questionnaire to the CRCG members at that location. Attached to each questionnaire was a cover letter and a self-addressed stamped envelope so that respondents could mail the completed form directly to the research team at CSWR.

In addition, the research team held a few meetings during the evaluation period with key staff of the State Office of CRCG. This was so that a dialogue could take place between the research team and the State Office around the development of the semi-structured interview format and the questionnaire, as well as how to analyze the data so that evaluation findings are meaningful to CRCG personnel.

### **Phase II**

During Phase II, the research team selected 32 CRCGs across the State of Texas to participate in this part of the study. Potential subjects included the parents/guardians of all children/adolescents served by the 32 selected CRCGs and who attended a CRCG meeting/staffing from January through July 1999. [A case staffing is a meeting where representatives from various agencies collaborate under the direction of a CRCG chair to discuss how to best meet multiple needs of individual youth, often with the youth and his/her family present.] Subjects had to be at least 18 years of age to participate in the study. The Texas Health and Human Services Commission, State Office of CRCG has divided the State of Texas into 11 regions (see Appendix B). Using those regions, the researchers and members of the State Office of CRCG selected 3 CRCG sites from each region (2 from the smallest region because it did not have an urban community), selecting one urban, one rural, and one suburban site. A stratified sampling procedure was used to select the 32 CRCGs; this was done to ensure that each of the 11 regions was adequately represented in the study, and essentially entailed randomly sampling (to avoid any bias) three CRCGs from each region. Demographers at the State Office of CRCG defined criteria for determining which category a site fell into as follows: populations that were more than 50% rural were defined as rural; populations that were 10%-50% rural were

defined as suburban; and populations that were less than 10% rural were defined as urban. With data collection beginning in January 1999, the research team realized by April that the response rate was lower than expected for that point in the study. Thus, in March, the research team met with the State Office of CRCG to broaden the sample. Beginning in April 20 additional CRCGs were selected to participate in the study in hopes of obtaining an adequate number of completed questionnaires. This brought the total (potential) number of participating CRCGs to 52 for the remainder of the project. For a list of participating CRCGs, see Appendix F.

Questionnaire packets (Client Satisfaction Questionnaires [CSQ-8], cover letters/ consent forms, and demographic face sheets) were mailed in bulk to each CRCG selected for participation in the study. The CRCG chair or coordinator handed out the packet to parents or guardians of the children or youth who have just engaged in the staffing, and the parents or guardians at that time determined whether or not they wished to participate in this study. All forms were available in English and Spanish. Potential subjects were given a cover letter explaining the purpose and nature of the study, including a statement informing them that their participation was voluntary and that their involvement would in no way jeopardize the services they received from their CRCG. A phone number was included for families to contact the research team if they had any questions or concerns, as well as a self-addressed stamped envelope for them to return their completed forms directly to the research team. Subjects that agreed to participate and mail in their completed forms were also asked (in the cover letter) to complete a 2<sup>nd</sup> (follow-up) CSQ-8 two months later to determine if their perceptions about the CRCG process changed over time.

The follow-up packets (CSQ-8, cover letter) were mailed to respondents' homes, along with a stamped envelope in which they were able to mail completed forms back to the research team. However, once again the response rate was lower than expected for returned follow-up questionnaires using this approach. Thus, the research team reverted to a phone survey methodology in May to increase the success rate for obtaining completed follow-up questionnaires from respondents. The phone survey method was more successful than the mail survey method for obtaining follow-up questionnaires, and increased the response rate substantially. Twenty-two responses were obtained using the telephone survey method. In order to deepen our understanding of the families' experience of participating in CRCGs, four qualitative questions were asked of the respondents after getting their responses to the CSQ-8. These four questions were developed through input from key personnel from the State Office of CRCGs in Texas.

Client Satisfaction Questionnaire (CSQ-8). The Client Satisfaction Questionnaire (CSQ-8), (See Appendix G), is an eight-item pencil-and-paper instrument, measured on a four-point Likert scale, which has been used successfully in numerous settings to assess client satisfaction with services provided. The CSQ-8 is not necessarily a measure of a client's perception of gain from intervention, or outcome, but rather elicits the client's perspective on the value of services received.

The reliability and validity of the CSQ-8 have been studied extensively (e.g., see Attkisson & Zwick, 1982; LeVois, Nguyen, & Attkisson, 1981; Nguyen, Attkisson, & Stegner, 1983; Pascoe, 1983; Roberts, Pascoe, & Attkisson, 1983), which was one of the primary reasons that it was chosen over other measures for use in this evaluation. There is also an 18-item version, but it was thought that 18 items was too long for most

potential CRCG respondents, and it has been demonstrated in at least one study (Attkisson & Zwick, 1982) that the CSQ-8 performed as well as, and often better than, the CSQ-18.

The CSQ-8 seems to operate about the same across ethnic groups, which is also true of the Spanish version (which was used in this study as needed). The CSQ-8 has excellent internal consistency, with coefficient alphas that range from .86 to .94 in a number of studies. Generally, coefficient alphas that are .60 or higher indicate that a scale is appropriate for use in research, while alphas of .85 or higher indicate that a scale is reliable enough for use with individual clients (Fischer & Corcoran, 1994; Hudson, 1982). Additionally, the CSQ-8 has very good concurrent validity. Scores on the CSQ-8 are correlated with dropout rates (less satisfied clients have higher drop-out rates). The CSQ-8 is easily scored by summing the individual item scores to produce a range of 8 to 32, with higher scores indicating greater satisfaction.

### **Results: Phase I**

The data and comparisons here are not presented as perfect in terms of scientific rigor. The results are based on a relatively small number of cases and therefore are limited to the extent that it is possible to account for various factors (e.g., age, education, gender, employment position) that may have influenced the type of responses received. No attempt was made to control for these extraneous variables in this analysis.

Thirty-nine (39) respondents participated in the semi-structured face-to-face (or phone) interview or completed the items in the format of a pencil-and-paper questionnaire. Over one-half (56.4%) of respondents participated by completing the questionnaire format, with the remaining respondents (43.6%) participating in a face-to-

face or phone interview with a member of the research team. Two-third (66.7%) of respondents were female, and one-third (33.3%) were male. Nearly three-fifth (59%) of respondents identified themselves as White, Non-Hispanic, with nearly one-fifth (17.9%) as Hispanic and about one-quarter (23.1%) omitting this information. A majority (71.8%) of respondents identified themselves as CRCG members, with just over one-quarter (28.2%) responding as a CRCG chair or coordinator. Approximately three-fifth (59%) of respondents had been involved in some capacity with their CRCG for four years or more, with the remaining having three years (15.4%), two years (15.4%), one year (2.6%) and less than year (5.1%) of CRCG experience.

A majority of respondents came from a rural CRCG (69.2%), with the rest urban (30.8%). Travis County (20.5%) and Bexar County (10.3%) represent the urban respondents, while the rural respondents are from Bastrop/Fayette/Lee Counties (15.4%), Gilmore-Upshur (12.8%), Tom Green, Coke, Sterling, Reagan, Irion, Crockett, Concho Counties (7.7%), Burnet (7.7%), Bell County (7.7%), New Braunfels (5.1%), Guadalupe County (5.1%), Laredo (5.1%), and Seguin (2.6%).

Prior to conducting face-to-face and phone interviews and having respondents complete questionnaires, the research team conducted a focus group of CRCG members. The analysis from the focus group responses is presented below, followed by results of the interviews and questionnaires.

### **Focus Group Results**

#### **1. Tell us your name, where you're from, and how you got involved with CRCGs.**

Respondents introduced themselves and gave some information on which agency(s) they worked for, their position, and the number of CRCGs they worked with

depending on the number of counties in their area. Responses included parent representatives, mental health association, health department, and regional educational service centers. Respondents also mentioned how they became involved in CRCGs such as having to go through the process as a parent, or being asked by friends/coworkers to be a CRCG representative.

**2. I understand that individual CRCGs operate differently. Tell me in what ways the CRCG process helps the clients in your community.**

A few participants mentioned that their CMT and CRCG groups were combined, which was perceived as a successful merger. Community Management Teams are the local operating mechanism for the Texas Children's Mental Health Plan, which is an integrating initiative targeting mental health needs of children and youth. Parent involvement was mentioned as an important focus, as was keeping children in the home. Division of duties was identified as a helpful practice, along with creating new follow-up forms rather than the state forms because they better fit that CRCG's needs. In terms of staffings, a variety of practices were mentioned such as encouraging private for-profit agencies, non-profit agencies, mandated local agencies, and anyone invested in serving a child (e.g., retired judge), to attend. Other CRCGs have been struggling with this due to restrictions placed on the number allowed to attend. Also important to staffings is knowing who to invite, as some representatives are more flexible even though they have their own restrictions. One small town/rural CRCG is struggling with not being allowed a parent representative due to concerns regarding confidentiality, yet some participants mentioned the strength of knowing each other and the resources available in their community. Both elements have enabled members to meet clients' needs informally, and given them more meeting time to work on other projects. One urban CRCG, which

employs two full time paid CRCG coordinators, has been tracking outcome measures and providing an annual report, but cautioned those interested in doing so that it is a time-consuming task.

**3. If you could, what things would you change or do differently with the CRCG process?**

Much of the discussion focused on needing more money for services for the children, useful for pre-preparation, follow-through, and follow-up. It was suggested that some discretionary money be put in place, not tied to any specific agency, to be used for any child for any needed services, including non-traditional services such as paying for pastoral counseling. With the money, however, needs to come the authority and responsibility in being able to use it. *The idea of every CRCG having a paid coordinator (and therefore one service coordinator or case manager a family has to work with), and a parent representative was thought to be crucial.* The idea of a monitoring process was mentioned to ensure that mandated agencies attend meetings, which might entail requiring agencies to call the state CRCG if they are unable to attend. Opening meetings to more agencies (Tough Love, Literacy Council) as well as requiring those that attend to know the information on the child was suggested. Another suggested change was having a focus on disabilities and not just on mental health. Finally, participants wanted some monitoring practices in place to track the number of times CRCG representatives are called, and a formal 2-year State of the Child and Family report produced by each area CRCG looking at specific factors such as how many children are served, how many are in the juvenile justice system, etc. From this data, new programs can be created to meet needs that are not presently being met.

#### **4. What are the key ingredients to a successful CRCG?**

Respondents felt that family involvement and having a mandated parent representative are crucial to successful CRCG practice. The idea of a paid-coordinator was mentioned again, including the usefulness of the coordinator in being able to enforce follow-up on plans. The idea of ensuring that those invited to coordination meetings can be team players was felt to be an important aspect of the CRCG process, as was requiring mandated agencies to attend all meetings. Finally, it was suggested that agencies that offer services be held accountable to provide those services.

#### **5. What are the best practices that you are currently doing that work?**

Responses included creating new resources, especially in rural communities where resources are limited. Continuing to meet every month was also suggested, even when there is no child or youth to staff. Using the time to familiarize each other on resources as well as working on other projects was deemed important. Combining the CMT and CRCGs together in order to work on both micro and macro issues was found extremely helpful. Inviting a variety of agencies and participants, such as judges, to offer their expertise, if not resources and money, was highlighted. Finally, the combination of parents and agencies getting together, laying their resources out on the table and allowing parents to have input in the plans was identified as an essential part of CRCG practice.

#### **6. What needs of the clients are the most difficult to meet?**

A variety of needs were mentioned including before and after school care for children, respite care, and substance abuse treatment. Lack of needed residential care settings is a challenge faced by CRCGs, as are centers that do not allow non-participative or violent clients to remain in their care. Finally, children/youth with dual diagnoses

(i.e., mental health and substance abuse) present problems for representatives for a variety of reasons. One in particular is that one diagnosis allows a child to be eligible for a particular service, but another diagnosis disqualifies the child.

#### **7. What are the biggest breakdowns in the CRCG process?**

Responses were similar to those previously mentioned. Lack of money was seen as a large part of the breakdown, as was the lack of parent participation in the planning. The idea of team players was brought up again, with the realization that participants who are not team players are negatively effecting the process. The fact that there is no system of enforcement requiring mandated agencies to attend was seen as a breakdown, as was the fact that not all participants are informed about specific problems (e.g., medically fragile cases) or all of the resources available, thus not being able to plan ahead if specific resources are limited. Finally, participants complained of the lack of congruence in laws. Specifically, Texas law holds parents responsible for their children up until age 18, yet children under the age of 18 are allowed to release themselves out of placement.

#### **8. What are the things we should be looking for when visiting individual CRCGs to do our evaluation?**

One suggestion was to look at whether or not the CRCG is doing the 1-month and 6-month follow-ups, and if not, why. Respondents also suggested looking at who is and is not attending the meetings, along with possible reasons. Looking into the parent piece of the site was mentioned, including whether or not a parent representative is there, how many clients he/she staffs, how many parents attend, etc. A follow-up to that issue was checking into whether or not children/youth are staffed without parent permission. Obtaining satisfaction from participants as well as clients was suggested, in terms of their satisfaction with the process and its effectiveness; and specifically, whether or not plans

were being carried out. Finally, respondents wanted an evaluation of staff meetings including whether or not participants arrive on time and stay for the entire meeting, and if the meeting time is used for things other than staffings such as sharing new resources.

**9. If you had one minute to talk to Governor Bush, what would you say to him about CRCGs?**

Again, respondents mentioned the need for more money. Other responses included suggesting that CRCGs be implemented on the adult level as well as duplicating this model in other groups. A concern about health care laws was mentioned, and participants wanted to ensure that CRCGs are not left out of the decisions in Medicaid Managed Care roll outs. Finally, respondents wanted Governor Bush to know that the CRCG process is working, that CRCG representatives have learned how to talk to one another, who to talk to, and that the process has brought the community together.

**Open-Ended Interview Responses**

Due to differences in experiences between participants in urban and rural areas, responses have been separated into these two categories.

**1. What is working best with your CRCG?**

*Urban:* A number of respondents talked about the flexibility in the CRCG process. In other words, respondents stated that the CRCG process customizes services to meet the unique needs of each youth. They felt that participants are extremely resourceful and that they are willing to try unorthodox strategies and to think outside the box. Most respondents felt that there was a high level of participation, and that most agency representatives will step up and offer resources. Those groups that have been together for several years mentioned the healthy dynamics that exist. Since they have worked together for a while, they are able to be confrontive, to utilize peer pressure to gain

agency involvement from agencies who are hesitant, and use negotiating skills in high-pressure circumstances to work for the best interest of the families. Respondents mentioned the sense of community involvement. Participants know, trust, and respect each other, and there is a spirit of cooperation that exists. Participants work together on a professional level, and bring a high level of expertise to the table. Many respondents described the high quality of brainstorming and problem solving that takes place as representatives work together to establish feasible plans for each child or youth. Another best practice cited by a number of respondents was the quality of the chair. Respondents identified how their chair were skilled at identifying appropriate cases, and inviting the right people to the table. Additionally, respondents mentioned the necessity of having a paid coordinator - some thought full time, others mentioned part time - as well as having a good grant writer. Another useful practice cited was the opportunity participants were given to learn about what resources are available. Involving parents and family members in the decision-making process was also mentioned by a number of respondents, as was the overall concern and commitment of the participants. Participants stated that CRCG teams are comprised of individuals who invest time and money to try to help the families they staff, and they are willing to staff any case. The ability to use CMT money to fund services, as well as those sites where CMT and CRCG participants were the same people, were mentioned as good practices.

**Rural:** Respondents in rural towns also believed that their CRCG teams consisted of a core group of individuals who truly care about the community, and will go above-and-beyond the job description to help the families they staff. Respondents felt that they come in contact with many children and youth that could be helped by the CRCG team.

an effort that could keep the child or youth in the home. Chairperson skills were also mentioned, including how chairpersons go the extra mile to pull the best group together to meet the needs of the community. Some respondents felt that attendance and participation is good, that a wide variety of agencies are represented, and that many participants come with resources and money to offer. Mini-staffings were mentioned as a helpful aspect to the process, as was family involvement. Respondents mentioned the helpfulness of different perspectives, the willingness of participants to share ideas and collaborate, as well as their willingness to offer support to parents. Like respondents from urban areas, participants talked about the usefulness of learning about the different resources in their area. The sense of community was again mentioned by many participants, and respondents felt that a reciprocal process occurs whereby participants help each other outside of CRCG activities. In addition, participants talked about the fact that they often see each other outside the meetings, in their respective job tasks, and thus are more familiar with each other and work well together. As such, they are supportive of one another, are able to network with each other, and know who to talk to. Respondents felt that the process itself builds trust between participants, and some mentioned communication as a strength in their team. Respondents mentioned that the CRCG process helps to identify program needs as well as areas in which to develop resources that are lacking in the community. Some respondents talked about how participants take responsibility and follow-through with what they've committed to do, thus making the process a successful one. Making sure that state-required agencies attend was mentioned as a best practice, as was obtaining grants to fund services. Some respondents mentioned that structuring meetings that are family-friendly is a helpful

practice, as was having open membership. As cited by many urban participants, the necessity of having a good chair was mentioned, as was having a variety of participants with a wide knowledge-base of community resources. Finally, some respondents talked about the helpfulness of their yearly program where speakers, agency representatives, judges, sheriffs, and other community members come together to share information and learn about the resources in their community, as well as the role of the CRCG.

**2. What do you see as the biggest challenges your CRCG operation is faced with?**

*Urban:* Lack of money and other resources were cited by the majority of respondents as the biggest challenges. While members felt that they are able to come up with plans that coincide with what is clinically indicated for a client, the resources are not there to follow through with it. In addition, respondents mentioned the nature of the task itself as a challenge. The clients they see are children with multifaceted complex problems and seem to have the least services available, thus making it extremely difficult to effectively meet their needs. Keeping people involved, especially when meetings last several hours and members are donating their time, is also a challenge, as is the high number of children and youth served, and the addition of mini-staffings. In terms of participants, many respondents mentioned the challenge in having members participating that are not the bearers of their agency's funds, as well as the difficulty in involving private agencies or business enterprises, and gaining meaningful contributions from them. Lack of minority representation among CRCG participants was identified, as was the difficulty of collaborating. A number of gaps in services were indicated by several respondents, including obtaining donated services for residential and inpatient treatment, especially when community resources have been exhausted, as well as respite care, day treatment,

and therapeutic summer camps. Similarly, respondents mentioned the challenge of providing services for kids as government services continue to be cut. Some respondents mentioned the challenge in continuing to provide quality services and in providing the needed safety net for families. The creation of CRCGs served as a last ditch effort to address this frustrating safety net process. Furthermore, plans are created with the knowledge that funds are not available. Thus, plans are based on the best plan for which services are available. The frustration of seeing kids go through the revolving door of inpatient treatment, and not receiving the longer-term services that offer a fuller impact, was cited as a major challenge. Some respondents felt that, while their team is able to identify gaps in services, they have no authority to do anything about it. Others mentioned the challenge some representatives are faced with in terms of wanting to be a miracle worker, and leaving the meetings feeling disappointed. Not having a full-time paid coordinator was mentioned by a number of respondents, as was the need to actively recruit new members and new services. Finally, respondents talked about the challenge of gaining a better understanding of each agency's limitations.

**Rural:** As with the urban respondents, the majority of rural respondents identified the lack of money and resources as their biggest challenges. Similarly, respondents noted that sending representatives that do not have money to offer, who cannot commit to resources, and do not have the authority to do so is a major challenge, as is time, since again, participants are volunteers. A few respondents talked about the narrow door for kids to get into the CRCG process. They felt that families had to wait until their situation was very bad, and been "beaten down" by a number of agencies, until finally they could utilize the CRCG process. They mentioned the challenge of having CRCG be the last

resort for these families, and wanting it, instead, to be an earlier resort. A number of gaps in services were identified by a majority of respondents. The gaps identified were: residential treatment, treatment for emotionally disturbed kids, alcohol and inhalant abuse treatment, psychiatric care, families with chronic problems, medically fragile kids, long-term group and individual counseling, crisis shelters for kids and families whose needs exceed typical family shelters, and mental health services for very young kids. While a few of these needs could be met by sending children to other cities, local resources were not available. Developing such services locally was mentioned as another challenge, coinciding with the challenge of accessibility of services (e.g., transportation) that are available in the area. Getting organizations to stretch beyond their mandates was cited as a challenge, as was the inconsistency of participation. Many respondents mentioned the lack of having a full-time coordinator, or having to share a part-time coordinator, as major challenges, as well as trying to spread the word about CRCGs to the rest of the community. Many mentioned the frustrations and difficulties when families are not willing to work on the plans. Others talked about the difficulty in getting parents to give their permission to refer kids to CRCG, and the trouble in the process of obtaining release information. The fact that some members wait to bring children/youth in for coordination meetings was mentioned as a challenge, as was trying to get cooperation between schools, probation, and other departments. The overwhelming challenge mentioned by respondents was the lack of options and resources in the rural areas.

**3. These next few questions deal with how your particular CRCG operates.**

**a. How often do you meet?**

*Urban:* All respondents said they meet once a month, and some mentioned having mini-staffings during the month as needed.

*Rural:* All respondents said they meet once a month, some noting a break in July. Respondents also noted having mini-staffings as needed, and some mentioned having an executive committee that meets.

**b. Do you meet even when you don't have cases to staff? Why or why not?**

*Urban:* The majority of respondents said they always have children to serve. A few said they would probably not meet if they did not have children to serve, while others identified updates with children/youth, follow-ups, and other business at meetings where no children were staffed.

*Rural:* Again, the majority of respondents said that they always have children/youth to help, and that if there are no children to serve, they meet to do updates, share information and resources, complete administrative duties, have inservice training, and network. Some respondents noted that if there are no youth to serve for a particular month they will not meet because of the lack of participation of members.

**c. Who attends the meetings, and who determines permissible nonattendance?**

*Urban:* Responses included public agencies, non-profit agencies, information-givers such as teachers and psychologists, and those state agencies mandated by the MOU. Several respondents mentioned that their chairperson calls agencies that fail to attend meetings, while others said they did not know how non-attendance was handled. One respondent mentioned that CMT determines non-attendance.

**Rural:** Again, public and private agencies, private non-profit, and for-profit agencies were cited, as well as families. Like urban respondents, many said their chairperson contacts those agencies that do not attend, while others said they did not know how non-attendance was handled. Some respondents said that non-attendance is not a problem, and one noted that non-attendance is addressed in the by-laws.

**d. Who leads the meetings?**

**Urban:** All respondents cited the CRCG chair as the meeting facilitator, and a few mentioned the vice-chair as sometimes facilitating.

**Rural:** Again, respondents said their chair leads the meetings. Some noted that sometimes specific members facilitate when families are participating. One identified the chair person as the facilitator noting that the position is passed around yearly to different members. Another mentioned that the chair, vice-chair, and then secretary, in that order facilitate meetings.

**e. Are their by-laws or protocols followed?**

**Urban:** A number of respondents said they did not know if there were by-laws or protocols followed. Others mentioned functioning as a multi-disciplinary team, using Robert's Rules of Order, and using a flexible agenda and common sense. Many noted obtaining confidentiality and release forms, and one respondent mentioned certain understood rules such as not taking confidential information outside the room.

**Rural:** Again, confidentiality and consent forms were mentioned. Some respondents talked about having to sign in, vote on and sign the specific plans, reading and approving the minutes at the meeting, calling the meeting to order, reading the mission statement, and introducing everyone. Some said there were no by-laws or protocols followed. One

respondent mentioned that they were working on getting the policies and procedures in writing.

**f. How are clients referred, and is there a prioritizing system?**

**Urban:** The majority of respondents said clients were referred by CRCG members or anyone in the community - parents, teachers, and so on - while one respondent said there was no protocol for referring. In terms of prioritizing, some mentioned that the chair (or coordinator for those CRCGs that have one) screens and prioritizes cases, and follows up with referrals. Others noted an informal prioritizing system. One respondent said that more difficult cases go before the big staffing team while others are handled in mini-staffings. Several respondents said they did not know if there was a prioritizing system. Some mentioned that their coordinator tries to work as many clients as possible by himself or herself, and then brings the most severe children or youth to the CRCG. A few others said there was no prioritizing system.

**Rural:** The majority of respondents said that anyone can refer a family to CRCG, citing CRCG members, parents, private counselors, the health department, and the school district as examples. One respondent said that the school district refers 90% of the children they serve. A few mentioned that their chair actively talks to people to see if they have kids who require services, while others felt that there was no community awareness of CRCG so families and other agencies do not use them. In terms of staffings, a few respondents mentioned that mini-staffings help with prioritizing, while others noted that their chair determines priority. One cited the process whereby members first check with other CRCG members for options and resources for a family. If none are found, they complete a CRCG intake form and a client release authorization form and

submit them to the CRCG executive staff. A few participants said they did not have a prioritizing system because there were not that many kids who needed services. One participant noted that anyone in the community can fill out a form and submit it to the chair, who then gets together with one other member and they review the referral and prioritize it according to established criteria.

**4. Thinking back on each of those questions, how satisfied are you with the following?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Neutral</b>	<b>Satisfied</b>	<b>Very Satisfied</b>

**a. How often you meet. (See Appendix H - Figure 1).**

**Urban:** Many respondents mentioned that they could not meet more often and still get the quality they have now.

**Rural:** Some mentioned that they would like to meet more but that scheduling conflicts make it too difficult. One mentioned that, if needed, emergency staffings can be called.

**b. Attendance at meetings. (See Appendix H - Figure 2).**

**Urban:** Some respondents mentioned wanting more non-traditional resources in attendance such as those offering volunteer programs that provide respite for caretakers, recreation activities, and mentoring for kids and siblings. Some respondents said they would like consistent high attendance, noting that attendance would fluctuate from 5 to 30 members. Many mentioned the need to have more members with resources to offer.

**Rural:** Respondents mentioned that attendance can be sporadic, with as little as 3 to 4 members attending on a consistent basis. Some noted that they would like school districts to be more involved, while others cited probation, TRC, and CPS as agencies

they wished to see more often. One respondent said there was about a 60% attendance rate, and that some agencies do not send representatives for months.

**c. Notification. (See Appendix H - Figure 3)**

**Rural:** A few respondents said they needed more advanced notice of meetings and of meeting changes. Many said they received letters mailed monthly, while a few said they receive a calendar at the beginning of the year. Some respondents mentioned that minutes from previous meetings also served as reminders, as well as having meetings on a set day of every month. One mentioned notification as a big problem, and that they were just now starting to get notification about upcoming cases. Several said that notification has been consistent.

**d. Facilitation of meetings. (See Appendix H - Figure 4)**

**Urban:** One member mentioned that the meetings are an informal gathering of professionals who generally know each other well, so the process works well.

**Rural:** One member said that facilitation used to be better, but felt that the current leadership style was not good. The respondent felt that the chairperson is not assertive, and does not structure meetings well. Another participant noted that the lack of policy and procedures hinders facilitation, while another mentioned wanting to develop some new leaders (chairpersons) by recruiting new members and subsequently preparing them to assume the role of chair.

**e. Protocols or by-laws. (See Appendix H - Figure 5)**

**Urban:** One respondent said that new members needed to be trained in terms of the protocols and by-laws of the CRCG. Another felt that existing members need reminding of objectives, goals, and by-laws.

**Rural:** One respondent felt that work was needed in this area, and mentioned that a project has begun there to address this issue. Another mentioned a lack of written protocols and by-laws.

**f. Referrals to CRCG. (See Appendix H - Figure 6)**

**Urban:** One respondent talked about how disheartening it was not being able to resolve issues immediately due to the difficulty of the kids' circumstances. A few mentioned that parents sometimes come solely looking for residential treatment, and do not understand that the team does not have money to provide the services. Another respondent said they would like more referrals from a wider variety of sources.

**Rural:** A few respondents said that more public awareness of CRCGs was needed. One respondent felt that they needed more referrals. Another noted that the process could be smoother if there was not such frequent chairperson turnover. One respondent wanted to get more kids referred earlier rather than as a last straw.

**5. How has your CRCG successfully addressed issues regarding:**

**a. Participation (of agencies, local representatives, parent)?**

**Urban:** Several respondents said that they were active recruiters in getting others involved. It was important to them to maintain a good relationship with all the members, and to make sure that their needs are met so that they can then meet others' needs. Several cited that simply word of mouth to "get their buddies involved" was a successful way to address participation. Having dedicated members committed to the mission was also mentioned, as was the commitment of members. One member noted that participation was addressed through CMT. A few respondents stated that notification of meetings helped with participation, as did having a chair who is good at acknowledging

and showing appreciation for the team's participation (e.g., sending letters of appreciation to members). Another respondent noted that having supervisors with dynamic agendas is helpful.

**Rural:** Successful practices, such as making calls to mandated agencies, and having good public relations within the community due to community awareness fairs and newspaper articles, were mentioned. One respondent noted that their chairperson solicits the opinions of all the members, making them feel that they belong. Another said that their chair has tied counties together that used to be independent, which has made a positive impact on participation. Having mini-staffings was mentioned as helpful in getting people interested in attending, as was a push to have families attend. A few respondents mentioned that receiving a schedule at the beginning of the year was helpful, as was knowing and seeing each other outside of meetings. One respondent mentioned that participation has not been addressed directly. Another participant felt that seeing answers at the meetings gave the members motivation to attend.

**b. Funding (with CMT, inter-agency cost-sharing)?**

**Urban:** One respondent said that MHMR pays for their coordinator, while another said that CMT funds their coordinator. In terms of cost sharing, many respondents said that members volunteer funds and services, with sometimes 3 or 4 agreeing to pay for part of the needed service. Some noted there was not much of a solution other than interagency cooperation. Others mentioned having grants and donations, but noted the need for state funds to maximize donations. Another respondent mentioned having a lot of in-kind services donated.

**Rural:** Many respondents felt that funding was a huge problem, and said that many representatives do not offer money or service because they do not have the power to do so. Two particular agencies were noted as providing all the money for their respective sites. One respondent mentioned inter-agency cost sharing as the exception rather than the rule, while a few others said that different members volunteer services and funds. One member cited a discretionary fund obtained through a grant as a successful practice, while another mentioned having non-education money available. A few respondents said they did not know how this issue was being successfully addressed.

**c. Communication (among staff, outside of meetings, outside CRCG)?**

**Urban:** One respondent talked about having a bonding retreat at the beginning of the year as being helpful. Another mentioned that having lots of flexibility and people that are willing to try different things was also helpful. Time and practice were mentioned as beneficial in achieving effective communication, as was the fact that representatives work together in other ways outside of the CRCG. One respondent mentioned that the chair follows-up to ensure that members come through on commitments made.

**Rural:** One respondent said that since many members are part of the CMT and CRCG that they know and trust each other, and that makes for good communication. As mentioned by urban representatives, seeing each other outside of meetings enhances communication. Another representative stated that they were taking steps to develop policies and procedures to guide the flow of communication. Having a chair that is a good facilitator was cited as a helpful practice, as was the support from the community. Another mentioned that simply having such a small community allowed for good communication.

**d. Eliminating duplication of services? Are there laws, regulations, or policies that cause duplication? Do you notify anyone of those?**

*Urban:* A few respondents said that the CRCG process usually eliminates duplication since all the players are at the table, and that it is the role of the CRCG to prevent duplication. One stated that they really pay attention to duplication when making a plan, while another cited the chair as responsible for handling these issues, indicating some discrepancy among respondents on this issue. Many mentioned that there were no laws that caused duplication, or that they were unaware of any. Several were unaware of whether or not anyone was notified if a law was identified. One respondent said that this was a major problem in their area, and that a task force was working on this issue.

*Rural:* Many respondents said that they have so few services that duplication is not an issue. One cited that many agencies will not work with kids without insurance, and as a result, duplication was not occurring. Again, having different agencies at the meeting helps to eliminate duplication.

**e. Increasing access to services?**

*Urban:* Several respondents said that sharing resources was a helpful practice, as was having all committee members actively recruit resources. One participant felt that this issue is one of the prime assets of CRCGs, stating that they open many doors, expedite services, and break through bureaucracies. Specific agencies donating services was mentioned as increasing access. One member felt that having trust and good interagency representation at meetings was helpful.

*Rural:* Again, having different people with access to grants and funds was mentioned as helping to increase access to services. Specific agencies were cited as helping by donating services, as was having a chair that comes up with more and more resources. A

few respondents said that increasing access to services happens because there is a creative process. Another cited that gaining the cooperation of the police department was an essential practice.

**f. Developing CRCG service plans?**

**Urban:** Several respondents said that having the chair or coordinator monitor follow-up was a successful practice, as was the collaboration of the team. A few respondents liked having everyone sign the service plan.

**Rural:** One respondent talked about having a chairperson who listens to what they have to say, and using members' expertise as being a successful practice. They noted that the chair uses the right person to do a particular task. Again, the collaboration of members was cited as key in developing plans, as was having all sign the plans at the end of the meeting. A few respondents mentioned having a case manager to follow-up as a good practice. One participant talked about having a chair who is great about welcoming the family in, and getting their wants and needs identified, therefore making the planning process smoother and less intimidating for the family. A few respondents talked about how each member takes a lead, offers their services, and follows through with their part. Having a structured meeting was also identified as being helpful.

**g. Conflict resolution (interagency disputes, between agencies)?**

**Urban:** One respondent talked about how they used to have conflicts, and that, in working through them, they have learned how to "fight professionally". Discussions, follow-ups, and apologies were also mentioned as helpful practices, as was having a chair who can facilitate such processes. A few respondents said that the group resolves

conflicts themselves, sometimes doing so outside of the meetings. Several respondents said they do not really have any conflicts with others.

**Rural:** Several respondents said that they rarely have conflicts, and one cited that having a preliminary meeting where representatives can get to know each other was a helpful way to prevent conflict. One mentioned that those with a problem do not attend the meetings anymore. Another felt that conflicts had to be handled behind the scenes because the chair is not comfortable with conflicts. Having a chair that is a good mediator was also cited, as was the fact that the representatives are a professional group. Again, knowing each other well was mentioned by several respondents as reducing conflict, as was simply talking about issues that are causing tension. One participant mentioned the MOU as being a helpful guide to follow.

**6. How does your agency/organization benefit by participation in the CRCG?**

**Urban:** Many respondents talked about having a solid contact with individuals in other agencies whom they can contact and get immediate help for their clients. Many said they benefit by being able to keep aware of available resources, as well as what is happening with them, and by getting more involved with other agencies. Good public relations and recognition was cited by many, as was the excellent learning process that takes place. One member noted that, occasionally, they have received funding as a result of their participation. Having the CRCG as a referral source for participants was identified as a benefit, as was the networking and relationship-building opportunities. One respondent mentioned the benefit of exposure to each others' treatment philosophies. Another talked about gaining an understanding of how services are similar, different, unique, and complementary. One respondent cited the benefit of being able to follow-up on after-

care of patients being staffed at CRCG that have been at their hospital. Another talked about how the process makes them more sensitive to poverty, social problems, and gaps in services. Prevention, such as being able to get kids services to prevent them from coming into a respondent's correctional facility, was also noted.

**Rural:** Many respondents talked about how being a part of the CRCG makes them feel good in that they are able to provide services to their community. This sense of positively effecting one's community, and helping to revolutionize it was cited by a number of respondents. Others talked about the pleasure in being able to help families they might not have had the opportunity to help. Also, being able to identify community needs and being able to pay the community back were identified by a few participants. As mentioned by an urban respondent, being able to learn about other programs and resources, have a personal contact there, as well as the opportunity for others to learn about their agency was mentioned. Also, the educational and informative opportunities provided, exposure to new ideas, and staying informed about various agency activities were mentioned. One participant said that he can use what he gathers from listening to the other members in his own counseling practice. Being able to fund local resources in a rural area was mentioned by one participant. One agency talked about how they get several referrals from CRCG kids, and can therefore meet their quota. Others mentioned being able to staff their kids at the CRCG meeting as a benefit. Being able to share the responsibility for hard to serve clients was mentioned.

7. **Tell me about the challenges your CRCG faces in meeting client needs (e.g., residential care, dual diagnosis).**

**Urban:** The lack of resources and services across the board was mentioned by most respondents. Specifically, respite care, residential care, and alcohol or substance abuse

detoxification programs for adolescents were mentioned. Funding was mentioned by the majority of respondents as one of the major challenges. Another participant mentioned that the duration of services is often too short.

**Rural:** The number one challenge cited by all participants was that of funding. Several specific needs were identified including: in-home treatment, residential care, home visits, transportation, placement outside the home, hospitalization (for 3 to 4 months), half-way houses or safe houses for adolescents, intense counseling resources, a place for older kids to go “cool off”, funding for placement of kids with serious problems, therapeutic foster homes, substance abuse outpatient treatment, therapeutic placements for juvenile delinquents, children’s crisis centers, contract psychiatrists, counselors, placement for sexual offenders, placement for kids with severe problems (e.g., fire setting), mental health services for young children, dual diagnosis kids that do not fit MHMR criteria and are indigent, services for youth ages 3 to 7, detoxification programs, treatment for emotionally disturbed children, local transitional services, and community resources for kids and teens in poor and/or dangerous home environments. Getting families to agree to participate was mentioned by several respondents. A few mentioned the difficulty in working with Medicaid HMO. One respondent mentioned the challenge of having high turnover in agencies and thus sending new agency representatives. Several respondents talked about having parents that will not follow through with the service plans. One participant mentioned the challenge in getting referrals, while another talked about the difficulty of bringing services to the community where family, school, and student work out a common goal.

8. What additional resources does your CRCG need?

*Urban:* Resources identified by several respondents included: respite care, short-term residential care, day treatment, mentoring, free counseling, long-term planning help, scholarship beds, scholarship services (e.g., to pay for family counseling for a family who can not afford it), and non-traditional services. In addition, most respondents said they needed more services, greater availability to agencies, and more money for placement. Having agency representatives at the table that can bring in more services, as well as having a grant writer to secure funds, were additional resources mentioned. Some noted the need for an assistant or administrative support for their chairs or coordinators. Others talked about the need for a full-time, paid coordinator.

*Rural:* The overwhelming response was money. Specific resources noted as lacking in the different areas were: local in-home service providers, educational resources for families, hospital beds, sponsors to help pay utilities, petty cash for emergency needs, unrestricted funds, funds for clients not on Medicaid, transportation, local services for medically fragile kids, intensive treatment, family support groups to allow families to vent, alcohol and drug abuse treatment for kids, MHMR treatment and therapeutic care, and a local acute-care facility. A few respondents mentioned the need for training for the chair, co-chair, and secretary. One respondent noted the need for a running address and phone list, while others mentioned having a database to keep all CRCG and other agencies on line. Several respondents said they needed more community awareness and exposure. Coordination of services was identified as a needed resource to keep groups on track. One participant mentioned having a psychologist available to help in coordinating services. As mentioned by urban respondents, the need for a full-time coordinator was

mentioned. A few respondents said they were unsure of what resources they needed, while one respondent said they were alright, and seemed to find the money somewhere.

**9. What support does your CRCG need from the state, regional and local levels?**

**Urban:** Money was noted by the majority of respondents. Specifically, funds for the following services were listed: legislative money targeted for at-risk, multi-problem families for acute intervention and long-term care; money for direct services; and discretionary money and money that is flexible. Locally, respondents mentioned the need for marketing so that communities know about the CRCG. A few mentioned the need for support for the chair position, while a few others said they did not know what support was needed.

**Rural:** Again, the overwhelming majority of responses indicated money as the most needed support. A few respondents mentioned needing help with grant writing or having a grant writer. Others talked about wanting training workshops for the chair. One respondent mentioned the need for advocacy from the legislature for the programming they need, while another talked about the need for state level intervention when an agency is not coming through. A few respondents talked about the desire to know what other CRCGs are doing, suggesting a newsletter describing successful practices, and as a way to share information, including how each CRCG operates. Along those lines, one respondent mentioned having a database with CRCG information, as well as a way for CRCGs to communicate back and forth with each other. One respondent mentioned the need for the state to establish a measurement and evaluation system to find out if the families actually received the services. One respondent discussed having more support from CPS in terms of quicker investigations and assistance in cases. Locally,

respondents felt they needed more community education and awareness, including flyers and brochures to advertise CRCGs, as well as more participating agencies. A few participants felt that they were receiving the support they needed, mentioning having had speakers come, while a few others said they were not sure what support was needed.

**10. Describe the parent involvement aspect of your CRCG. How are families involved? How often do they attend meetings? Do they assist in the planning process and, if so, how? Is parental consent always obtained? Is the CRCG family-friendly?**

**Urban:** The majority of respondents felt that families are very involved in the CRCG process. They felt that families are almost always at the meetings, with a few members citing an 80-90% attendance rate. Respondents described family participation in the process in terms of families discussing their wants and needs, with one respondent stating that family input was a mandatory part of the process. A few respondents talked about having a parent liaison there to support families. The majority of respondents noted that consent is required in order to discuss options for a child, which is always obtained, usually by the person who has referred him/her. A few noted that the kids were usually not at the meetings unless being introduced to the treatment plan. A few respondents felt that their CRCG was not family-friendly, and many families were not involved citing that many of them are faced with a number of challenges, and have difficulty attending these meetings.

**Rural:** Again, most respondents felt that their CRCG was family-friendly, and that families were very involved. In terms of attendance, however, estimates ranged from 15% to 95% attendance rates. Respondents also noted that consent was always obtained. Several participants talked about their concerns with the family aspect. Some mentioned

how parents are often hostile because they have been “beaten down” by a number of people to get there. Others mentioned how difficult it is for parents to attend because they have so much going on in their lives, while others discussed how the meetings can be intimidating to parents due to group size and decision-maker’s involvement, and how essential it is to talk to parents before the meetings to prepare them. Several participants stated that not all members of their team are providing this kind of support. Several respondents felt that parents were willing to help with the planning, and described how families state their wants and needs and what they can agree to in terms of a plan. There was a discrepancy in opinions noted by a few members regarding whether or not to have the child and parents attend the meetings. A few participants said they had a parent representative and that it was a helpful part. Others said that the meetings were set up so that parent involvement is major part. A few respondents felt they could be more family-friendly, and suggested having the executive committee meet with parents prior to the big meetings to help alleviate intimidation and apprehension. One respondent felt that parental attendance was rare.

**11. To what extent are the families you work with satisfied with the services they receive?**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Neutral</b>	<b>Satisfied</b>	<b>Very Satisfied</b>

*Urban:* Several respondents said they were unsure how satisfied families were. A few participants said that the families that were not satisfied with the services are, in general, too dysfunctional to use the services. Several noted that many parents come to meetings already having given up and that they want the CRCG team to put their kids into the

state's care, do not want to be involved, etc., and are therefore not satisfied with the plans they receive. Many cited residential treatment, specifically, as what parents want, and that when funds simply are not available that parents are dissatisfied. A few respondents felt that families are satisfied when the team can give them other options.

**Rural:** A few respondents felt that they needed better follow-through to improve the satisfaction level. Others said they did not believe families have been surveyed regarding their satisfaction, although they have not heard any complaints. A few felt that those who follow-through with the plans are very satisfied. One noted that satisfaction would be even greater if there was not such a "stiff, formal atmosphere". Another person felt that parents do not see the meetings as helpful since they do not know the participants. As with the urban respondents, some mentioned that families want to get their kids out of their homes for a while because they are frustrated, and they are not satisfied when they are not given that option (e.g., respite care, residential treatment).

**12. How essential do you feel it is to have a standing CRCG parent representative? Does your CRCG have one and, if so, what role does he or she play?**

**Urban:** Responses were mixed in terms of having a parent representative. While some felt that a liaison could be useful in putting the family at ease, others felt they were not essential. One noted that feedback from a parent representative was helpful. Another mentioned that the parent representative would be helpful in terms of preparing clients for the meetings. A few participants said they did not know if it would be a good idea, stating that they do not have one, and are not sure what the representative's role or function would be. One noted that it is more important to have a client's parents there, rather than a parent representative.

**Rural:** Feelings were again mixed in terms of the usefulness of a parent representative. Several respondents felt it would be an asset. They felt the liaison could help relay parents' wishes and provide the team with the parent perspective that is sometimes overlooked. Many said that they had not had a parent representative, and one mentioned they were having trouble having one consistently attend. A few said that having a parent representative would help keep the focus on the family and be a great advocate for families. One participant felt that a parent liaison would be helpful, especially because they felt the chair was not good at orienting parents. Many others, however, were concerned with issues of confidentiality since they were in such small towns. Some felt that children/youth and their families usually trust professionals, but might not trust citizens (parents). One participant mentioned that they would not be able to pay the representative very much, and felt they would subsequently get someone with no expertise. Another felt that parents might not want to attend meetings if another parent in their town is there to "get into their business". One respondent mentioned that a lot of CRCG members are parents, thus fulfilling the parent representative role. A few others said they had not had one, and were not sure how it would be essential.

**13. Do you submit CRCG staffing data to the State Office? Why or why not?**

**Urban:** The majority of respondents said they did not know if data was submitted to the State Office. Many noted that it was the chair's job. One respondent said that they have not done so in the past, but plan to, while another said they were backed up now but trying to get that going. One respondent mentioned that they send the data for funding and legal requirements, and another noted that they do submit data but that it was a time-consuming job.

**Rural:** Again, most respondents said they did not know, and that they thought their chair probably did. One mentioned that they do send in data because it is required by the state. Another said he presumed the data was sent in for statistics and to get a sample of cases to evaluate and follow-up on.

**14. How do you conduct follow-ups on CRCG staffings? Do you submit one- and six-month follow-ups to the State Office? Why or why not?**

**Urban:** Many respondents stated that the chair (or coordinator where applicable) does the follow-up and reports to the state, while others mentioned they did not know the frequency or to whom the information is sent. Several mentioned that one and six month follow-ups are completed in staffings, and one member said they do two and three month follow-ups to keep the visibility of cases until they can be managed. One respondent said they have not submitted data in a couple of years, mentioning that the state does not “pressure them” to do so. The respondent further noted that if it is a priority, the state needs to let them know, and needs to convince them of the merit of doing so. Another representative said he would like to see the data the state receives.

**Rural:** Again, the majority of respondents said the chair is responsible for tracking data, doing follow-ups, and updates. Several others said they did not know if data was sent. One mentioned that data was not being sent when this was the responsibility of the chair (unpaid position), but is now that they have a coordinator (paid position). Many mentioned that one and six-month follow-ups are done at the meetings, verbally and in writing, and at other times as needed. A few others cited that the person who writes up the plans, along with the chair, was responsible for sending members a letter to inform them of updates.

**15. Do you think the CRCG is focused on the appropriate client population?**

**Urban:** The majority of respondents felt that CRCGs were focused on the appropriate client population. Some mentioned that there may be other youth out there who are unaware of some of the resources, and one respondent brought attention to the small numbers of 16 and 17-year-olds they see. One responded stated that they do not get many emotionally disturbed children, and that, if they did, they would need to expand their expertise. Another cited the lack of medical cases, again being content with that because of the lack of expertise in that area. A few mentioned that while the focus is on the child, the plan is for the entire family. Others said they felt they were doing exactly what they were created to do. One respondent felt that they saw a fair number of kids with mental retardation (30%), with approximately 70% of kids with mental health issues. Several noted the need to have an adult CRCG, although one member felt that they should not attempt an adult CRCG until CRCGs became more efficient at serving children.

**Rural:** Many respondents felt that CRCGs were focused on the appropriate client population, with one citing that now, more than ever, our children are at-risk and in need of this service. One respondent was more hesitant, stating that part of the problem is in people not being fully informed of the availability of CRCGs as a referral source. A few mentioned that CRCGs are supposed to be a stop of last resort but that does not always happen. One participant said that they were focused appropriately, but that some CRCGs serve a lot more kids than others. One respondent said they would like to see more of a focus on families with kids and elderly. A few mentioned the frustration of not having local services to offer families, therefore having to send them outside of the community,

which they felt seems to defeat the intent of CRCGs. Several also mentioned the need to have a CRCG at the adult level.

**16. Overall, how satisfied are you with how well your CRCG meet the needs of kids who have fallen through the cracks?**

1	2	3	4	5
<b>Very Dissatisfied</b>	<b>Dissatisfied</b>	<b>Neutral</b>	<b>Satisfied</b>	<b>Very Satisfied</b>

**Urban:** Many respondents felt that the job they do is very satisfactory, yet the lack of resources available effects their overall satisfaction. Many felt that they do an excellent job, are a committed group, but cited that the crack in services is sometimes too large for CRCG to deal with. One member noted a dissatisfaction with the need for increased support from the top down, stating that the process itself is fine. Residential treatment was again noted by several as a major stumbling block. One participant said that services and determination are the key, while several stated that it is always a funding issue that can not be resolved that prevents them from meeting the needs of the kids.

**Rural:** The majority of respondents felt somewhat discouraged in terms of their satisfaction because of the lack of money and resources. They felt that they did the best they could with what they had, but said that was not much. One representative said that if they can identify gaps in services and have some mechanism to address them, they are successful. One mentioned that they do well with one-time plans, but that there should be a more thorough follow-through process. She mentioned that, if a plan made in January falls through later, they do not hear back from the client and are unaware of problems. A few participants said that there are many more kids out there that need us

that we are not getting to. Another mentioned the parent aspect as part of their problem, in that parents do not always follow-through or work with the CRCG team. Another frustration mentioned was the fact that many clients are passed from one department to another with no one serving them because no one seems to have jurisdiction.

**Additional Comments:**

**Urban:** One member noted a need for a thorough follow-up, going back at least 2 years, suggesting it might be a good project for the LBJ School of Public Affairs at The University of Texas at Austin. Several respondents mentioned the need for a push for extra resources for the community. Others expressed the necessity of having a paid coordinator, while one felt that only active CRCGs that function and cooperate should receive money for a coordinator.

**Rural:** The necessity for a paid coordinator was also mentioned by several respondents. A few mentioned the need to be able to catch kids early on rather than weeks, months, or years after the onset of the problem. One member noted a difference in opinion among members regarding the CRCG process. Specifically, while some see the CRCG meetings as a therapeutic process, and want the kids to attend and take responsibility for the plans, others see it as an administrative task, and do not see the need for the child to attend. One participant mentioned the frustration when representatives do not attend mini-staffings and then are out of context for the large meetings. A few others mentioned struggles around a difference of opinion regarding who should attend mini-staffings. One participant felt that these should occur more often. Another respondent said that just because he might not know what to do with a particular kid, that does not mean an entire group of people can not come up with some good ideas.

### **Likert-Scale Item Responses**

As part of the interview, respondents were also asked to answer several items on a 5-point Likert scale (very dissatisfied, dissatisfied, neutral, satisfied, very satisfied) regarding various facets of their CRCG process and operation. These results are summarized below (see Table 1).

All thirty-nine (39) respondents completed most of the Likert scale items. Where percentages do not add up to one hundred percent, it is due to missing data (i.e., some respondents did not complete that item).

Respondents were overwhelmingly satisfied with how often their CRCG met, with the majority (92.3%) indicating they were either very satisfied or satisfied (see Appendix H - Figure 1). Respondents were not as satisfied, however, with attendance at meetings. While two-third (66.6%) indicated that they were either very satisfied or satisfied with attendance, nearly one-fifth (17.9%) expressed being dissatisfied or very dissatisfied (see Appendix H - Figure 2). This supports findings from the open-ended responses presented above. A majority of respondents were very satisfied or satisfied with how they were notified about meetings (94.8%) (see Appendix H - Figure 3) and the facilitation of meetings (87.2%) (see Appendix H - Figure 4). Just under two-third (64.1%) indicated they were very satisfied or satisfied with the use of protocols or by-laws at meetings, with 10.3% indicating that they were very dissatisfied or dissatisfied (see Appendix H - Figure 5). Approximately three-quarter (74.4%) respondents reported being very satisfied or satisfied with client referrals to the CRCG, and interestingly, one-fifth (20.5%) remained neutral on this item (see Appendix H - Figure 6).

**Table 1: Interview and Questionnaire Results**

Item	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied
	%	%	%	%	%
4. How satisfied are you with:					
a. how often you meet?	5.1%	0%	2.6%	25.6%	66.7%
b. attendance at meetings?	5.1%	12.8%	15.4%	48.7%	17.9%
c. being notified about meetings?	2.6%	2.6%	0%	41%	53.8%
d. facilitation of meetings?	5.1%	2.6%	5.1%	28.2%	59%
e. use of protocols or by-laws at meetings?	2.6%	7.7%	15.4%	28.2%	35.9%
f. client referrals to CRCG?	2.6%	2.6%	20.5%	35.9%	38.5%
11. To what extent are the families you work with satisfied with the services they receive?	0%	7.7%	17.9%	46.2%	10.3%
16. Overall, how satisfied are you with how well your CRCG meets the needs of kids who have fallen through the cracks?	2.6%	10.3%	7.7%	48.7%	25.6%

When asked to what extent the families are satisfied with the services they receive from the CRCG, only a few (10.3%) respondents predicted very satisfied. However, just under half (46.2%) predicted that families were satisfied, and a handful (7.7%) dissatisfied (see Appendix H - Figure 7). A few more respondents (12.9%) expressed being very dissatisfied or dissatisfied regarding how well their CRCG meets the needs of kids who have fallen through the cracks. Nevertheless, nearly three-quarter (74.3%) expressed being very satisfied or satisfied in this area (see Appendix H - Figure 8).

### **Relating Findings to Memorandum of Understanding (MOU)**

***Overall, the Community Resource Coordination Groups (CRCGs) that participated in this study appear to be meeting the stated objectives of the Memorandum of Understanding (MOU).***

Most respondents agreed that family participation is important to the CRCG process, and many expressed a desire for an increase in the amount of family participation. Some respondents felt that more could be done to prepare the families for meetings, as it can be an intense process. As indicated above, when asked to what extent the families are satisfied with the services they receive from the CRCG, only a few respondents predicted very satisfied, indicating that there is room for improvement in this area, or that family members have unrealistic expectation regarding what the CRCG process can offer (e.g., residential treatment). It is important to note that the charge of CRCGs is to promote resources that encourage the least restrictive environment for youth and to avoid the perception that they are a placement service. This is a challenge for most CRCGs as many families enter the process with the hope or expectation that residential placement or respite care will be provided.

The CRCGs appear to be serving children/youth and families with multi-agency needs. There is at times confusion over what the specific criteria are for referrals (e.g., 22 is the cutoff age of youth served). The referral process is at times loosely structured with unclear guidelines. Nevertheless, the majority of respondents reported satisfaction with client referrals to the CRCG. However, the fact that one-fifth of respondents remained neutral on this item might indicate lack of interest or critical thinking on this issue.

With regard to interagency cost sharing, most CRCGs seem to be effectively meeting the charge of the MOU by offering the services and funds available. It is important to note that interagency cost sharing indicates that different agencies share responsibility for delivery of services to the client, and is not intended to reflect any formal pooling of funds among agencies. However, there are often restrained resources and limited members with the proper decision-making authority to donate services or funds (especially in rural areas), in which case a handful of select agencies end up carrying the load.

There does not appear to be a duplication of services, and there are no identified laws or regulations that cause duplication. Dispute resolution was typically handled competently and this was not cited as a major problem for most sites. However, it is imperative that the chairs have adequate mediation skills.

It appeared that most mandated agencies were attending staffings, but a greater variety of participants was desired. Respondents were overwhelmingly satisfied with how often their CRCG met, but not quite as satisfied with attendance at meetings. Mandated agencies not attending was cited as more of a problem in rural areas. Some respondents recommended recruiting new members, such as judges. Many CRCGs hold

mini-staffings as needed that allow them to convene in between regular monthly staffings. A majority of respondents expressed satisfaction with how they were notified about meetings and the facilitation of meetings. Comparatively, however, respondents were generally less satisfied with the use of protocols or by-laws at meetings.

Most respondents had no knowledge about permissible non-attendance, but in several cases it was reported that the chair contacted mandated agencies that did not attend a staffing. Most did not recognize non-attendance as a pressing problem. The CRCGs that were observed all used a confidentiality form that members had to sign. A concern for rural CRCGs regarding confidentiality and parent representatives was that in a small community most people know one another and have contact with each other on a regular basis and it may therefore be more challenging for a parent representative to maintain a client's right to privacy.

### **Best Practices**

In addition to the above findings relating to the Memorandum of Understanding, several "best practices" were identified among CRCGs, some of which are outlined below.

- Creating new resources (e.g., respite care), especially in rural communities where resources are limited.
- Continuing to meet every month, even when there is no child to serve. This time could be used to familiarize each other on resources and to work on other projects.
- Combining the CMT and CRCGs together in order to work on both micro and macro issues was found extremely helpful.
- Inviting a variety of agencies and participants, such as judges, to offer their expertise, if not resources and money, was highlighted.

- The collaborative effort of parents and agencies getting together, laying their resources out on the table, and allowing parents to have some input in the plans was identified as an essential part of CRCG practice.
- Immediate implementation of service plans (e.g., making relevant phone calls while interagency service planning is still on-going at the meeting).

Additional suggested and recommended best practices are explored at greater length below in the discussion section.

## **Results: Phase II**

### **Initial Administration Immediately Following CRCG Staffing**

Fifty-two (52) respondents completed and returned the Client Satisfaction Questionnaire (CSQ-8) immediately following the CRCG staffing (see Table 2 below). While the actual respondents who completed the questionnaire for Phase II were adults (parents/guardians) that were staffed by a CRCG with/on behalf of their child(ren), the demographic information that is presented below reflects the make-up of the youth that were staffed at the CRCG. In other words, the parents/guardians provided basic demographic information about their child (excluding name).

Over two-thirds (70%) of the children were male, with one-third (30%) female. Just over half of the children staffed were White (52%), with the remaining children being African American (18%), Hispanic (24%), American Indian (2%), and mixed (4%). This ethnic representation is very comparable to the ethnic make-up of all youth referred to CRCGs in 1998 (see Appendix I). The youth served by the CRCGs ranged in age from 1 to 18 years old. Almost two-thirds (64%) of the youth in this sample fall into the 13-17 year-old age bracket.

Table 2: Client Satisfaction Questionnaire (CSQ-8) Pretest Results (N = 52)

	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>Excellent</u>
<b>1. How would you rate the quality of service you have received?</b>	3 (5.8%)	1 (1.9%)	11 (21.2%)	37 (71.2%)
<b>2. Did you get the kind of service you wanted?</b>	<u>No, definitely not</u> 2 (3.8%)	<u>No, not really</u> 3 (5.8%)	<u>Yes, generally</u> 15 (28.8%)	<u>Yes, definitely</u> 32 (61.5%)
<b>3. To what extent has our program met your needs?</b>	<u>None of my needs have been met</u> 2 (3.8%)	<u>A few of my needs have been met</u> 8 (15.4%)	<u>Most of my needs have been met</u> 23 (44.2%)	<u>Almost all of my needs have been met</u> 19 (36.5%)
<b>4. If a friend were in need of similar help, would you recommend our program to him/her?</b>	<u>No, definitely not</u> 0 (0%)	<u>No, I don't think so</u> 1 (1.9%)	<u>Yes, I think so</u> 9 (17.3%)	<u>Yes, definitely</u> 42 (80.8%)
<b>5. How satisfied are you with the amount of help you have received?</b>	<u>Quite dissatisfied</u> 5 (9.6%)	<u>Indifferent or mildly dissatisfied</u> 3 (5.8%)	<u>Mostly satisfied</u> 15 (28.8%)	<u>Very satisfied</u> 29 (55.8%)
<b>6. Have the services you received helped you to deal more effectively with your problems?</b>	<u>No, they seemed to make things worse</u> 1 (1.9%)	<u>No, they really didn't help</u> 4 (7.7%)	<u>Yes, they helped somewhat</u> 15 (28.8%)	<u>Yes, they helped a great deal</u> 32 (61.5%)
<b>7. In an overall, general sense, how satisfied are you with the service you have received?</b>	<u>Quite dissatisfied</u> 3 (5.8%)	<u>Indifferent or mildly dissatisfied</u> 4 (7.7%)	<u>Mostly satisfied</u> 12 (23.1%)	<u>Very satisfied</u> 33 (63.5%)
<b>8. If you were to seek help again, would you come back to our program?</b>	<u>No, definitely not</u> 1 (1.9%)	<u>No, I don't think so</u> 2 (3.8%)	<u>Yes, I think so</u> 9 (17.3%)	<u>Yes, definitely</u> 40 (76.9%)

The average age among the youth was 13 years of age (S.D. = 3.9). Again, the ages of youth represented in this sample is very comparable to the ages of all youth served by CRCGs from 1996 to 1998 (see Appendix J).

Respondents (parents/guardians) were overwhelmingly satisfied with the quality of service received by CRCGs, with the majority (92%) citing the services received as either “good” or “excellent” (see Appendix K - Figure 9). A majority (90%) of respondents indicated that they “generally” or “definitely” received the type of service they wanted from the CRCG (see Appendix K - Figure 10). Four-fifths (81%) of respondents found that the program met their needs, indicating that “most” or “almost all” of their needs had been met (see Appendix K - Figure 11). Four-fifths (81%) also would “definitely” recommend the program to a friend (see Appendix K - Figure 12). Most respondents (85%) were “mostly” or “very” satisfied with the amount of help received by CRCG (see Appendix K - Figure 13). When asked if the services received helped them to deal more effectively with their problems, 90% of respondents replied that the CRCG services helped either “somewhat” or “a great deal” (see Appendix K - Figure 14). In an overall, general sense, 87% of respondents were “mostly” or “very” satisfied with the services they received (see Appendix K - Figure 15). Finally, a majority (94%) replied that they would come back to the CRCG program (responding either “Yes, definitely” [77%] or “Yes, I think so” [17%]) (See Appendix K - Figure 16).

The CSQ-8 can be easily scored, with scores ranging from 8 to 32. Higher scores reflect greater levels of satisfaction. For the initial administration, scores ranged from 9 to 32, with a mean score of 28 (S.D. = 5.1). Two-thirds (66%) of respondents scored

between 29 and 32, indicating that overall respondents were satisfied with the CRCG process.

There were no significant differences in CSQ-8 scores by ethnicity, gender, or whether a CRCG was led by a (paid) coordinator or (volunteer) chairperson.

### **Two-Month Follow-up**

**CSQ-8 Results:** Thirty-five (35) respondents completed the Client Satisfaction Questionnaire (CSQ-8) approximately two months following their CRCG staffing (see Table 3 below). Respondents (parents/guardians) were overwhelmingly satisfied with the quality of service received by CRCGs, with over four-fifths (83%) citing the services received as either “good” or “excellent” (see Appendix L - Figure 17). Just over four-fifths (83%) of respondents also indicated that they “generally” or “definitely” received the type of service they wanted from the CRCG (see Appendix L - Figure 18). Approximately three-quarter (77%) of respondents found that the program met their needs, indicating that “most” or “almost all” of their needs had been met (see Appendix L - Figure 19). Three-fifths (60%) would “definitely” recommend the program to a friend (see Appendix L - Figure 20). Just over three-quarter (77%) were “mostly” or “very” satisfied with the amount of help received by CRCG, with one-fifth (20%) stating they were only “mildly” satisfied (see Appendix L - Figure 21). When asked if the services received helped them to deal more effectively with their problems, 86% of respondents replied that the CRCG services helped either “somewhat” or “a great deal” (see Appendix L - Figure 22). In an overall, general sense, approximately three quarter (74%) of respondents were “mostly” or “very” satisfied with the services they received, with one-fifth (20%) reporting they were only “mildly” satisfied (see Appendix L - Figure 23).

**Table 3: Client Satisfaction Questionnaire (CSQ-8) Two-Month Follow-Up Results (N = 35)**

	<u>Poor</u>	<u>Fair</u>	<u>Good</u>	<u>Excellent</u>
<b>1. How would you rate the quality of service you have received?</b>	2 (5.7%)	4 (11.4%)	12 (34.3%)	17 (48.6%)
<b>2. Did you get the kind of service you wanted?</b>	<u>No, definitely not</u> 2 (5.7%)	<u>No, not really</u> 4 (11.4%)	<u>Yes, generally</u> 11 (31.4%)	<u>Yes, definitely</u> 17 (48.6%)
<b>3. To what extent has our program met your needs?</b>	<u>None of my needs have been met</u> 3 (8.6%)	<u>A few of my needs have been met</u> 5 (14.3%)	<u>Most of my needs have been met</u> 15 (42.9%)	<u>Almost all of my needs have been met</u> 12 (34.3%)
<b>4. If a friend were in need of similar help, would you recommend our program to him/her?</b>	<u>No, definitely not</u> 1 (2.9%)	<u>No, I don't think so</u> 3 (8.6%)	<u>Yes, I think so</u> 10 (28.6%)	<u>Yes, definitely</u> 21 (60.0%)
<b>5. How satisfied are you with the amount of help you have received?</b>	<u>Quite dissatisfied</u> 1 (2.9%)	<u>Indifferent or mildly dissatisfied</u> 7 (20.0%)	<u>Mostly satisfied</u> 13 (37.1%)	<u>Very satisfied</u> 14 (40.0%)
<b>6. Have the services you received helped you to deal more effectively with your problems?</b>	<u>No, they seemed to make things worse</u> 2 (5.7%)	<u>No, they really didn't help</u> 3 (8.6%)	<u>Yes, they helped somewhat</u> 13 (37.1%)	<u>Yes, they helped a great deal</u> 17 (48.6%)
<b>7. In an overall, general sense, how satisfied are you with the service you have received?</b>	<u>Quite dissatisfied</u> 2 (5.7%)	<u>Indifferent or mildly dissatisfied</u> 7 (20.0%)	<u>Mostly satisfied</u> 11 (31.4%)	<u>Very satisfied</u> 15 (42.9%)
<b>8. If you were to seek help again, would you come back to our program?</b>	<u>No, definitely not</u> 1 (2.9%)	<u>No, I don't think so</u> 2 (5.7%)	<u>Yes, I think so</u> 12 (34.3%)	<u>Yes, definitely</u> 20 (57.1%)

Finally, a majority (91%) replied that they would come back to the CRCG program (responding either “Yes, definitely” [57%] or “Yes, I think so” [34%]) (See Appendix L - Figure 24).

Recall that the CSQ-8 can be easily scored, with scores ranging from 8 to 32, and higher scores reflecting greater levels of satisfaction. For the two-month follow-up, total scores on the CSQ-8 ranged from 10 to 32, with a mean score of 26 (S.D. = 6.1). Just under half (46%) of respondents scored between 29 and 32 (compared with 66% of respondents who scored in this range during the first administration), and almost one-fifth (17%) scored a 24 at the two-month follow-up. While these follow-up scores generally indicate that respondents were satisfied two months following the CRCG staffing, it is evident that scores dropped slightly over time. There were no significant differences in CSQ scores by ethnicity, gender, or whether a CRCG was led by a (paid) coordinator or (volunteer) chairperson.

***Open-ended Questions:*** The following is a summary of responses to four (4) open-ended questions that interviewers asked of the twenty-two (22) respondents that were contacted by telephone during the follow-up phase. These responses supplemented the quantitative data derived from the CSQ-8, providing richer information. After a respondent completed the CSQ-8 with the interviewer over the phone, they answered these four questions.

**1. In what way has the CRCG staffing been most helpful to you and your family?**

Respondents reported that the CRCGs were most helpful in providing options for placement and overall support for their family. Several respondents reported that the CRCGs gave them options that they had previously been unaware of, or confirmed

for clients that they had in fact exhausted all possible resources, which was validating for the clients. Many respondents noted the caring attitude and availability of the staff, stating that the CRCG team was a source of relief for their family. One of the respondents spoke of the change in their daughter as being “beyond expectations . . . mind boggling”, and another said that their son had “turned his life around” as a result of the CRCG’s efforts.

**2. In what way has the CRCG staffing been least helpful to you and your family?**

Most respondents reported that the CRCG staffings had been helpful and many stated that they had nothing negative to report about the program. However, one noted area for improvement was the lack of appropriate placement options for their children (e.g., waiting lists were too long, no options available at all). One respondent stated that she had to wait too long for the CRCG staffing to convene, as her family was in a crisis and needed more immediate attention.

**3. What are your suggestions for how the CRCG staffings can be more helpful?**

Many respondents commented that the CRCG worked well together, that the staff were professional and helpful, and offered no suggestions about how to make the staffings more helpful. Several respondents stated that the CRCG could be more helpful by providing additional options (e.g., placement) for young children. Several also noted that there was an increased need for regular follow-up contact with the CRCG staff.

**4. Did you get what you wanted by attending the CRCG staffing?**

Respondents reported that, overall, they got what they wanted by attending the CRCG staffing. They stated that they had been listened to, gained insight, had solutions

provided, received needed information, and were “backed up” by the CRCG team.

There was one respondent that stated she did not get what she wanted from the staffing.

### *Change Over Time*

On the CSQ-8, the average total score from the initial administration (Mean = 28.0; S.D. = 5.1) to the two-month follow-up (Mean = 26.0; S.D. = 6.1) lowered by two points. Only those respondents who had completed the initial administration and the follow-up ( $n = 35$ ) were included in this analysis. Thus, there were 17 of the original 52 respondents that the research team was unable to contact during the two-month follow-up data collection period. While slight, this two-point difference was enough to produce statistically significant differences ( $\alpha = .05$ ,  $p = .02$ ) between the first and second administrations of the CSQ-8 when comparing the mean scores. There was a general trend towards degeneration of satisfaction with the CRCG process as time passed. One possible explanation for this trend is that immediately after the initial staffing parents/guardians feel some relief from having their concerns addressed and they hope for the future resolution of their child’s problem.

The test used to detect any statistically significant differences in CSQ-8 scores is called the Wilcoxon Signed Ranks Test, which is the nonparametric equivalent to the paired-samples  $t$  test, and in this case, tests the hypothesis that the CSQ-8 scores from the two administrations have the same distribution. If the  $p$  value (.02) reported above is less than or equal to  $\alpha$  (.05), then the results are said to be statistically significant. This means that there are less than 5 chances in 100 that the results occurred due to chance alone. The Wilcoxon takes into account information about the magnitude of differences

by looking at each respondent's scores, and gives more weight to respondents that show large differences (from the first score on the CSQ-8 to the two-month follow-up) than to respondents that demonstrate small differences.

It is worth mentioning that other research has found that oral administration of the CSQ-8 produces as much as 10% higher satisfaction ratings than written administration (LeVois, Nguyen & Attkisson, 1981). Thus, one could hypothesize that if we had utilized written responses only (i.e., continued with the mail survey method rather than utilize the phone survey as we did) for all respondents in the follow-up, we might have gotten results that indicated even less satisfaction at follow-up. However, this is strictly speculation and is only one possible explanation based on available literature.

### **Limitations of this Study**

It is inevitable that when a research study is designed and implemented there will be limitations. It is important to keep those limitations in mind while considering the findings. In this study (in particular, Phase II), the major limitation was a relatively small sample size given the number of parents/guardians that could have potentially responded in Phase II. For example, we can't determine what it was that motivated respondents to participate in this study when compared to those parents/guardians that chose to not participate. One possible explanation is that parents/guardians that participated were more motivated, were experiencing less stress, were overall higher functioning, and so on when compared to parents/guardians who did not participate by returning the CSQ-8 in the mail. While there is no evidence to support this, it at least needs to be considered as a possibility when reviewing the findings and any subsequent conclusions presented in this

report because it introduces the possibility that the sample may be biased in some way. Additionally, not all eleven regions in Texas are represented by the sample. This raises the concern that this sample may not be truly representative of all children served by CRCGs across the state. However, recall that the ethnicity and age of children served in this sample are comparable to the 1996 to 1998 data from the State Office of CRCG, which does provide some level of comfort that there is adequate representation at least on these variables.

### **Recommendations**

The operation of interdisciplinary efforts has the potential to bring many benefits, but also brings stress and complications. Both strengths and areas needing improvement are discussed below, and recommendations are made when appropriate.

There are many strengths of the CRCG process, which tends to be flexible. Many resources are brought to the table, and it appears that representatives are able and willing to share their expertise and available resources as needed. The teamwork and collaboration within each CRCG is dynamic, yet members respect and trust one another enough that healthy confrontation and challenging takes place between members, which is always in the best interest of the client. The chairs appear to possess the needed skills to facilitate the meetings. Importantly, the CRCG process lends itself to fostering an enhanced sense of community among helping professionals within a geographical area, which in and of itself increases the likelihood of seamless services.

While many CRCG staff complained of not having enough resources (in-cash and in-kind) in this study, data compiled by the State Office of CRCG from 1996 to 1998 examining barriers to service (see Appendix M) reveals that approximately 75% of CRCGs reported “no barriers” in 1998 to providing services, and that less than 10% of

CRCGs reported “service unavailable” as a problem for the same year. Thus, even though many respondents noted anecdotally in face-to-face interviews in this study that they needed additional resources, more comprehensive data collected by the state indicates that barriers to service provision are relatively minimal. However, the State Office of CRCG has also compiled data that indicates a need for specific services (e.g., residential care, respite care) in many communities (see Appendix N). Based on our interviews with respondents, it is safe to assume that each community has different and unique needs.

This leads one to the conclusion that it may be necessary to utilize additional resources by building community action structures in each community. Most communities do not have a structure that allows local citizens to identify health care/mental health needs and to make decisions relevant to these issues. Planning and decision making are often governed by federal and state policy officials, by health professionals, and by local social service providers. For a community to become organized, action structures must be developed or revitalized (Poole, 1997). Action structures provide channels through which responsible citizens can take part in community health and mental health decision making through local planning and voluntary social action. Typically, these channels are called councils, commissions, and task forces. According to Poole (1997), “to qualify as *action* structures, they must include the top political, economic, and social welfare leadership of the community” (p. 82). For instance, a reformed Texas service delivery system known as “Safeguarding Our Future” links state and communities in the planning and delivery of services by making decisions at the local level. This program enables state government and

individual communities to work towards common goals, to increase knowledge, and to identify and utilize resources in order to help families.

While such an effort may be beyond the charge of the MOU for CRCGs, they certainly have in place some of the needed infrastructure to actively participate in (and maybe spearhead!) community action structures. For example, CRCGs with a paid coordinator could assume such a charge. However, due to the time and energy of such an effort, we recommend that a paid position (at least half-time if not full-time) is required. Getting at top-level issues in each community requires top-level leadership involvement, especially from the business community and key elected officials (Poole, 1997). One CRCG (Travis County) that we know of is already participating in a similar network by actively participating in the Children's Mental Health Partnership, which actively involves parents and community leaders to drive the delivery of community-based wraparound services to children and their families. (Note: The Travis County CRCG has a full-time paid coordinator.)

A major philosophical difference among respondents was whether CRCGs should be staffing youth as a tertiary prevention effort (as a last resort) or whether the focus should shift to a primary prevention effort. Some argued that more positive outcomes might result if youth are staffed before their problems become so complex. This is supported by the juvenile treatment literature, which suggests that more favorable outcomes are realized when youth receive competent treatment when the problems are first observed, before self-defeating patterns become deeply ingrained. It is important to note that the MOU states that youth must present with multi-agency needs and must be receiving or must have received services to be referred to a CRCG, which lends itself to a

secondary or tertiary prevention initiative. This is not the only philosophical debate that warrants discussion.

The medical, or deficit, model permeates the helping profession. Using this theoretical framework or model, clients are often viewed as having some type of specific problem(s) that warrant “expert” help from the professional. In this process, the client is often assigned some diagnostic label (e.g., Oppositional Defiant Disorder) that is used to describe the “illness”. Many times, professionals use a diagnostic label to the extent that the client is described only as a label and not as a unique individual with special needs.

A suggested alternative to this approach is to use a strengths perspective (Saleebey, 1997), such as solution-focused treatment (Selekman, 1997) or an ecological (life model) perspective (Germain & Gitterman, 1986), which allows the professional to view the client as an inherently worthwhile person who is lacking a goodness-of-fit with the environment. The focus then becomes on how to improve the fit between the person and environment. This approach may entail the use of diagnostic labels to facilitate communication among professionals, but this model does not include focusing solely on the weaknesses or deficits of the client. For example, using the medical model, one might refer to a client as “resistant” when the client is not receptive to help offered to them. By contrast, a professional using a strengths perspective would assume more responsibility for this dilemma, assuming in part that they just had not figured out how to reach that client yet.

There is research that provides evidence of success using this strengths approach (Saleebey, 1997; Selekman, 1997). For example, it has been effective when implemented

for substance abuse treatment (Berg & Miller, 1992; Mason, Chandler, & Grasso, 1995) and for inpatient treatment settings (Webster, Vaughn, & Martinez, 1994).

In short, a strengths approach is concerned with the client's strengths, resources, and abilities that promote health. This directs the treatment providers to focus on the individual and not the illness or disease, which, in turn, leads beyond the narrow vision of "one disease - one cure" thinking typical of traditional medical treatment programs. The developmental perspective that is incorporated into the solution-focused approach lends itself well to working with adolescents (Selekman, 1993). The strengths perspective is one of many possible alternatives to the medical model, and may not fit every CRCG's culture or needs, which should be taken into consideration when exploring its implementation as an option.

It may be helpful to provide additional training around such issues for the chairs and coordinators, as their personal biases and frameworks for viewing clients can certainly shape the facilitation and focus of the CRCG process. This is not to suggest that every chair and coordinator should adopt a strengths perspective, but rather that they should at least be aware of such issues. Chairs and coordinators might also benefit from training on burnout prevention. (The State Office of CRCG would be responsible for providing such training.) Complex issues such as the one described above lend support for the need for paid coordinators whenever feasible, with the expectation that the coordinator possesses a certain skill level to deal with different treatment providers and increasingly challenging cases. The added benefits that a paid coordinator brings to the CRCG include the flexibility to: follow up on service plans, clean up complex client histories for presentation to the decision-makers at the CRCG, prioritize referrals to be

served by the CRCG, maximize decision-makers' time and make the process more efficient, and hold frequent mini-staffings as needed.

The children/youth being served are often challenging in a variety of ways. Typically, it seems that there are enough sophisticated treatment providers at CRCG staffings to adequately address treatment issues. However, there seems to be a dearth of medical and legal expertise at the staffings. CRCGs might consider including medical doctors, nurses, and attorneys to fill this lacuna. One added benefit of having medical and legal professionals sitting on CRCGs is that these professions often bring resources (in-cash and in-kind) to the table. It is important to emphasize, however, that the CRCG process should not be hindered while waiting for medical or legal professionals to attend (whether for scheduling conflicts or other reasons).

Some CRCGs begin the process of implementing a plan while the child/youth and his or her family is being staffed. For example, at one site, a treatment provider left the room during the staffing to call an agency about available beds. This immediate approach is recommended whenever possible. Also related to the process that takes place during the meeting is that of brainstorming for solutions. While this is an important process, at times so much effort was spent on this that it was difficult to serve all of the children and youth that needed resources. It is the chair's responsibility to set parameters around brainstorming and tangential discussions so that time is used more efficiently. A possible solution is to provide training to the chairs on facilitation of task groups.

Related to the facilitation of task groups, there were times when too much time was devoted to reviewing previous children and youth. Because this is done at the beginning of the meeting, less time is devoted to discussing the new kids at the end of the

meeting. In the interest of time, it is recommended that the review of past children served by CRCG be saved for the end of the meeting, or that fewer new kids be discussed when there are several former children/youth to review. Some CRCGs that were observed used a face sheet for each new child who was staffed. This appeared to be extremely helpful to the CRCG members so that they could get a snapshot of the client.

Having co-chairs, especially at larger CRCGs in urban or metropolitan areas, is suggested. Responsibilities, such as group facilitation and securing resources, could be shared. This, in turn, might prevent burnout in individual staff members and increase the flexibility of response in the overall staffing arrangement.

An important part of the success of a CRCG is an energetic, hard-working, and competent leader. This person should have strong interpersonal and facilitation skills. Additionally, each CRCG should have a paid coordinator. Having the right leader is a key ingredient to the success of any collaborative community network (Poole, 1997; Springer, Shader, & McNeece, in press). Because the leader is a key ingredient, each CRCG would benefit by having a leader who is compensated so that he/she will be able to devote the necessary time and energy to the tasks at hand.

If the State Office of CRCG finds it critical that CRCG chairs (or coordinators where applicable) submit the 1 month and 6 month follow-up data, then they will need to make it clear that this is a priority and explain the importance of this data. Currently, chairs know that non-compliance will not be met with any serious consequences. Having support staff or co-chairs may help in this area.

Additional support for chairs could come in the way of a grant writer. A few respondents noted the need for such a position to secure external funding. How many

grant writers are needed remains unclear at this point, but one possible suggestion is to hire one or two grant writers per region as needed.

Respondents identified lack of participation from certain agencies as a problem. (The non-participating agencies varied by site.) Some agencies appear not to have a representative at the CRCG staffings on a regular basis. One possible solution is to require that each mandated agency have a regular back-up representative that can serve as an alternate if the primary representative cannot attend. Additionally, attrition might decrease if mandated agency representatives are required to call the CRCG chair or the State Office of CRCG if they are unable to attend a meeting. If placing the responsibility on the individual representative is problematic, an alternative solution is to have the CRCG chair call the representative's immediate supervisor following missed meetings. Personnel might be more motivated to attend regularly, if at the beginning of the year, the chair holds a CRCG social gathering where members can become better acquainted with one another in the spirit of team building. This might also enhance communication and the overall dynamics of the group process throughout the course of the year. Finally, an additional solution is that CRCG participation becomes a part of the representative's job description, which would provide representatives with needed support from their employer as well as the responsibility to participate as part of their duties. Employers would then have the option of including the representative's CRCG participation in his or her performance evaluation.

It is plausible that the mission of CRCGs would be better supported by the community of citizens and helping professionals if there was an increased awareness of what CRCGs do in a given community. It is recommended that public service

announcements (PSAs) and other forms of media coverage (newspapers, radio, and television) be utilized. This might also enhance the variety of sources making referrals. The majority of respondents echoed this concern. Of course, this ties in to the discussion above about the importance of developing community action networks.

The State Office of CRCG produces a newsletter and maintains a website page. These are vital resources that can be used to share information (e.g., best practices) among the 151 CRCGs around the state. However, many respondents recommended that either a newsletter or a website be created, indicating that the CRCG members are unaware of the State Office's efforts in this area. Therefore, it is recommended that the CRCG members be made aware of these efforts, which will allow for the dissemination of information, and will also promote a greater sense of community among CRCG members across sites.

According to data compiled by the State Office of CRCG, the percentage of families in agreement with service plans has increased steadily, from 52% agreement in 1994, to 61% in 1995 and 63% in 1996. However, family attendance at CRCG staffings has seen a drop from 1995 (55%) to 1996 (50%). Relating these findings to the current study, respondents varied widely (ranging from 15% to 90%) on the estimated percentage of families that attend the staffings. Overall, respondents were concerned about family attendance and expressed concern that it needs to improve. Additionally, once families do attend, there was an overwhelming concern that the families need to be better prepared for the staffing as it can be a rather intimidating process. For example, the contact person should be responsible for obtaining background information (conducting an assessment) on the client, clarifying the expectations of the family, and exploring how this fits with

the CRCG mission. In addition, it would be helpful to explain beforehand how the CRCG process works and how a typical meeting proceeds.

Respondents from Phase II of the study appeared generally satisfied with the CRCG process and with the type of services received. Even though in some cases the child's/family's problems had not been resolved entirely, parents/guardians still had positive perceptions of the CRCG process and personnel after a period of time had passed since the initial staffing. [In relating these findings to data compiled by the State Office of CRCG (see Appendix O), it appears that 70% of 1<sup>st</sup> follow-up service plans are met by CRCGs across the state, while 79% of 2<sup>nd</sup> follow-up service plans are met.] In our study, there was a general trend toward degeneration of satisfaction with the CRCG process as time passed. For instance, there was change toward dissatisfaction on item five of the CSQ-8, which asked "How satisfied are you with the amount of help you have received?". Most respondents in the first survey (85%) were "mostly" or "very" satisfied with the amount of help received by CRCG. In the follow-up, just over three-quarter (77%) were "mostly" or "very" satisfied with the amount of help received by CRCG, with one-fifth (20%) stating they were only "mildly" satisfied. While still generally indicating satisfaction, the trend is evident. While not drastic by any means, the same declining trend can be seen in items six (6) through eight (8) on the CSQ-8.

One possible explanation for this trend is that immediately after the initial staffing parents/guardians feel some relief from having their concerns addressed and they have hope for the future resolution of their child's problem. Very few children that come to the attention of CRCGs will have a complete resolution of their problem in a short period of time (although some did). Over time, parents/guardians may become disillusioned

with the process when they continue to experience difficulty. This disillusionment with their life situation may carryover to their assessment of the CRCG process itself. For instance, Roberts, Pascoe and Attkisson (1983) found that there may be a relationship between service satisfaction and level of well-being overall in a respondent's life.

### **Considerations for Future Research**

The following suggestions for future researchers to consider in their efforts are based on the experiences that the research team gained over a two-year period of evaluating different aspects of Community Resource Coordination Groups (CRCGs).

- Examine to what extent CRCGs are involved in community action structures in their local community, as well as the impact that such efforts have on the community and the children and families that CRCGs serve.
- In the event that some CRCG chairs receive specialized training (e.g., using the strengths perspective as a guiding theoretical framework, how to facilitate task groups, community organizing), examine the impact that the trained chairs' leadership and facilitation skills have on the CRCG process when compared to chairs with no specialized training.
- Explore the best ways to utilize CRCG parent representatives in serving children/youth and their families.
- When implementing a mail survey with CRCG service recipients, follow-up phone contact (on evenings and weekends) will maximize the response rate.
- Attend local CRCG staffings, as they provide a setting with rich resources for data collection (e.g., CRCG chairs, staff and service recipients).

Overall, the CRCGs that participated in this evaluation appear to be meeting the stated objectives of the MOU and effectively meeting the needs of a difficult service population. As with any collaborative interdisciplinary effort, there is room for enhanced delivery of services. Nevertheless, the CRCGs should be commended on their continued progress, including the expansion of CRCGs at the adult level.

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## **Appendix A**

## **Memorandum of Understanding for Coordinated Services to Children and Youths**

### **&736.701. Coordinated Services for Children and Youths**

#### **(a) Overview**

(1) Pursuant to the Texas Human Resources Code, &sect;41.0011 [now Texas Family Code &sect;264.003], this memorandum of understanding has been developed by the Texas Department of Protective and Regulatory Services (TDPRS), Texas Commission for the Blind (TCB), Texas Department of Health (TDH), Texas Department of Human Services (TDHS), Texas Department of Mental Health and Mental Retardation (TXMHMR), Texas Education Agency (TEA), Texas Interagency Council on Early Childhood Intervention (ECI), Texas Juvenile Probation Commission (TJPC), Texas Rehabilitation Commission (TRC), and Texas Youth Commission (TYC), hereinafter referred to as "the agencies," in consultation with advocacy and consumer groups.

(2) The memorandum, as adopted by rule by each agency, provides for the implementation of a system of community resource coordination groups, hereinafter referred to as "coordination groups," to coordinate services for children and youths who need services from more than one agency, hereinafter referred to as "children and youths with multi-agency needs" or, more briefly, as "children and youths."

(3) All coordination groups established pursuant to this memorandum must conform to the Model of Community Resource Coordination Groups (CRCG model) approved by the Commission on Children, Youth, and Family Services on April 27, 1990. This model is adopted by reference and may be obtained from:

- (A) TDPRS, 701 West 51st St., Austin, 78751;
- (B) TCB, 4800 North Lamar Blvd., Austin, 78756;
- (C) TDH, 1100 West 49th St., Austin, 78756;
- (D) TDHS, 701 West 51st St., Austin, 78751;
- (E) TXMHMR, 909 West 45th St., Austin, 78756;
- (F) TEA, 1701 North Congress, Austin, 78701;
- (G) ECI, 1100 West 49th St., Austin, 78756;
- (H) TJPC, 2015 South IH 35, Austin, 78741;
- (I) TRC, 4900 North Lamar Blvd., Austin, 78751; or
- (J) TYC, 4900 North Lamar Blvd., Austin, 78751

(4) As specified in subsection (c)(5) of this section, this memorandum also requires the agencies, the coordination groups, and the Texas Health and Human Services Commission, hereinafter referred to as "the commission," to work together to ensure that the commission's strategic plan for delivering health and human services in Texas includes appropriate plans for delivering coordinated services to children and youths.

**(b) Role of the family.** Although the primary purpose of this memorandum is to establish a system for interagency coordination of services to children and youths, the agencies:

- (1) recognize the importance of the family in the life of each child and youth whom the agencies serve, and
- (2) are committed to providing services pursuant to this memorandum in the most normal and least restrictive environments possible.

**(c) Each agency's financial and statutory responsibilities.**

(1) Each agency's financial and statutory responsibilities for children and youth are described in *Health and Human Services in Texas: A Reference Guide*, published by the commission.

(2) Each agency agrees to provide coordination groups with relevant additional information about its financial and statutory responsibilities when such information is necessary for the groups to meet their responsibilities. The additional information may include, but is not limited to, descriptions of subcategories of funding for different types of service such as investigation, risk prevention, family preservation, emergency shelter, diagnosis and evaluation, residential care, follow-up services after a stay in residential care, and information and referral assistance.

(3) Whenever necessary in particular cases, coordination groups are responsible for further clarifying the agencies' financial and service responsibilities.

(4) The agencies agree to seek the resources needed to comply with this memorandum.

(5) To the extent that operating under this memorandum helps the agencies to identify structural problems, gaps, and inefficiencies in the state's systems for delivering health and human services to children and youths with multi-agency needs, the agencies agree to give the commission information about the problems, gaps, and inefficiencies so identified. The agencies also agree to ask the coordination groups to provide such information. The commission, in turn, will appropriately incorporate information provided by the agencies and the coordination groups into the commission's strategic plan.

**(d) Children and youths with multi-agency needs.** For the purpose of this memorandum, a "child or youth with multi-agency needs" is a person who:

- (1) is less than 22 years old,
- (2) meets an agency's statutory age-limitations for eligibility,
- (3) is now receiving services or has received them in the past, and
- (4) needs services that require interagency coordination.

**(e) Interagency cost-sharing.**

(1) The agencies agree to share the cost of providing needed services when:

(A) a coordination group confirms that a referring agency cannot provide all of the services needed, and

(B) the needed services are within the financial capabilities and statutory

responsibilities of one or more of the other agencies.

(2) Cost-sharing includes, but is not limited to:

(A) provision of services by more than one agency; and

(B) provision of services by

(i) one or more agencies, and

(ii) one or more third parties under purchase-of-service contracts with one or more agencies.

**(f) Eliminating duplication of services.** Within the limits of existing legal authority, each coordination group must make reasonable efforts to eliminate duplication of services relating to the assessment and diagnosis, treatment, residential placement and care, and case management of children and youths with multi-agency needs. Each agency agrees to notify the governor's office about federal laws and regulations that cause duplication of services. Each agency also agrees to notify its board about rules that cause duplication of services, and to pursue amendments to state laws, rules, and policies when necessary to eliminate such duplication.

**(g) Interagency dispute resolution.**

(1) Each agency must designate a negotiator who is not a member of any coordination group to resolve disputes. The negotiator must have:

(A) decision-making authority over the agency's representative on the coordination group, and

(B) the ability to interpret policy and commit funds.

(2) When two or more members of a coordination group disagree about their respective agencies' service responsibilities, the coordination group must send the designated negotiators for those agencies written notification that a dispute exists. Within 45 days after receiving the written notification, the negotiators must confer together to resolve the dispute.

(3) When an interagency dispute cannot be resolved in the manner described in paragraph (2) of this subsection, the aggrieved party may refer the dispute to the Health and Human Services Commissioner.

**(h) Composition of coordination groups.** Each coordination group must include one appointed representative from each participating state agency, and as many as five local representatives from the private sector. The private-sector representatives must be selected by their peers from private-sector agencies serving youths in the geographical area the coordination group serves. The private-sector representatives have the same status as state-agency representatives. The organizations they represent are considered member agencies of the coordination group, and they are encouraged to present cases from the private sector.

**(i) Case identification and referral.** Each coordination group must implement the procedures for identifying and referring cases specified in the CRCG model. Any member of a coordination

group may refer the case of any eligible child or youth to the coordination group if the referring member's agency cannot otherwise provide or arrange all the services the child or youth needs.

**(j) Convening coordination group meetings.** Any member of a coordination group may convene a coordination group meeting pursuant to subsection (i) of this section. Each coordination group must establish procedures for scheduling meetings.

**(k) Permissible nonattendance.** A member agency's representative may be excused from attending a coordination group meeting if the coordination group determines that the member agency's service responsibilities do not apply to the child or youth whose services will be discussed at the meeting.

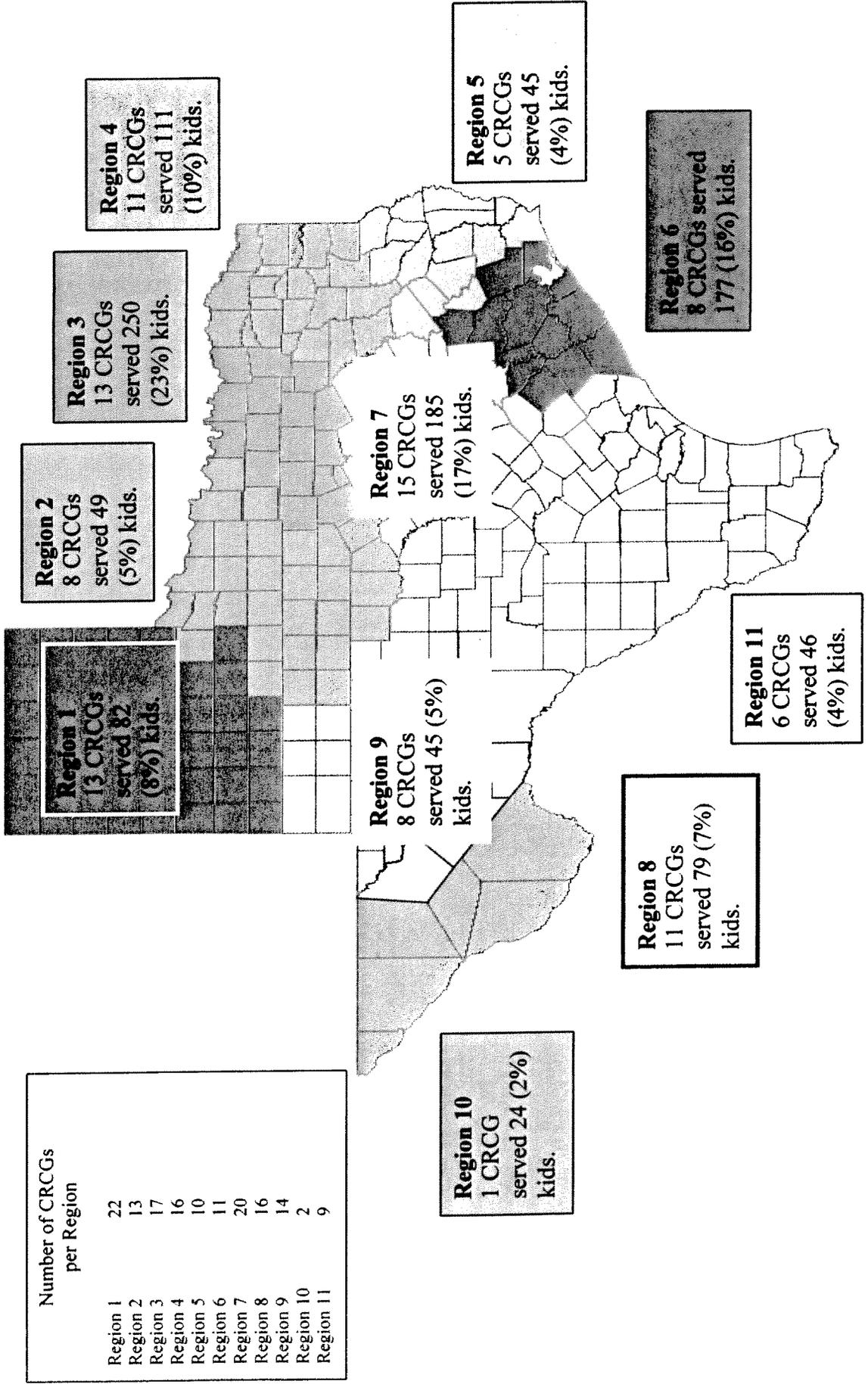
**(l) Sharing confidential information.** The members of each coordination group must treat all information about children and youths discussed at the group's meetings as confidential. Each member agency must ensure that the coordination group complies with the agency's legal requirements concerning disclosure of confidential records and information. When necessary, compliance may include case-by-case documentation of all parties reviewing a child's or youth's records.

**(m) Implementing this memorandum.** The state CRCG advisory committee, which includes private sector representatives and one representative from each participating state agency, must develop and recommend to the commissioners and executive directors of the agencies a comprehensive plan to implement this memorandum.

**(n) Adoption by rule and revision by unanimous consent.** Pursuant to the Human Resources Code, &sect;41.0011, each agency must adopt this memorandum by rule. The memorandum may be expanded, modified, or amended at any time by the unanimous written consent of the agencies.

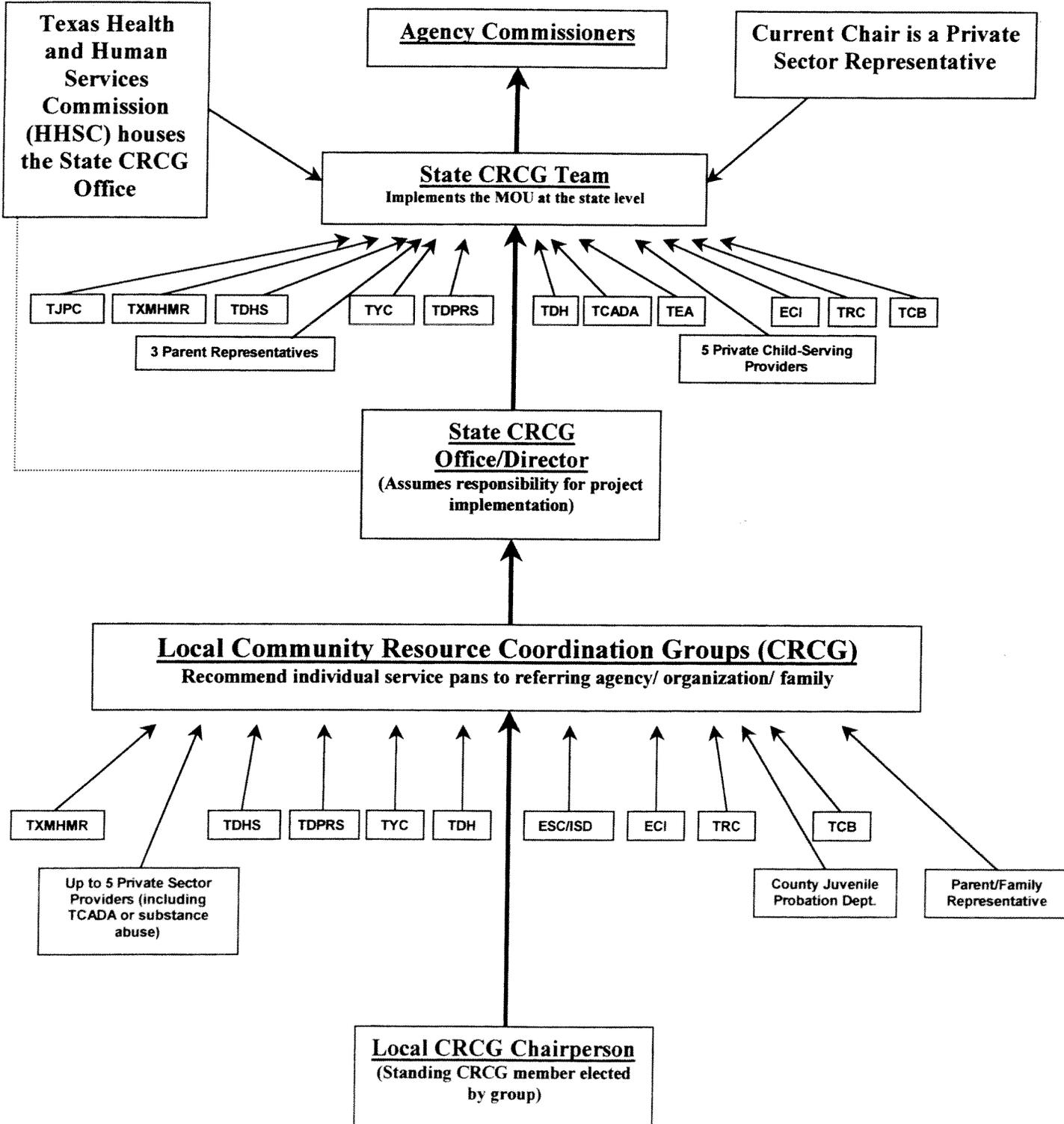
## **Appendix B**

## Number Of CRCGs Submitting Initial Staffing Forms Per Region & The Number Of Kids Those CRCGs Served



## **Appendix C**

# ORGANIZATIONAL STRUCTURE OF COMMUNITY RESOURCE COORDINATION GROUPS OF TEXAS



## **Appendix D**





4. Thinking back on each of those questions, how satisfied are you with the following?  
[Have respondent answer on the 5-point Likert scale below. Ask them to elaborate.]

	1	2	3	4	5		
	Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied		
a. How often you meet.			1	2	3	4	5
b. Attendance at meetings.			1	2	3	4	5
c. Notification.			1	2	3	4	5
d. Facilitation of meetings.			1	2	3	4	5
e. Protocols or by-laws.			1	2	3	4	5
f. Referrals to CRCG.			1	2	3	4	5

5. How has your CRCG successfully addressed issues regarding:
- a. Participation (of agencies, local representatives, parent)?
  
  - b. Funding (with CMT, inter-agency cost-sharing)?
  
  - c. Communication (among staff, outside of meetings, outside CRCG)?
  
  - d. Eliminating duplication of services? Are there laws, regulations, or policies that cause duplication? Do you notify anyone of those?
  
  - e. Increasing access to services?
  
  - f. Developing CRCG service plans?
  
  - g. Conflict resolution (interagency disputes, between agencies)?



9. What support does your CRCG need from the state, regional and local levels?

10. Describe the parent involvement aspect of your CRCG. How are families involved? How often do they attend meetings? Do they assist in the planning process and, if so, how? Is parental consent always obtained? Is the CRCG family-friendly?

11. To what extent are the families you work with satisfied with the services they receive? [Have respondents answer on the 5-point Likert scale below. Ask them to elaborate.]

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied



15. Do you think the CRCG is focused on the appropriate client population?

16. Overall, how satisfied are you with how well your CRCG meet the needs of kids who have fallen through the cracks? [Have them answer on the 5-point Likert scale below. Ask them to elaborate.]

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied

ADDITIONAL COMMENTS:

## **Appendix E**

## QUESTIONNAIRE FOR CRCG STAFF

Date \_\_\_\_\_ CRCG Location \_\_\_\_\_

Name (Optional) \_\_\_\_\_ Phone \_\_\_\_\_

Gender (Male \_\_\_ Female \_\_\_) Employer \_\_\_\_\_

Job Title \_\_\_\_\_

Role in CRCG \_\_\_\_\_ How long involved in CRCG \_\_\_\_\_

Ethnicity (circle one):      African American      White, Non-Hispanic  
   Asian                                      Native American  
   Hispanic                                      Other \_\_\_\_\_

1. What is working best with your CRCG?

2. What do you see as the biggest challenges your CRCG operation is faced with?



Please answer the questions on this page using the 5-point Likert scale below. Feel free to write additional comments in the space provided. For example, if you indicate on an item that you are satisfied (circling a 4), it is helpful to know what would need to happen for you to be very satisfied (circling a 5) in the future for that item, and so on.

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied

4. How satisfied are you with the following?

- |    |   |   |   |   |   |   |
|----|---|---|---|---|---|---|
| a. | How often you meet.                         | 1 | 2 | 3 | 4 | 5 |
| b. | Attendance at meetings.                     | 1 | 2 | 3 | 4 | 5 |
| c. | Being notified about meetings.              | 1 | 2 | 3 | 4 | 5 |
| d. | Facilitation of meetings.                   | 1 | 2 | 3 | 4 | 5 |
| e. | Use of protocols or by-laws<br>at meetings. | 1 | 2 | 3 | 4 | 5 |
| f. | Client referrals to CRCG.                   | 1 | 2 | 3 | 4 | 5 |



6. How does your agency/organization benefit by participation in the CRCG?

7. What are the challenges your CRCG faces in meeting client needs (e.g., obtaining certain types of services/treatment, meeting the needs of certain types of clients, etc.)?

8. What additional resources does your CRCG need?

9. What support does your CRCG need from the state, regional and local levels?

10. Describe the parent involvement aspect of your CRCG. How are families involved? How often do they attend meetings? Do they assist in the planning process and, if so, how? Is parental consent always obtained? Is the CRCG family-friendly?

11. To what extent are the families you work with satisfied with the services they receive?  
[Please answer on the 5-point Likert scale below. Feel free to elaborate on your answer in the space provided.]

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied

12. How essential do you feel it is to have a standing CRCG parent representative?  
Does your CRCG have one and, if so, what role does he or she play?

13. Does your CRCG submit staffing data to the State Office? Why or why not?

14. How are follow-ups conducted on CRCG staffings? Does your CRCG submit one- and six-month follow-ups to the State Office? Why or why not?

15. Do you think the CRCG is focused on the appropriate client population? (For example, should the focus be on some other type of youth, or should the focus be expanded to include certain types of adults?)

16. Overall, how satisfied are you with how well your CRCG meet the needs of kids who have fallen through the cracks? [Please answer on the 5-point Likert scale below. Feel free to elaborate on your answer in the space provided.]

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied

ADDITIONAL COMMENTS:

**THANK YOU FOR YOUR TIME AND HELP!!**

## **Appendix F**

**CRCGs Participating in Phase II**

<b>Region 1:</b>	Collingsworth/Donley/Hall Lubbock Hale Potter/Randall Terry	<b>Region 8:</b>	Bexar Calhoun Gonzales Guadalupe Lavaca
<b>Region 2:</b>	Floyd/Montley/Cottle Nolan/Fisher Scurry Shackelford Wichita	<b>Region 9:</b>	Andrews Crane/Upton Dawson Midland Tom Green/Coke/ Sterling/Reagan/ Irion/Crockett/ Concho
<b>Region 3:</b>	Dallas Denton Navarro Parker/Palo Pinto Tarrant	<b>Region 10:</b>	Brewster El Paso
<b>Region 4:</b>	Gregg Harrison Lamar/Delta Smith Upshur	<b>Region 11:</b>	Bee/Live Oak/ San Patricio Hidalgo Nueces Refugio Webb/Zapata/ Jim Hogg
<b>Region 5:</b>	Jefferson Nacagdoches Orange Polk Tyler		
<b>Region 6:</b>	Austin/Waller Braxoria Galveston Harris Montgomery		
<b>Region 7:</b>	Bastrop/Fayette/Lee Brazos Leon/Madison Travis Williamson		

## **Appendix G**

**CLIENT SATISFACTION QUESTIONNAIRE ©  
CSQ-8**

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

**CIRCLE YOUR ANSWERS**

1. How would you rate the quality of service you have received?

<u>4</u> <i>Excellent</i>	<u>3</u> <i>Good</i>	<u>2</u> <i>Fair</i>	<u>1</u> <i>Poor</i>
------------------------------	-------------------------	-------------------------	-------------------------

2. Did you get the kind of service you wanted?

<u>1</u> <i>No, definitely not</i>	<u>2</u> <i>No, not really</i>	<u>3</u> <i>Yes, generally</i>	<u>4</u> <i>Yes, definitely</i>
---------------------------------------	-----------------------------------	-----------------------------------	------------------------------------

3. To what extent has our program met your needs?

<u>4</u> <i>Almost all of my needs have been met</i>	<u>3</u> <i>Most of my needs have been met</i>	<u>2</u> <i>Only a few of my needs have been met</i>	<u>1</u> <i>None of my needs have been met</i>
---	---	---	---

4. If a friend were in need of similar help, would you recommend our program to him or her?

<u>1</u> <i>No, definitely not</i>	<u>2</u> <i>No, I don't think so</i>	<u>3</u> <i>Yes, I think so</i>	<u>4</u> <i>Yes, definitely</i>
---------------------------------------	---	------------------------------------	------------------------------------

5. How satisfied are you with the amount of help you have received?

<u>1</u> <i>Quite dissatisfied</i>	<u>2</u> <i>Indifferent or mildly dissatisfied</i>	<u>3</u> <i>Mostly satisfied</i>	<u>4</u> <i>Very satisfied</i>
---	---	-------------------------------------	---------------------------------------

6. Have the services you received helped you to deal more effectively with your problems?

<u>4</u> <i>Yes, they helped a great deal</i>	<u>3</u> <i>Yes, they helped somewhat</i>	<u>2</u> <i>No, they really didn't help</i>	<u>1</u> <i>No, they seemed to make things worse</i>
--	--	--	---

7. In an overall, general sense, how satisfied are you with the service you have received?

<u>4</u> <i>Very satisfied</i>	<u>3</u> <i>Mostly satisfied</i>	<u>2</u> <i>Indifferent or mildly dissatisfied</i>	<u>1</u> <i>Quite dissatisfied</i>
-----------------------------------	-------------------------------------	---	---------------------------------------

8. If you were to seek help again, would you come back to our program?

<u>1</u> <i>No, definitely not</i>	<u>2</u> <i>No, I don't think so</i>	<u>3</u> <i>Yes, I think so</i>	<u>4</u> <i>Yes, definitely</i>
---------------------------------------	---	------------------------------------	------------------------------------

The *Client Satisfaction Questionnaire (CSQ)* was developed at the University of California San Francisco (UCSF) by Drs. Clifford Attkisson and Daniel Larsen in collaboration with Drs. William A. Hargreaves, Maurice LeVois, Tuan Nguyen, Robert E. Roberts and Bruce Stegner. Every effort has been made to publish information and research on the CSQ for widest possible dissemination. Proceeds from the publication of the CSQ will be used to support postdoctoral training, student academic affairs, and health and human services research activities.

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Clifford Attkisson, Ph.D.

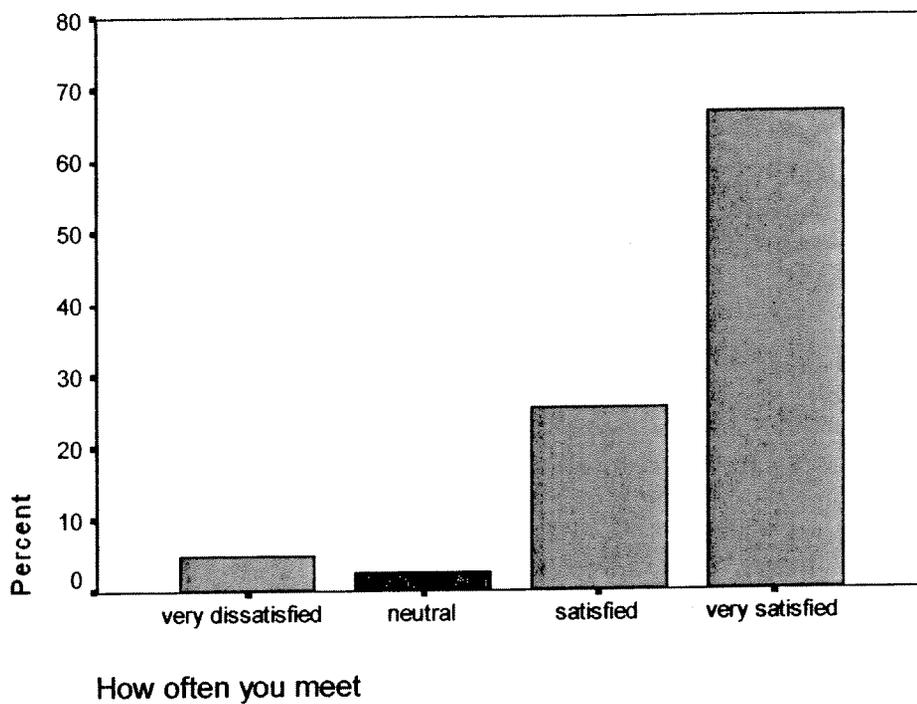
Used with written permission. Use, transfer, copying, reproduction, merger, translation, modification, or enhancement, in whole or in part is forbidden without the written permission of Clifford Attkisson, Ph.D.



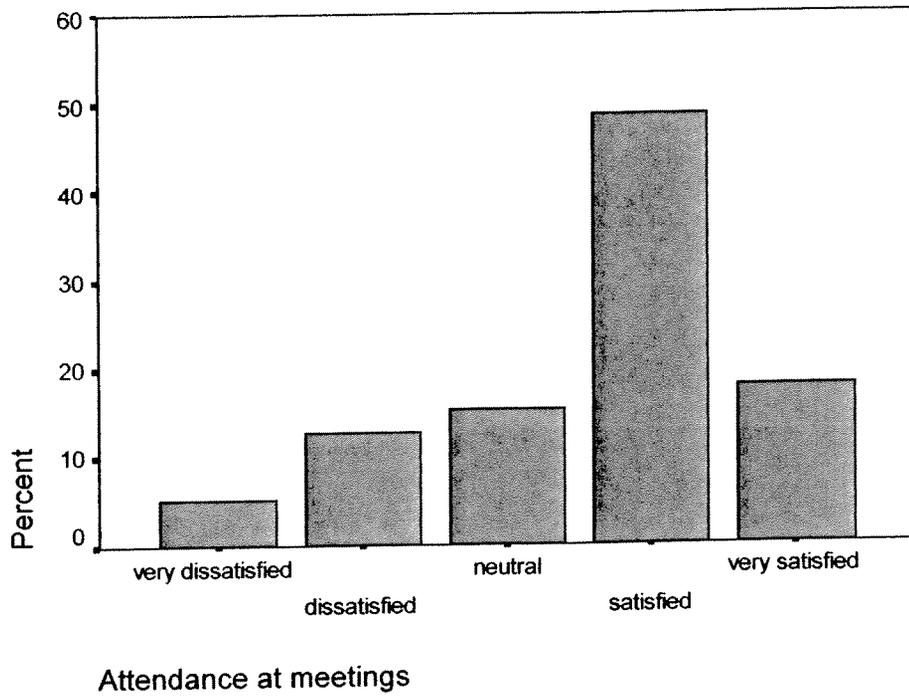
University of California San Francisco

## **Appendix H**

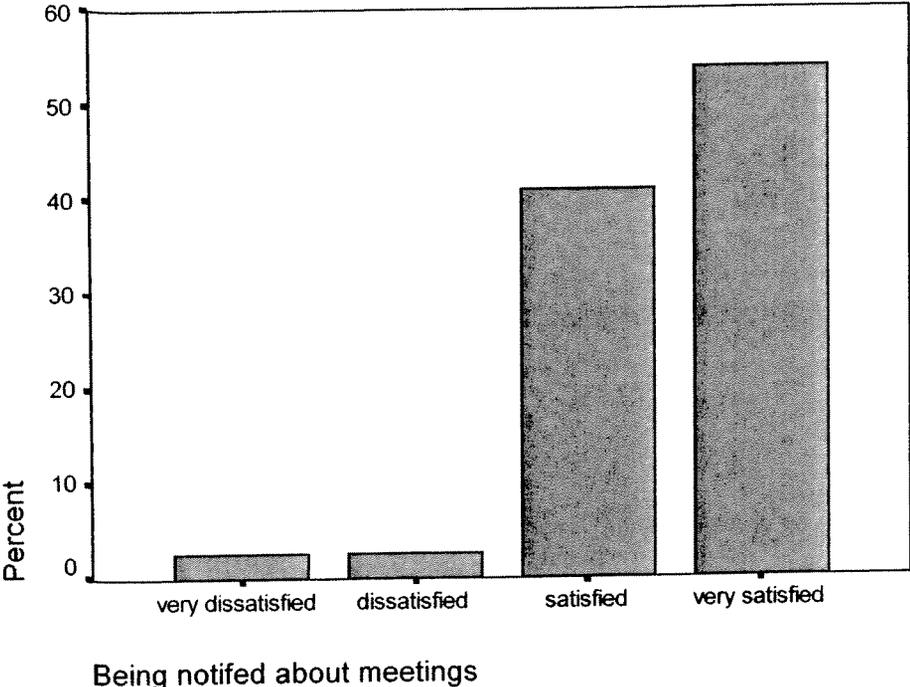
**Figure 1: How satisfied are you with how often you meet?**



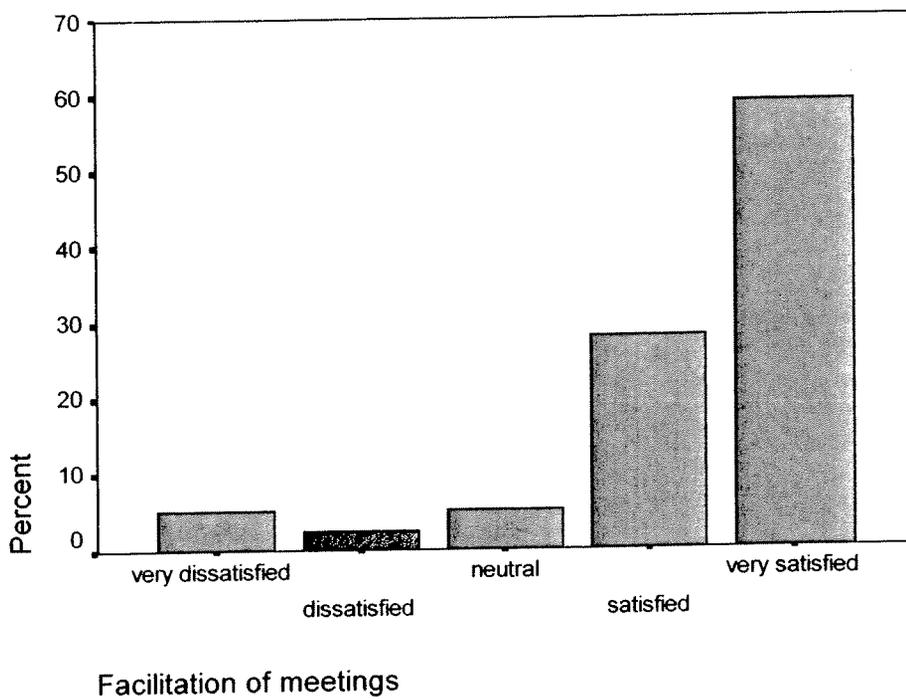
**Figure 2: How satisfied are you with attendance at meetings?**



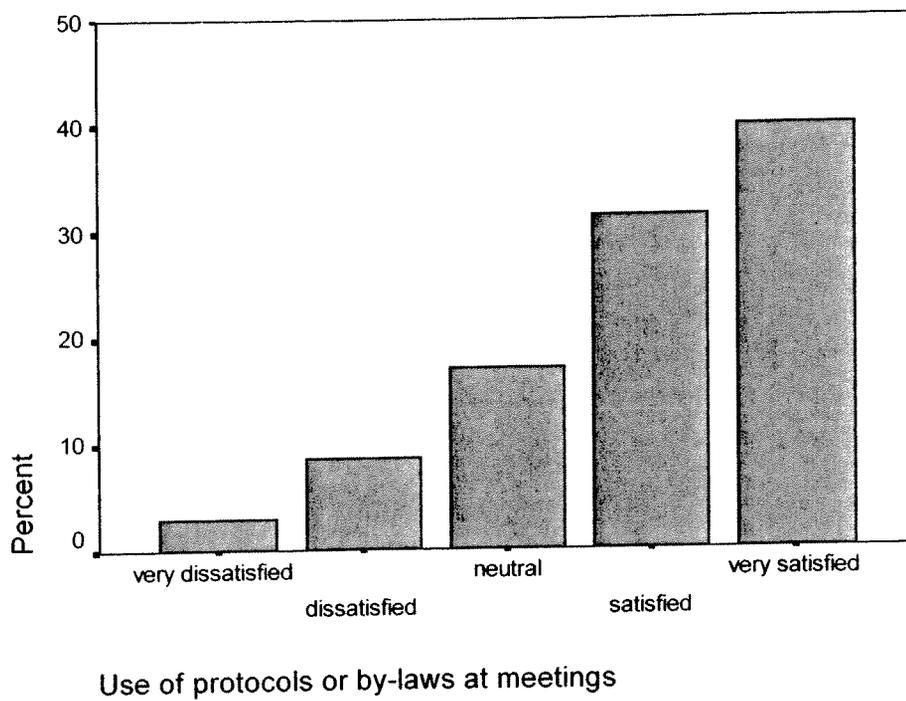
**Figure 3: How satisfied are you with being notified about meetings?**



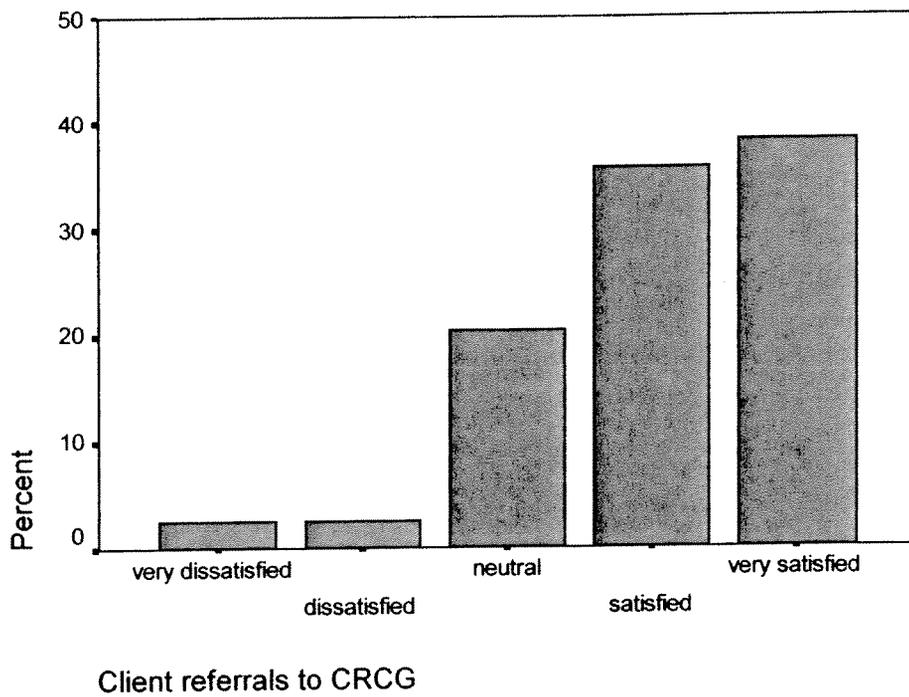
**Figure 4: How satisfied are you with facilitation of meetings?**



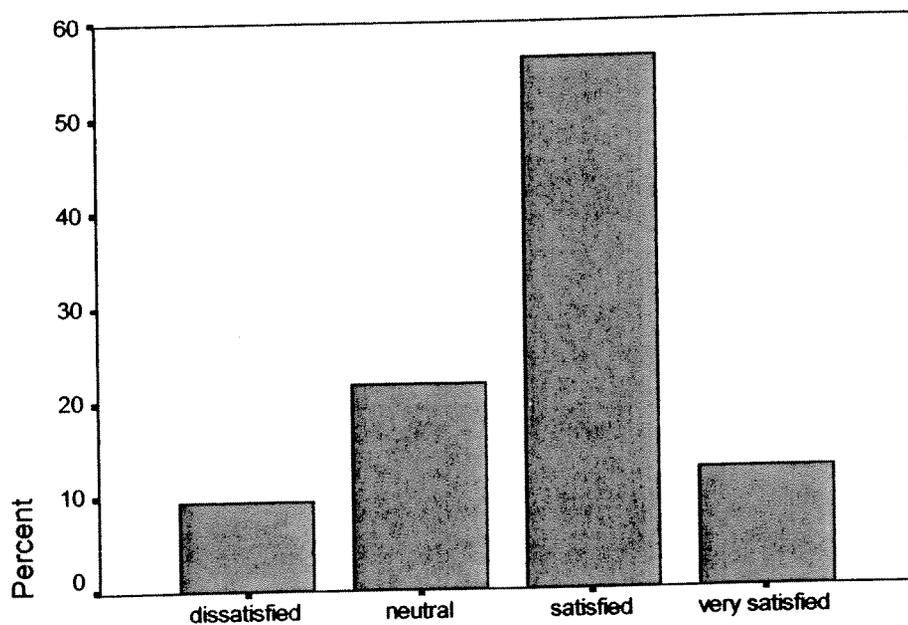
**Figure 5: How satisfied are you with use of protocols or by-laws at meetings?**



**Figure 6: How satisfied are you with client referrals to CRCG?**

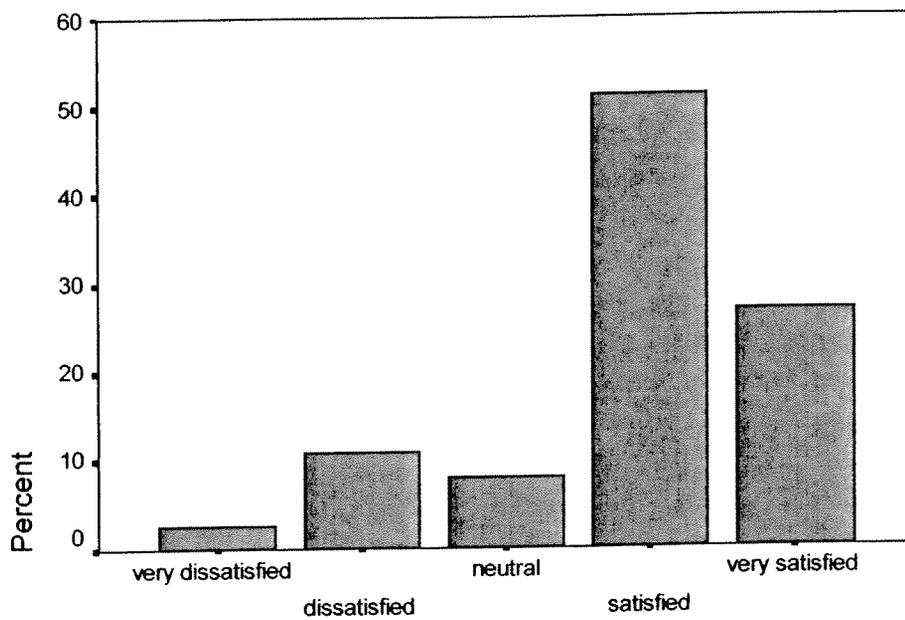


**Figure 7: To what extent are the families you work with satisfied with the services they receive?**



To what extent are families satisfied with services

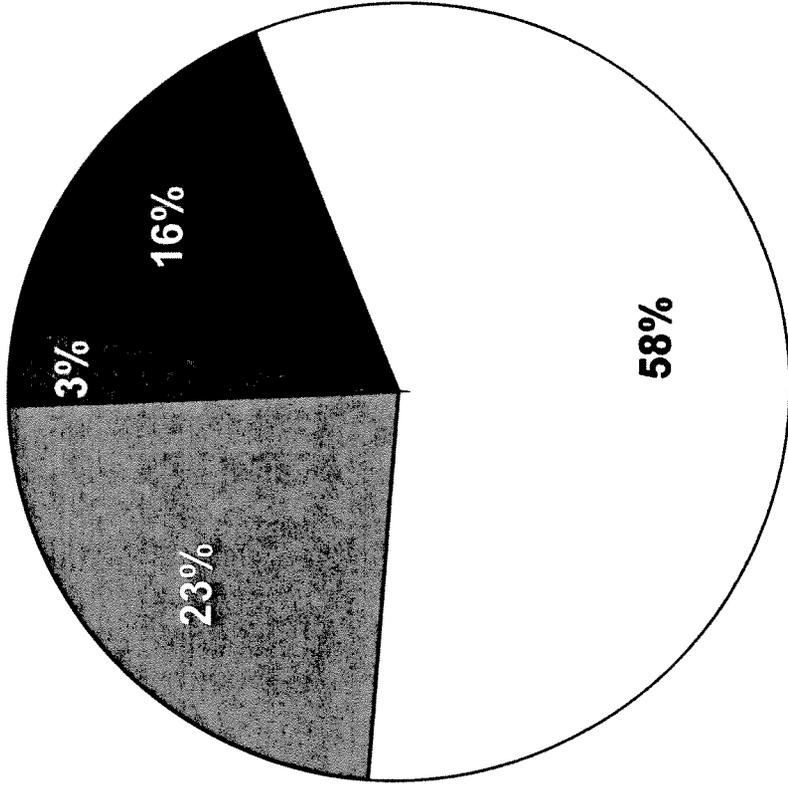
**Figure 8: Overall, how satisfied are you with how well your CRCG meets the needs of kids who have fallen through the cracks?**



Meeting needs of kids who have fallen through cracks

## **Appendix I**

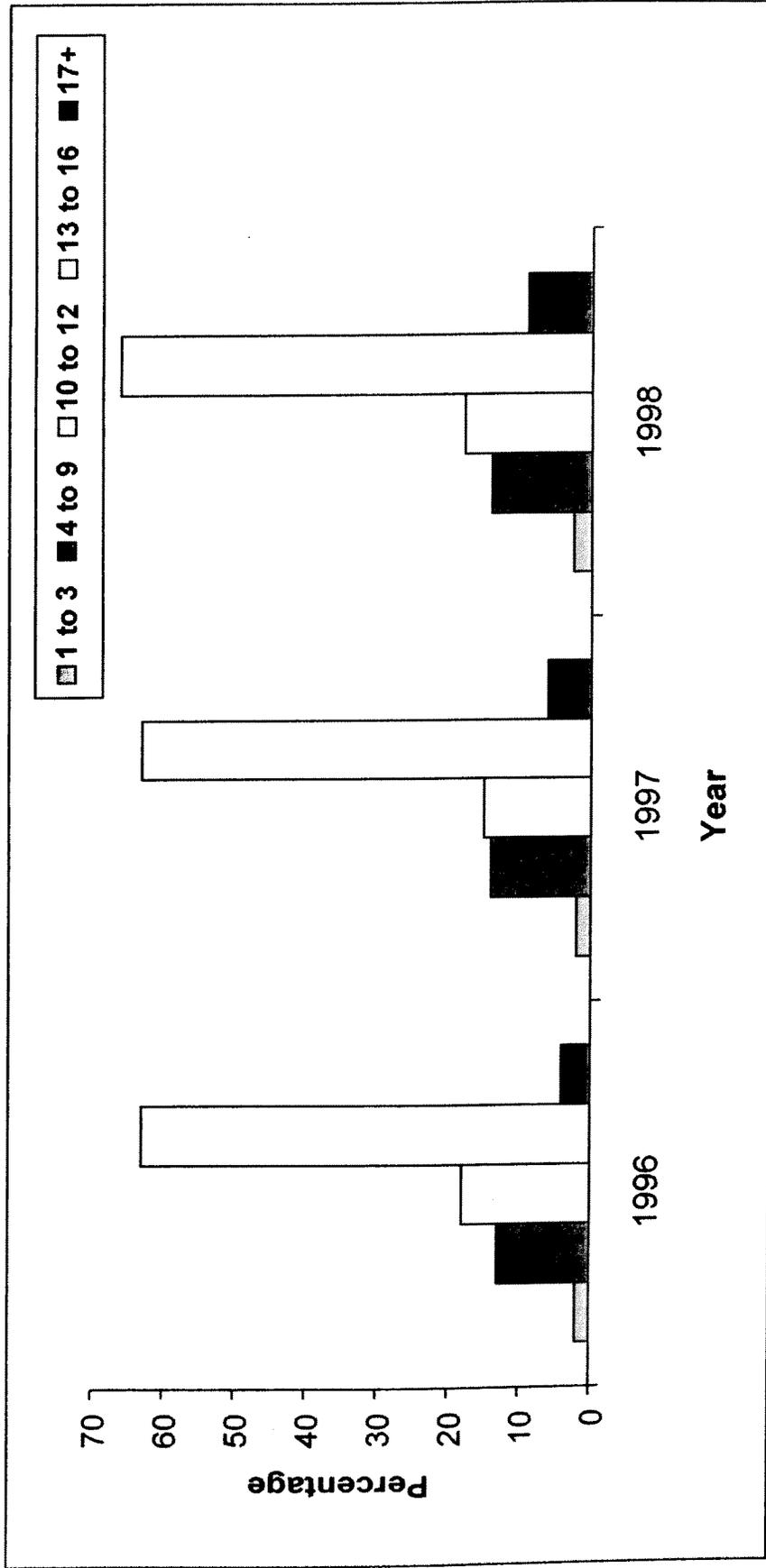
# Ethnicity of Children Referred in 1998



## **Appendix J**

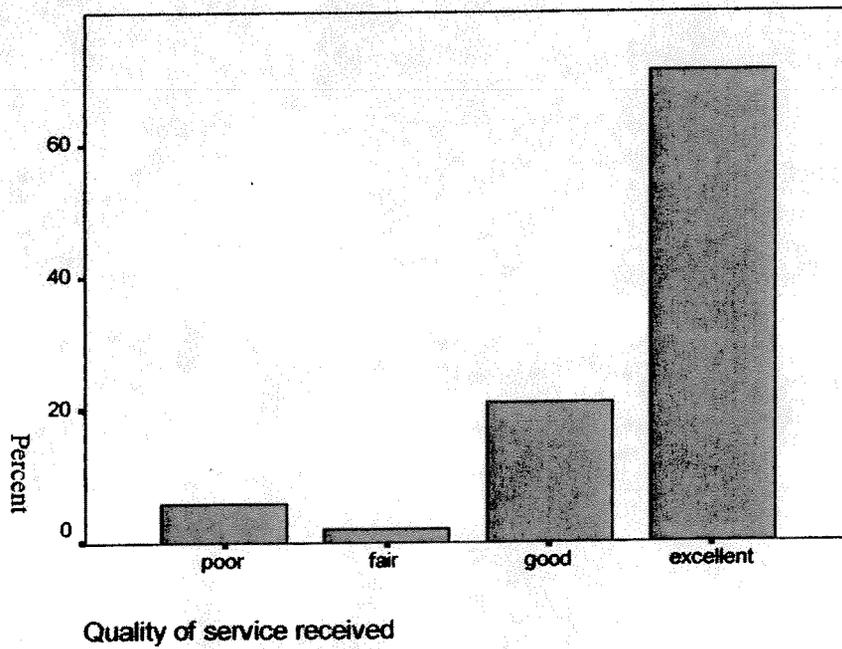
# Demographics of the Children Served

*Ages Served 1996 to 1998*

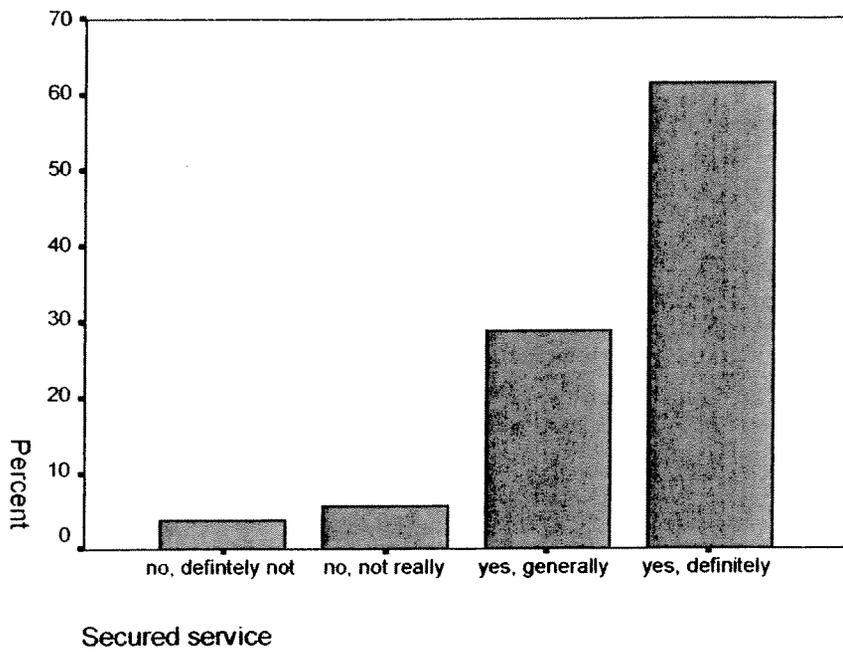


## **Appendix K**

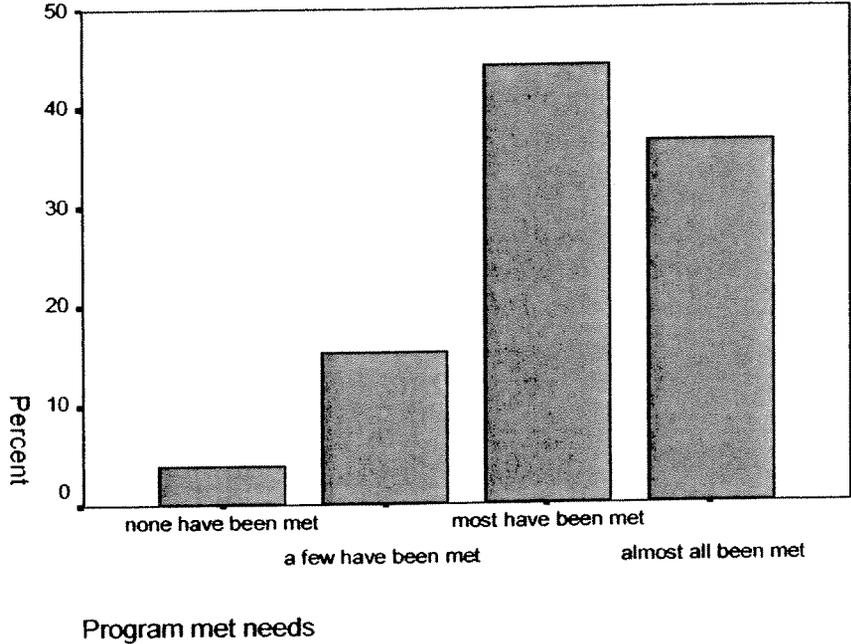
**Figure 9: CSQ-8 Question #1.**  
**How would you rate the quality of service you have received?**



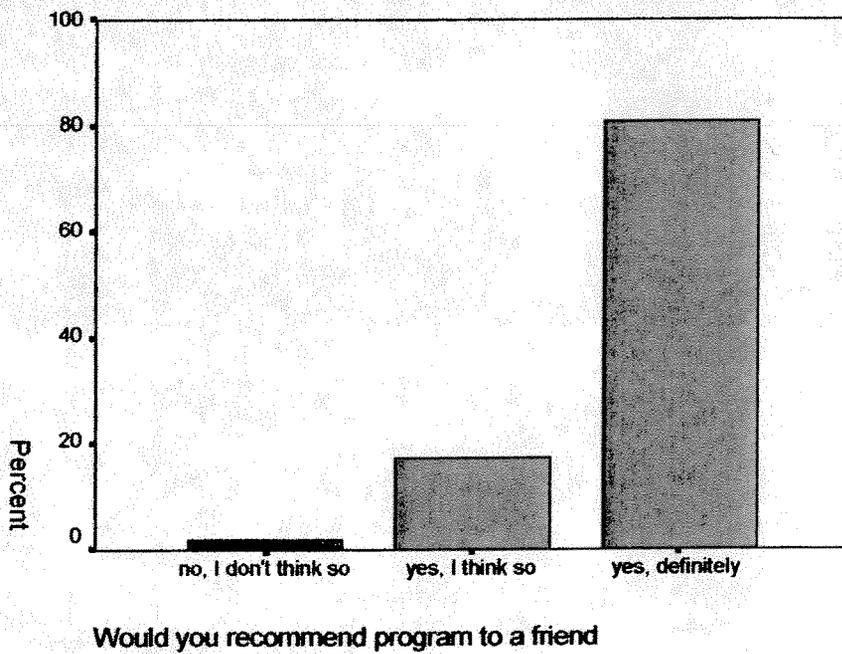
**Figure 10: CSQ-8 Question #2.  
Did you get the kind of service you wanted?**



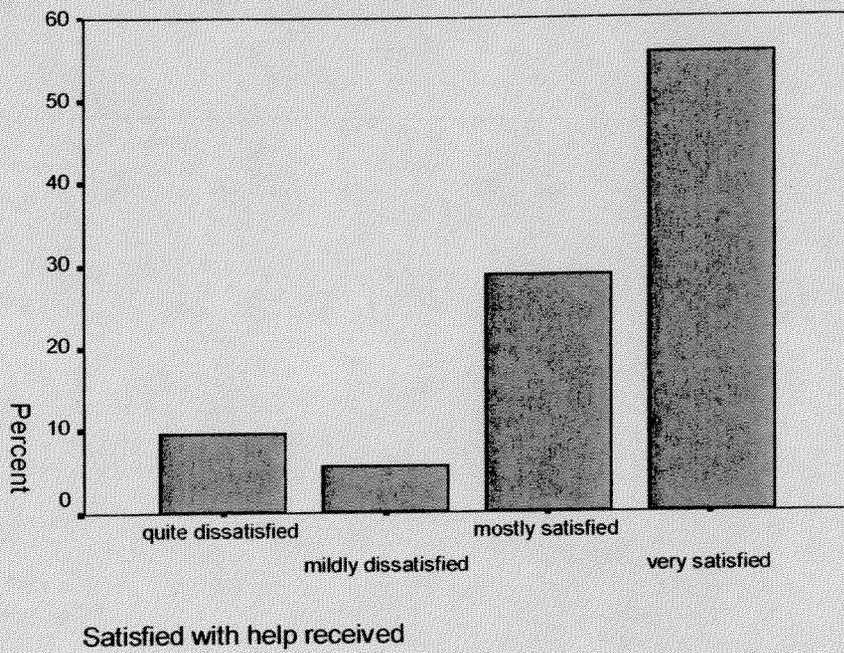
**Figure 11: CSQ-8 Question #3.**  
**To what extent has our program met your needs?**



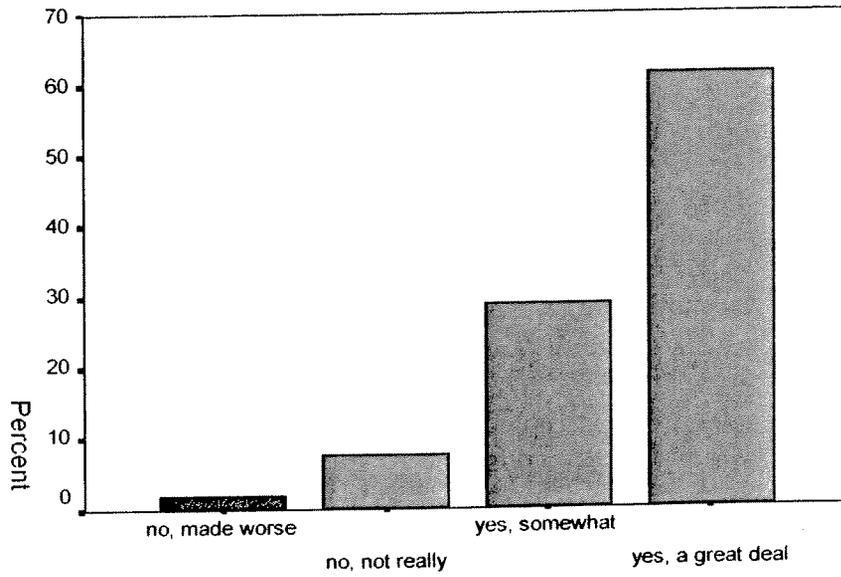
**Figure 12: CSQ-8 Question #4.**  
**If a friend were in need of similar help,**  
**would you recommend our program to him or her?**



**Figure 13: CSQ-8 Question #5.**  
**How satisfied are you with the amount of help you have received?**

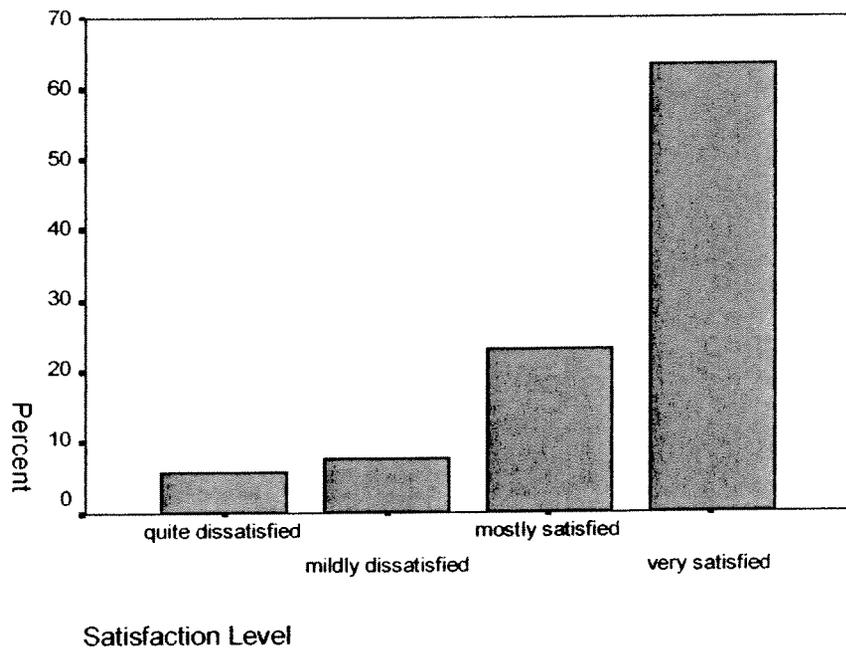


**Figure 14: CSQ-8 Question #6.  
Have the services you received helped you to  
deal more effectively with your problems?**

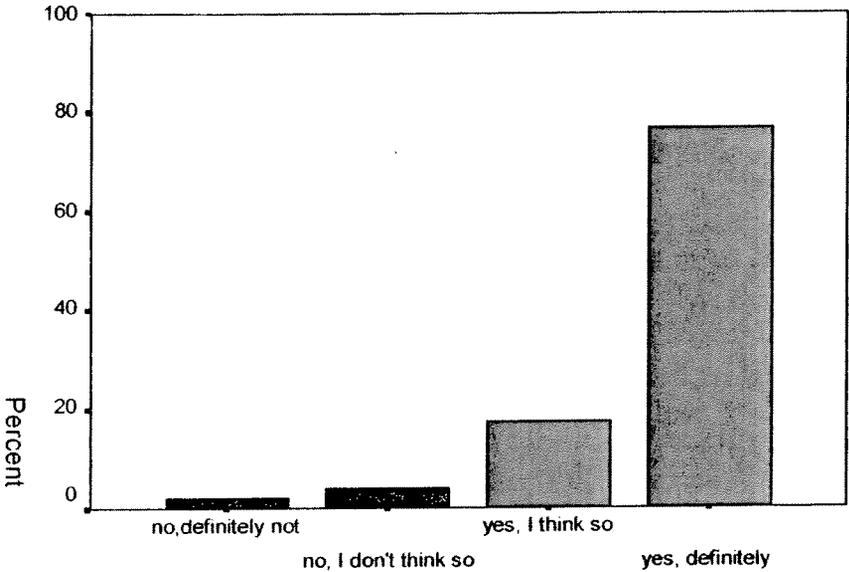


Have services helped you

**Figure 15: CSQ-8 Question #7.**  
**In an overall, general sense,**  
**how satisfied are you with the service you have received?**



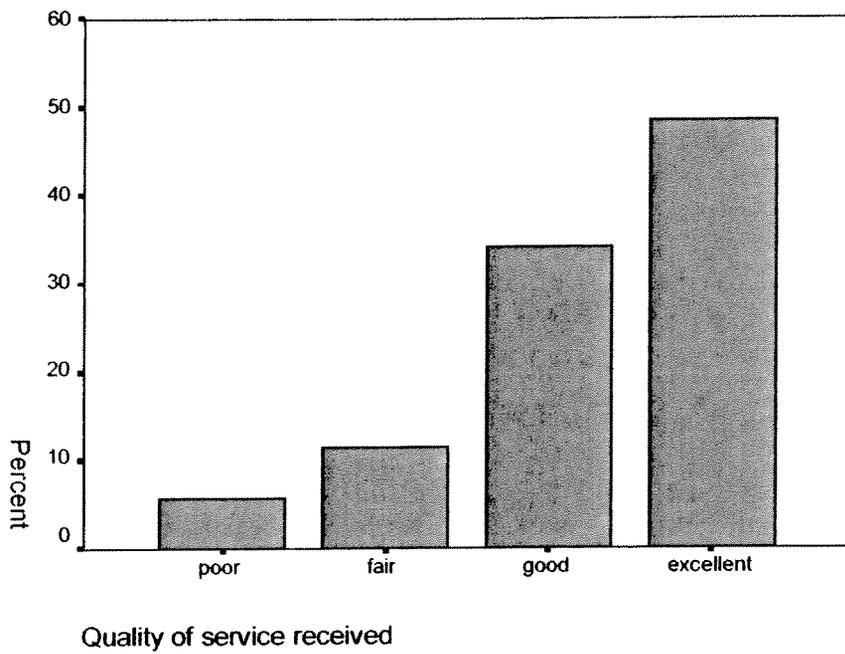
**Figure 16: CSQ-8 Question #8.**  
**If you were to seek help again, would you come back to our program?**



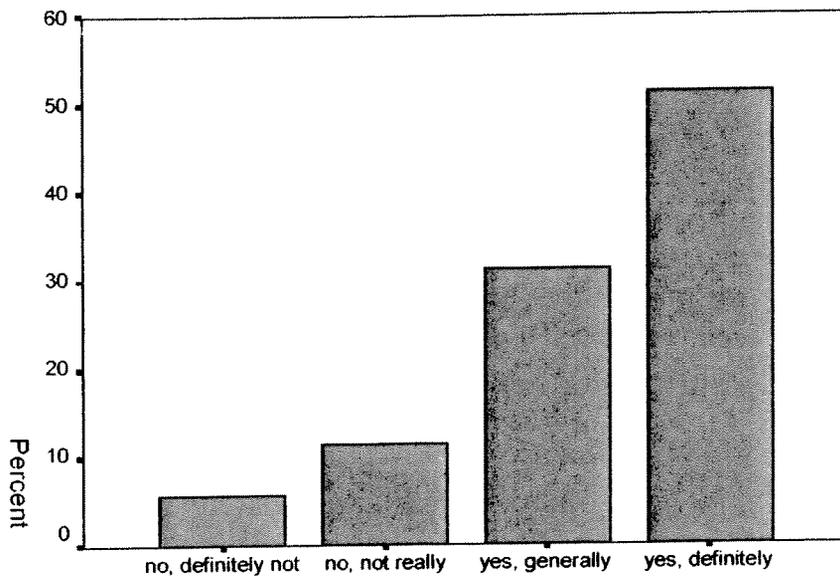
Would you return to CRCG program

## **Appendix L**

**Figure 17: CSQ-8 Question #1.**  
**How would you rate the quality of service you have received?**

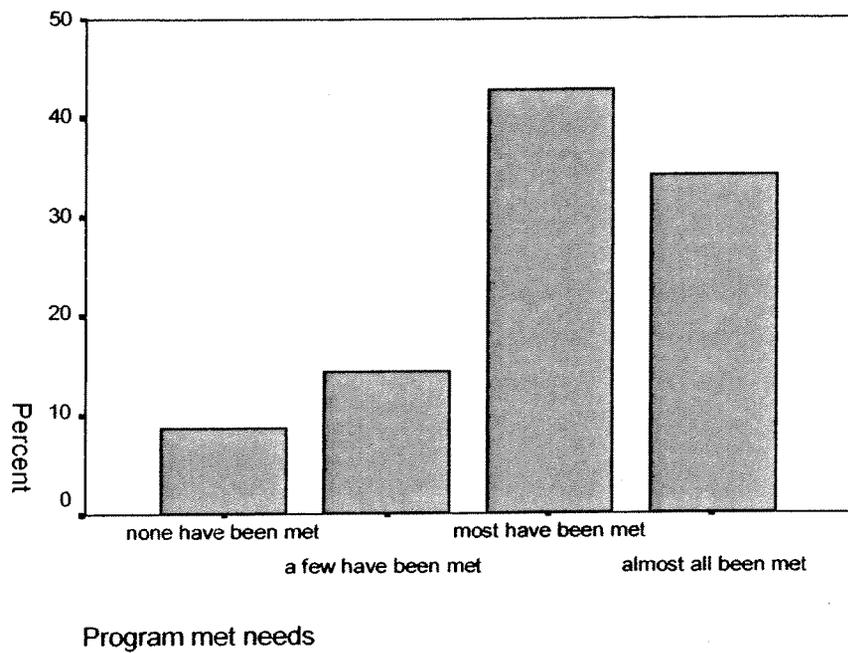


**Figure 18: CSQ-8 Question #2.**  
**Did you get the kind of service you wanted?**

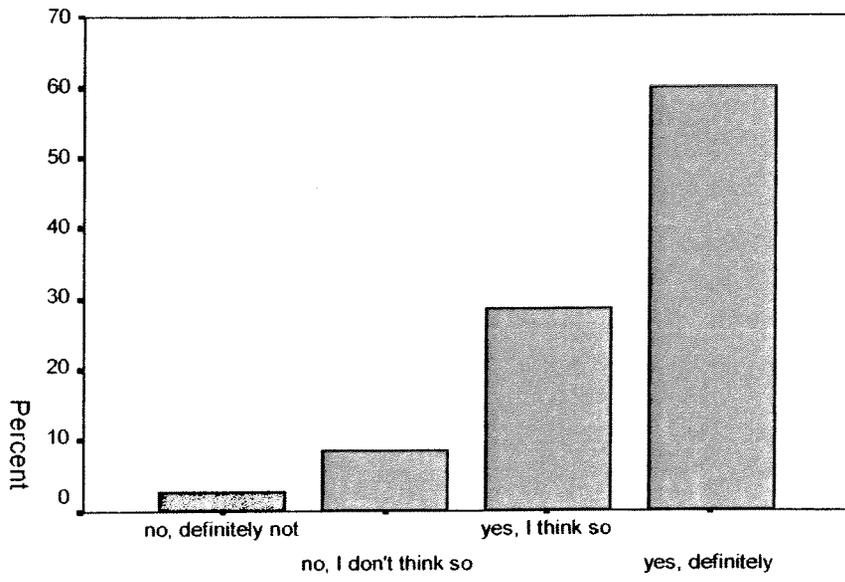


Secured service

**Figure 19: CSQ-8 Question #3.**  
**To what extent has our program met your needs?**

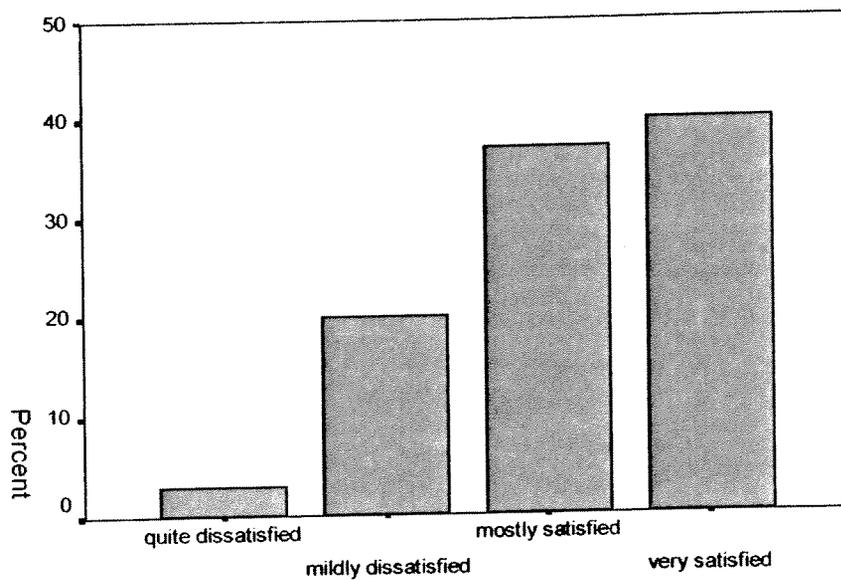


**Figure 20: CSQ-8 Question #4.**  
**If a friend were in need of similar help,**  
**would you recommend our program to him or her?**



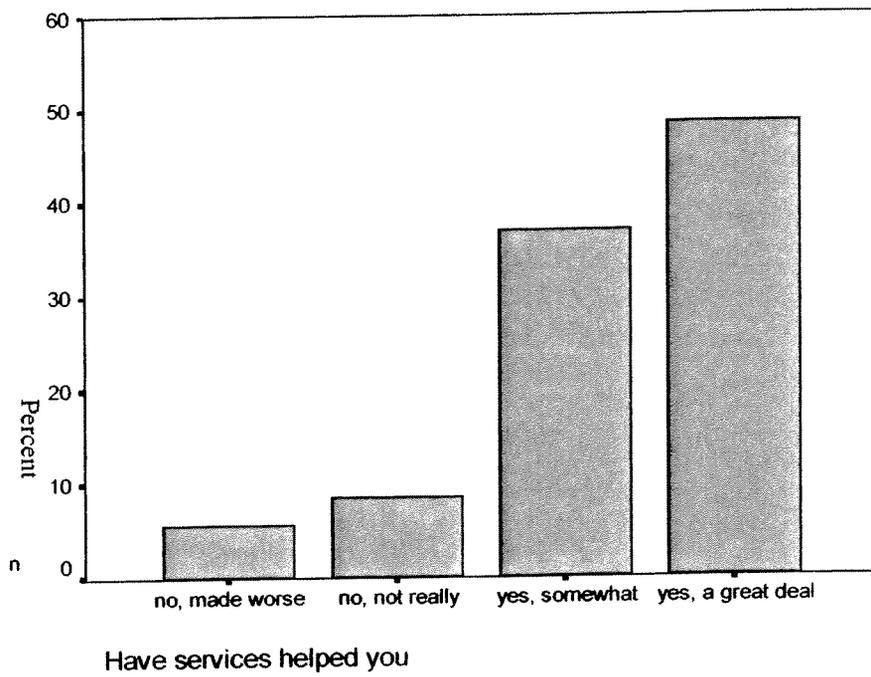
Would you recommend program to a friend

**Figure 21: CSQ-8 Question #5.**  
**How satisfied are you with the amount of help you have received?**

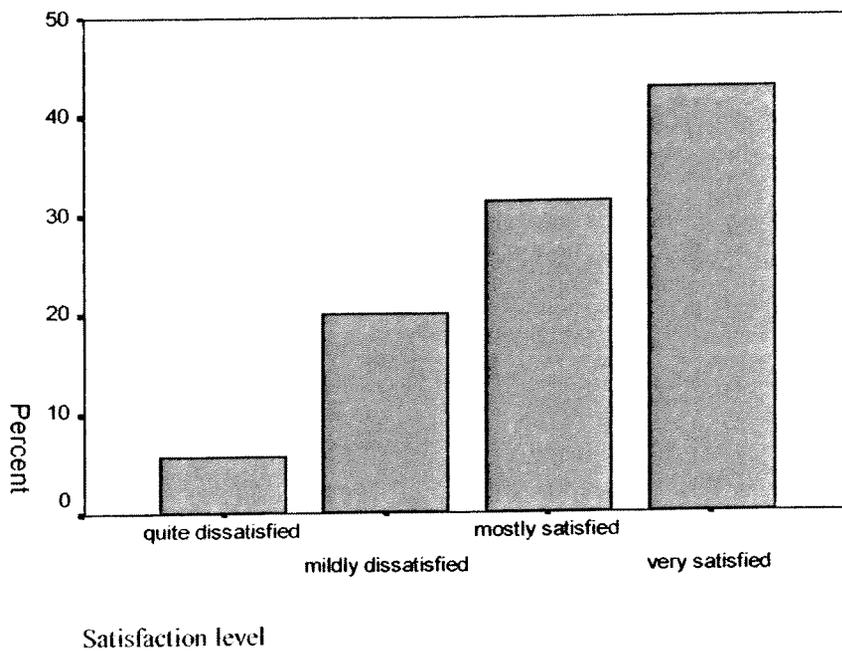


Satisfied with help received

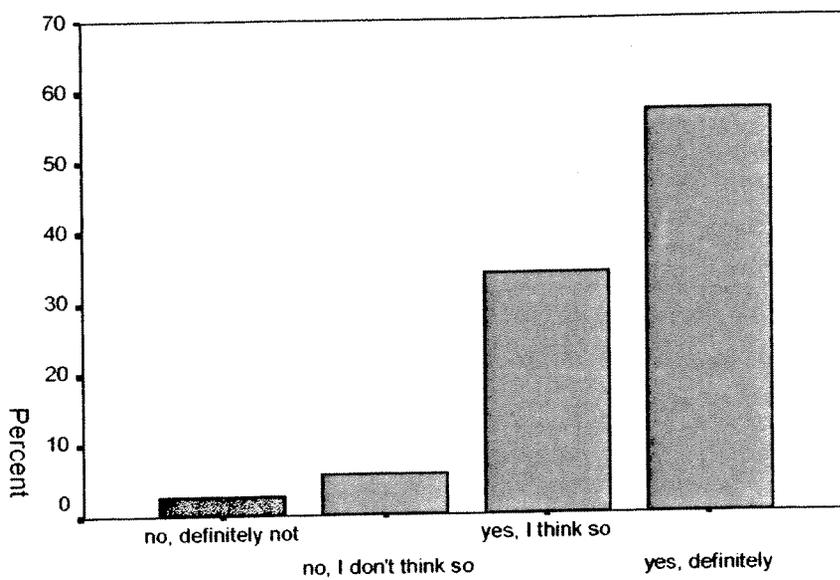
**Figure 22: CSQ-8 Question #6.**  
**Have the services you received helped you to deal more effectively with your problems?**



**Figure 23: CSQ-8 Question #7.**  
**In an overall, general sense, how satisfied are you with the service you have received?**



**Figure 24: CSQ-8 Question #8**  
**If you were to seek help again, would you come back to our program?**

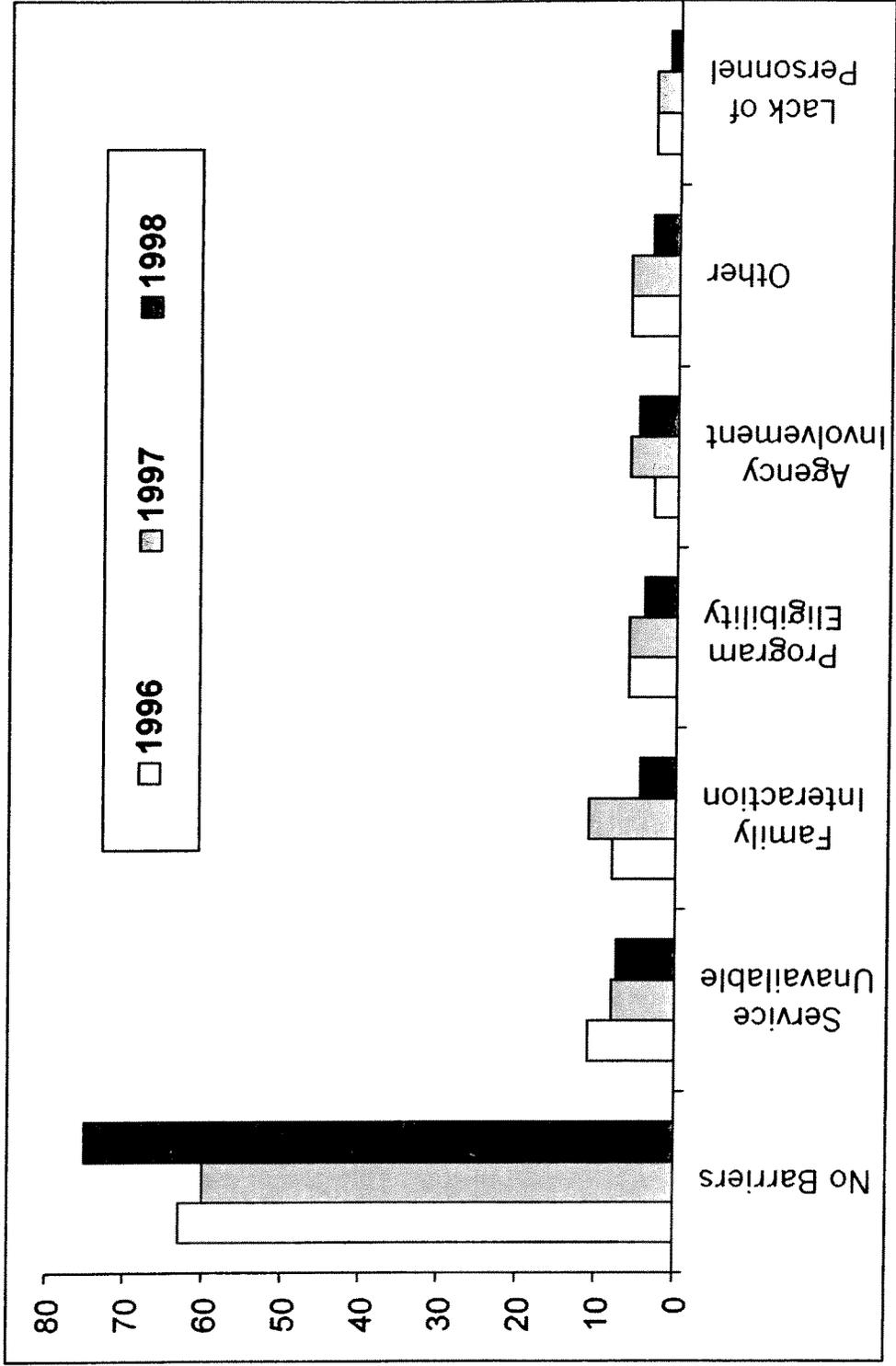


Would you return to CRCG program

## **Appendix M**

# Service Barriers

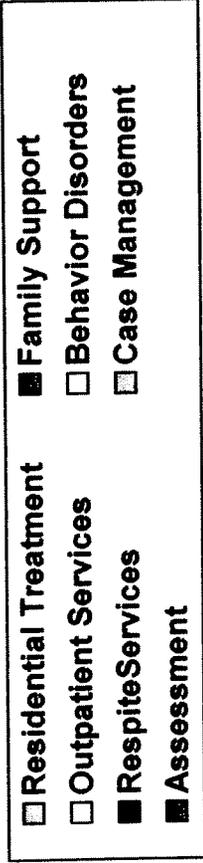
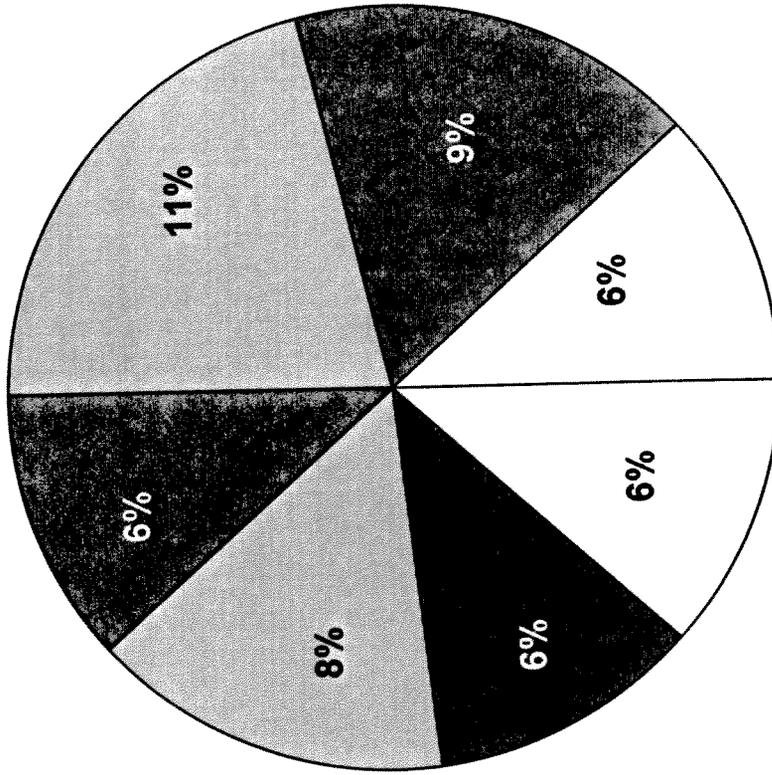
1996, 1997 and 1998 Barriers



## **Appendix N**

# Top Service Needs for the Past Three Years 1998

1,406 Needs were cited on the 986 initial staffings in 1998.



## **Appendix O**

# Follow Up Service Plans

- ✓ 70% of 1st follow-up Service Plans were met.
- ✓ 79% of 2nd Follow-up Service Plans were met.
- ✓ 65% all goals met on first follow-up
- ✓ 75% all goals met on second-follow-up

**Number of Service Plans on the Follow-up Forms**

