



Outcomes Report
2001



Submitted by Bernie Fabry
Revised: 8/20/02

Executive Summary

Over time, human services agencies have come to understand the importance of program evaluation. We have also come to understand that this is not a simple process. Nevertheless, it is essential that agencies that are entrusted with the task of providing essential services to the community, and entrusted with millions of dollars of public funds, be able to demonstrate that they provide high quality services, and that those services are having a positive impact on the lives of consumers.

Family Services of Western Pennsylvania has committed itself to just such an evaluation process. In this, the first year of implementation, not all programs are included in this process. That is our goal for the near future. However, wherever possible, we believe in giving the voice of the consumer priority. Clearly, the best people to describe the impact of our services on our consumers' lives, and to help suggest changes or improvements, are the consumers themselves. Therefore, this report is a compilation of their thoughts and reactions along with other measures of outcomes.

By and large, when our consumers speak, they speak well of FSWP. When asked to grade the agency, significant majorities of FSWP consumers have given the agency and its programs, services, and staff high marks.

- When asked about the convenience of FSWP services, 88% had positive or very positive reactions; and when asked to rate the services that they received, 96% of participants responded “very positive” or “positive”
- When asked to describe their overall well-being, at the time of leaving services, 74% of respondents answered “good” or “excellent”.

Similar outcomes were found concerning individual programs and services:

- Foster Care: Fully 83% of those young people who were discharged from care moved into “permanent” living situations, i.e., returned to families, adoption (or pre-adoptive homes), or independent living and, continued to live in those situations when their status was checked up to six months later. These are termed to be successful outcomes.
- Family Based Mental Health: 98% of those who completed treatment during the past year described themselves as being helped by their involvement; furthermore, only 9% of families experienced critical events (suicide attempts, emergency room visits, police involvements, or drug / alcohol treatment).
- MH Residential Services: GAF (Global Assessment of Functioning – a clinical measure of consumer well being) scores of 88% of those treated by FSWP’s CRR (a long term residential service) program showed an increase. Of consumers of MH-Respite (a much shorter term service), 45% also showed an increase in GAF.
- MR Residential: 91% of MR Residential consumers were satisfied with the services and supports they received along with their general life situations.

We see the feedback that we have received from our consumers as generally supportive of our belief in and commitment to provide top quality human services. At the same time, we know that the report is not an indication of perfection. In addition to outlining our strengths, the data in this report provide us with a clear indication of those areas that must be improved. The guidance provided by this report, translated into obtainable improvement goals, combined with our ongoing quality improvement process, will provide us with the means to continue to better serve our consumers as we work to fulfill our mission in the community.



This report presents highlights from an inaugural year of outcomes measurement. For the programs that were able to collect outcome data and are included in this report, the most noteworthy outcomes are presented. Copies of each program’s full report can be obtained from program directors.

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Consumer Survey

Each year Family Services surveys consumers regarding their perceptions of our services. The questions asked can be divided into three domains: Access – getting into services, Activities – what happens during services, and Outcomes – the results of services.

Perceptions of Access – getting into services. Consumers were asked to rate the convenience of services and their feelings about waiting time. Figure 1 shows the percent of consumers across all

programs whose ratings were very negative, negative, positive or very positive. As can be seen in Figure 1 most consumers rated the access questions as positive or very positive.

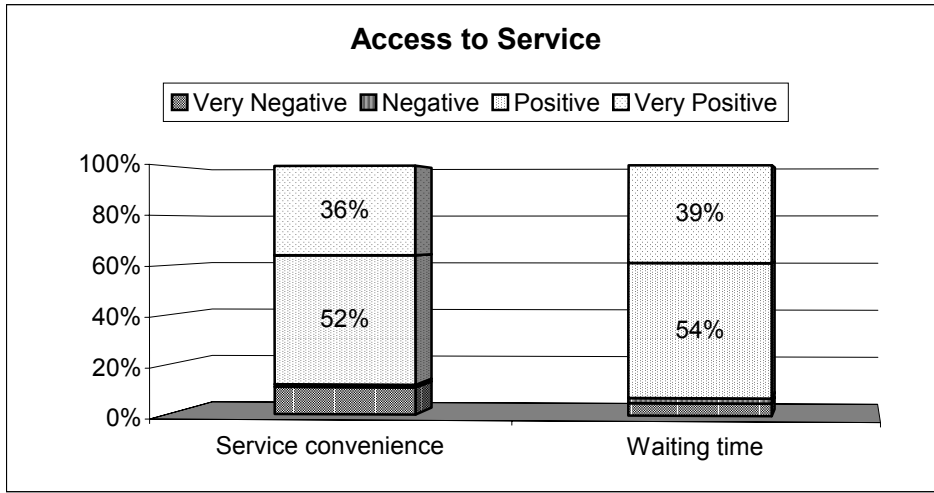


Figure 1

Perception of Activities – what happens during service. Consumers were asked to rate how often staff treated them respectfully, if services were provided frequently enough, and how often useful information was provided during the course of service. Figure 2 shows how consumers reported being treated during service delivery.

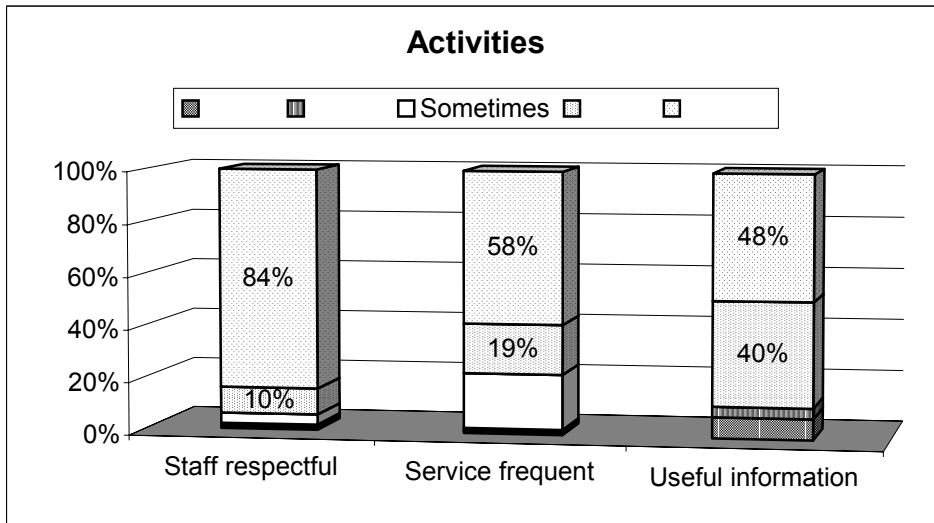


Figure 2

Perception of Immediate Clinical Outcomes – the results of services. Clinical outcomes are changes or improvements related to the original reason consumers sought services. As part of the consumer survey, consumers were asked to rate the condition of their symptoms/problems, rate the helpfulness of services, and in general rate the services. Figure 3 shows that 96% (67% + 29%) of consumers gave positive or very positive ratings of services. In other words, they liked services. However, fewer consumers – 61% (48% + 13%) – gave positive or very positive ratings for helpfulness. Then again, 70% (38% + 32%) rated the condition of their symptoms as positive or very positive.

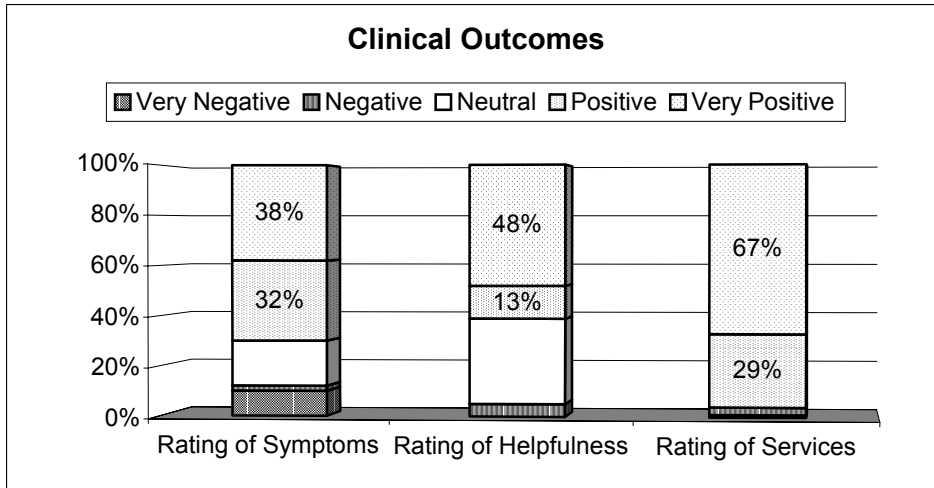


Figure 3

Perception of Immediate Functional outcomes – the ‘real world’ results of services.

Functional outcomes refer to the impact that services have in the lives of consumers. Three questions on the consumer survey asked for consumers’ perspectives on some aspects of their lives. While these aspects are not the ‘be all, end all’ of functional outcomes, they do provide some information. Figure 4 shows consumers’ ratings of their living situations, the safety of their living/school/work situations, and a rating of their overall well being. As can be seen, 89% of consumers rated their living situations as good or excellent. Overall, 81% reported that the safety of their worlds was good or excellent. Finally, 74% reported their overall well being as good or excellent.

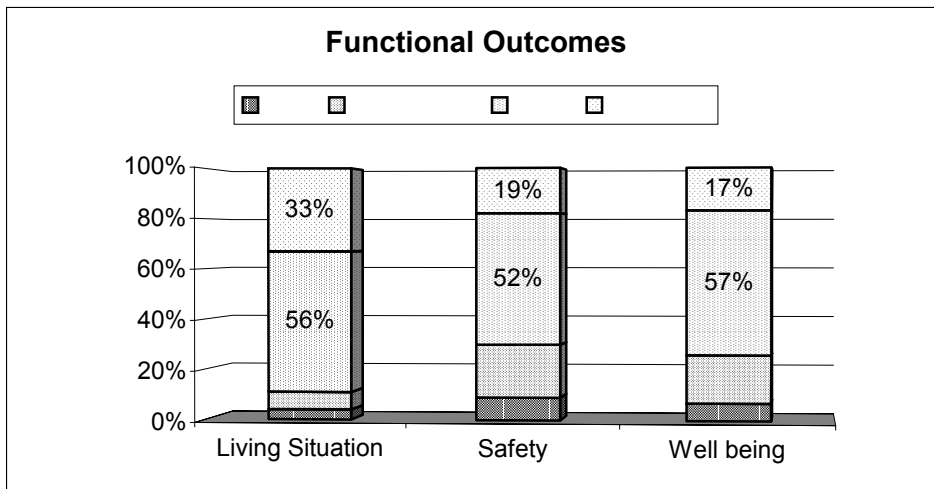


Figure 4

A Brief Perspective on Outcomes

The information presented in the preceding four figures summarizes **consumer perceptions of service** as measured through surveys given to consumers in 2001. The results are a summary across all agency programs. While some people consider these kinds of information to be

essential, there is also general agreement that it takes a variety of outcomes to get a comprehensive picture of any service and fully understand the impact of the service and how to improve the service. Therefore, the following sections highlight additional outcomes collected by different programs.

Information is presented according to the **logic model** for collecting outcome information, meaning that in order to understand a program's outcomes, it is important to know the program's **inputs and activities**. Inputs include the consumers to be served plus the staff and other resources used to achieve program goals. Activities are what a program does with the resources to serve its consumers and fulfill its mission. Activities include therapy sessions, residential services, transportation, etc.

Outcomes are the benefits to consumers as a result of the activities and can be categorized in a kind of hierarchy. **Perceptions of consumers** are as valid as **clinical observations** of staff and both kinds of outcomes are included in this report. **Immediate outcomes** are the results that are perceived by consumers or observed by staff when a service ends. **Enduring outcomes** are the results that unfold during the weeks and months after service has ended. They are the lasting impacts of the service. Some measurable outcome domains include **symptoms** (e.g., is a client experiencing less depression), **level of functioning** (e.g., level of impairment in social, occupational or school functioning assumedly resulting from mental health), **functional outcomes** (e.g., real world functioning such as living with no more supports/restrictions than actually needed, success in social endeavors, maintaining employment or succeeding academically in school, 'staying out of legal trouble,' etc.), and **quality of life** (e.g., consumer satisfaction with living arrangement, work/school arrangement, living in a safe environment, etc.). Knowing the enduring functional outcomes and quality of life for our consumers is the ultimate goal. However, that is not always feasible and in some cases not necessarily the mission of some programs. Therefore, a variety of outcomes are included in this report.

Student Assistance Program

Inputs and Activities. The Student Assistance Program (SAP) operates out of the New Kensington site. It consists of a staff of five full time masters level liaisons, each working with anywhere from 2 – 4 school buildings. SAP serves the students, teachers and families of middle and high schools in six school districts in the Allegheny Valley region: Allegheny Valley, Highlands, and Deer Lakes school districts in Allegheny County; and New Kensington/Arnold, Burrell, and Kiski Area school districts in Westmoreland County. SAP services also are offered to St Joseph High School in Allegheny County.

SAP is a prevention/early intervention program. The liaisons act as mental health and drug and alcohol consultants to the schools in which they are assigned. They provide educational services to the school faculty, prevention services to the students through classroom presentations and group facilitation, and community-based workshops and conferences to the community at large. Early intervention services are offered through assessment of students identified as having some type of behavioral, emotional, or academic problem by teachers, parents, peers, or the students themselves. After each screening assessment is completed, the liaison makes a recommendation to the student and his/her family, and to the school as to what type of intervention is most appropriate to help the student/family overcome an identified difficulty.

Immediate Clinical Outcomes. Figure 5 indicates the various services to which students were referred by SAP staff following assessments of students.

Figure 5

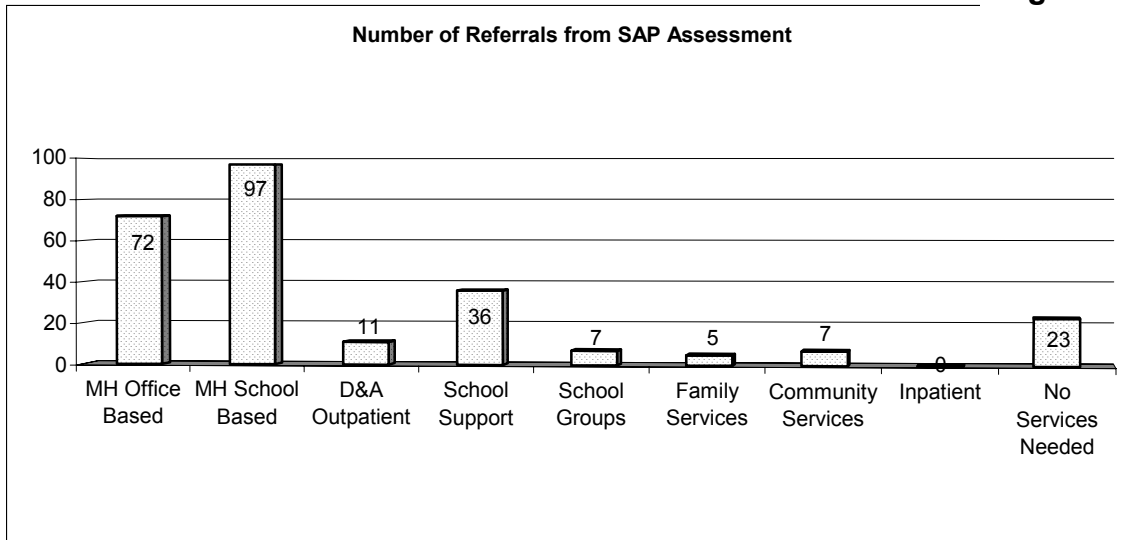


Figure 5 shows that the majority of the students assessed were referred for school-based counseling (MH School Based) or office-based counseling (MH Office Based or D&A Outpatient). Referrals for office-based services primarily came from schools where school-based counseling was unavailable or the school-based therapist had a full caseload. Some parents chose office-based over school-based services. Other students were referred for services available at their schools (School Support and School Groups) or in their communities.

The outcome of a SAP assessment is a referral that a student and his/her family feel is in the student's best interest. Therefore, the percent of referrals accepted by families is an important measure of this outcome. Out of a total of 260 students referred for assessment by the liaisons, 192 (74%) followed through with the recommended services, while 68 (26%) did not.

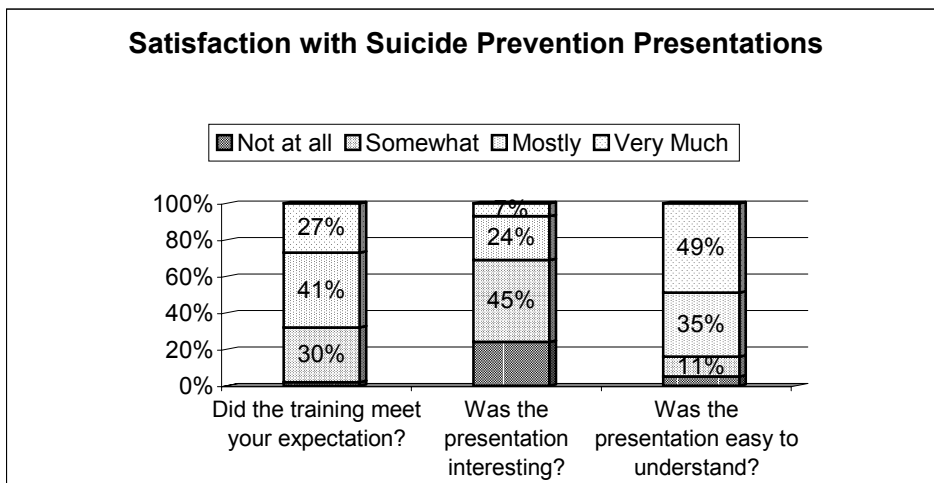


Figure 6

Perceptions of Immediate Outcomes. In addition to the screening assessments, SAP staff provide a variety of educational services related to mental health and drug and alcohol issues. More specifically, SAP staff have been trained to provide suicide prevention seminars for students, teachers, and community members. Figure 6 shows the attendees’ perceptions of the seminars

Employee Assistance Program

Inputs and Activities. The staff of the Employee Assistance Program (EAP) provide initial assessments, referrals and short-term (up to 3 sessions) office-based counseling for the employees of companies with EAP contracts. In addition, the program staff provide educational workshops on topics related to stress/coping and mental health issues in the workplace.

Perceptions of Immediate Outcomes. Following short-term counseling, clients were asked about their perceptions of their situations. Figure 7 shows that 52% of the clients felt that their problem or issue had gotten better after the very brief counseling that the EAP staff can provide. In addition, 56% of the clients felt better about themselves and 44% felt that their personal relationships were better. Thirty percent (30%) felt that their job performance was better.

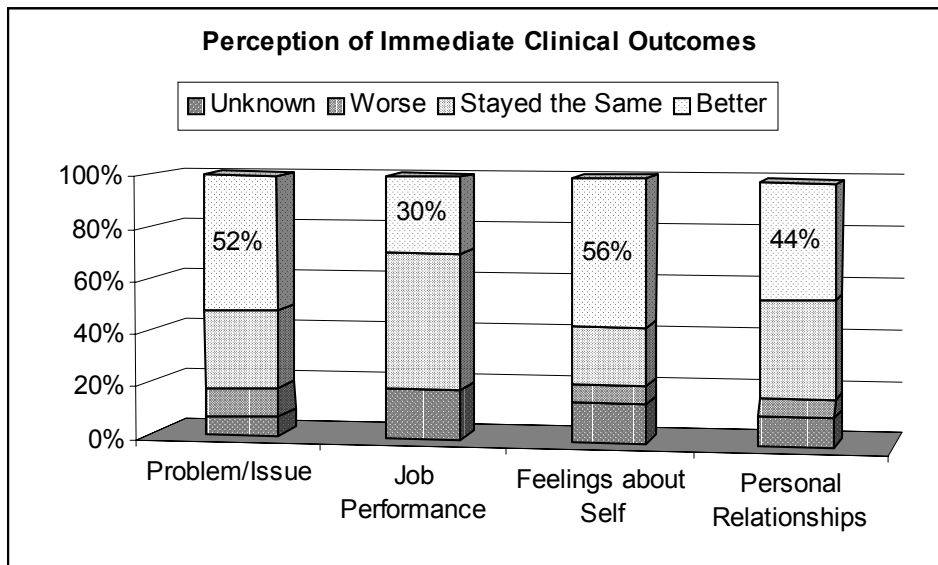


Figure 7

Site-Based Counseling and Therapy

Inputs and Activities. FSWP offers a variety of site-based counseling and therapy services including adult, adolescent and child outpatient counseling/therapy in Tarentum and New Kensington; school-based counseling/therapy in Deer Lakes, Allegheny Valley, Highlands, New Kensington/Arnold, Burrell and Kiski school districts; drug and alcohol counseling/therapy in Tarentum, New Kensington and East Liberty; and individual and family counseling/therapy in

East Liberty and various family centers throughout Allegheny County. When counseling/therapy ends for an individual or family, the primary therapist completes a “Disposition Form” to report the outcomes of the counseling/therapy episode. Sometimes a consumer may seek more than one episode of counseling, coming to a site for several sessions, ending that episode of counseling/therapy, and then a few months later returning for another episode of counseling that covers several more sessions. A separate disposition form is completed for each episode and counted in the data presented here.

Immediate Clinical Outcomes - Symptoms. A therapist establishes goals with each consumer or family at the start of an episode of counseling/therapy. When completing the disposition form the therapist rates the consumer/family’s progress as “goals attained,” “improvement on goals,” or “no improvement on goals.” Goal attainment information was obtained for 616 consumers in 2001. Since this was the first year of implementation with its attendant growing pains, this number is not equal to the total number of consumers seen in all of the site-based counseling/therapy services. It is a sample with possible biases. However, the information from these 616 consumers provides a representative picture of outcomes.

There are 20 possible reasons listed on the disposition form for why an episode of care might end. Most episodes ended for one of three reasons: 1) the consumer and therapist jointly agreed to end the episode (Consumer Therapist Agreement), 2) the consumer told the therapist that the consumer would not be coming back even though the therapist felt the consumer could benefit from additional counseling (Consumer Decision), and 3) the consumer – or the consumer’s guardian – withdrew and stopped coming but did not notify the therapist so that the reason was left unknown (Unknown). A small proportion of episodes ended for any of the other reasons. Figure 8 shows goal attainment compared with the reason for ending an episode.

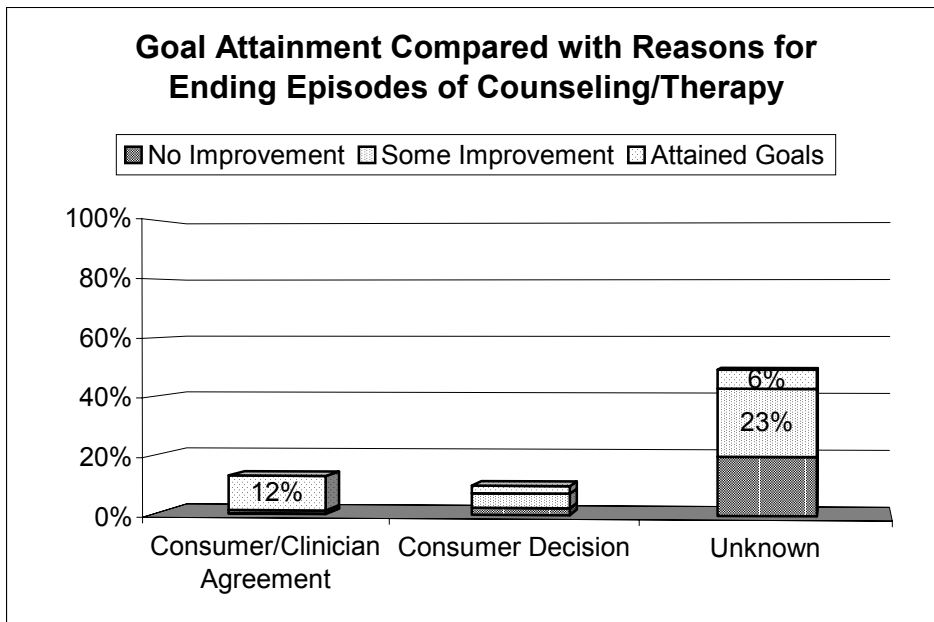


Figure 8

As the far right bar of the figure shows, 49% of consumers stopped coming to sessions without any kind of notice. Clinicians rated 29% (6% + 23%) as having attained goals or made some progress on their goals. The middle bar shows that another 10% of the consumers chose to stop coming and told their clinicians that they would not be returning even though the clinicians felt that the consumers could benefit from additional sessions. There is a tendency to refer to these as

'dropouts,' but this term adds an undeserved negative connotation. It is possible that many of the consumers in this group had gotten as much as they wanted and/or needed from counseling.

The far left bar shows that for 13% of the cases, both the clinicians and the consumers mutually agreed that therapy should end; and the clinicians rated all of those consumers as having attained all of their goals (12%) or having made at least some improvement (1%). There was an additional 28% (not shown in the figure) for whom the clinicians indicated one of the many other reasons for ending an episode of therapy. All of the reasons address situations in which the clinician felt that goals had not been attained but one circumstance or another resulted in the episode of therapy ending.

To summarize, clinicians felt that a grand total of 48% of consumers attained their goals or made some progress. Almost half of all consumers stopped coming for services and gave no notice as to why.

Immediate Functional Outcomes. While the judgments of clinicians about treatment progress are important, we want to know if counseling/therapy made a difference *in the real world*. *Real world*, or functional outcomes include how a person is functioning in life domains such as living situation and work/school situations. Figure 9 shows the living and school/work situations of consumers at the end of counseling/therapy. Natural living situations include living independently and living with family, relatives, or friends. Restrictive living situations include living situations that are funded to support or restrict people (e.g., a group home, a foster home, a prison, etc.). Figure 9 shows that 89% of consumers lived in natural situations at the time that episodes of therapy ended. Natural school/work situations include attending regular schools and/or working at paid jobs. Restrictive situations include classrooms or schools for special populations and supported work situations or unemployment. Figure 9 also shows that 74% of consumers were either attending regular schools and/or working at paid jobs.

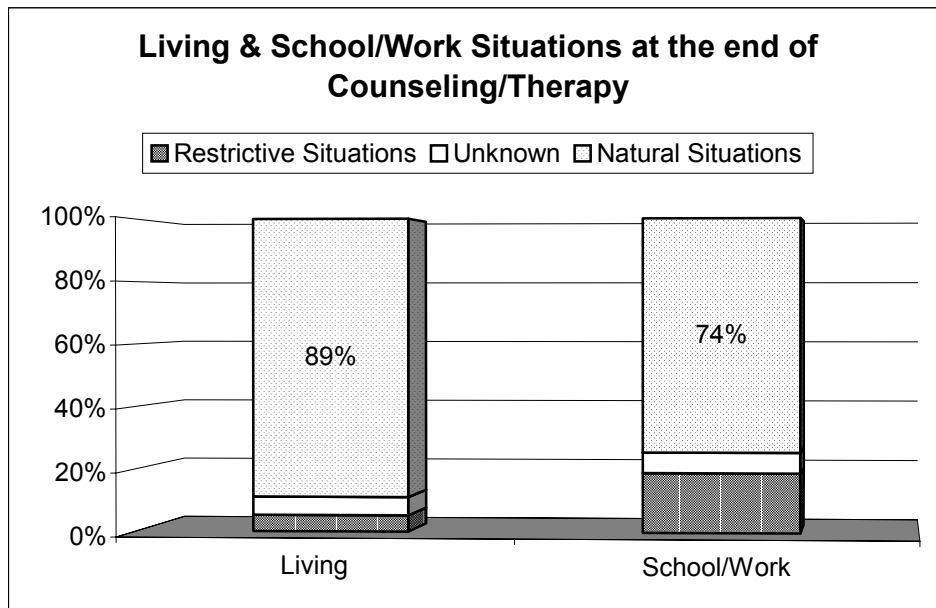


Figure 9

Outpatient Drug & Alcohol

The preceding section, Site-Based Counseling and Therapy, includes outcomes for the Outpatient Drug & Alcohol program since it is one of the site-based counseling and therapy services. However, data for this program has been reported separately by the program staff, and is included here because the goal is for each program to report separate data.

Inputs and Activities. Outpatient Drug & Alcohol treatment is an organized, non-residential service providing psychotherapy for at most 5 hours per week. Services include biopsychosocial assessment, case management and individual, group or family counseling. Staff include a clinical supervisor and certified addiction counselors.

Immediate Clinical Outcomes. There are 20 possible reasons listed on the disposition form for why an episode of care might end. For the Outpatient Drug & Alcohol program, 50% of consumers did not complete, withdrew or never appeared for service. Another 10% completed services with full attainment of goals.

Staff recorded Global Assessment of Functioning (GAF) scores at admission to the program and again at the time of discharge. Figure 10 shows the percent of consumers who experienced changes in their GAF scores. No change in GAF was reported for 20% of the consumers while 16% showed a 1 to 2 point change. Another 22% showed a change of from 3 to 5 points while 29% showed a change of 6 to 9 points. Most noteworthy, 13% showed a change of 10 or more points. To put these scores in perspective, a 10-point change might be a change in functioning from serious impairment in social, occupational or school functioning to a moderate impairment; or a 10-point change might reflect a change from moderate impairment to mild impairment.

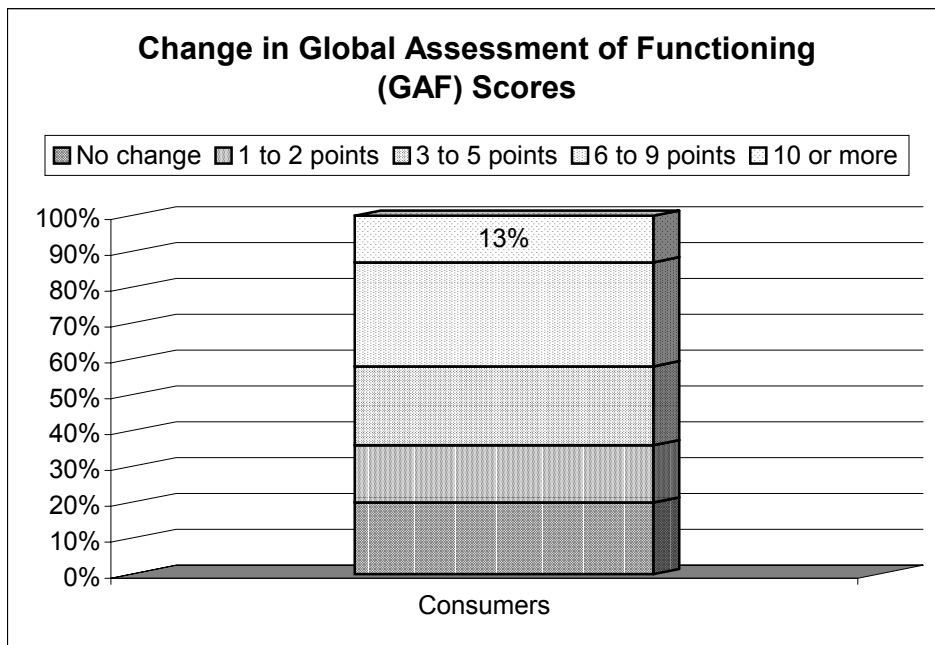


Figure 10

Case Management

Inputs and Activities. Intensive Case Management and Resource Coordination services operate out of the Tarentum site to serve northern Allegheny County and a small portion of northern Westmoreland County. There are 16 case managers and three management level staff who serve 375-400 youth and adult consumers at any given time. Case management staff provides education, support and preventive services for consumers at risk of serious mental illness including assisting consumers to live independently, productively, and healthfully by coordinating diverse services within the community. The average length of stay in service is approximately two years. A primary goal of the program is to divert psychiatric hospitalizations and/or decrease the length of needed hospital stays.

Immediate Functional Outcomes. Figure 11 shows the total number of days Intensive Case Management consumers were not in 'home settings' over a 4-year period. The figure shows that consumers spent a total of 3,066 days in either a community hospital, a state mental hospital, a criminal detention facility, or were homeless or living in a shelter during the '97-'98 fiscal year. The total has decreased each year with there being no consumers spending any time in psychiatric hospital settings, detention settings or being homeless during the '00-'01 fiscal year.

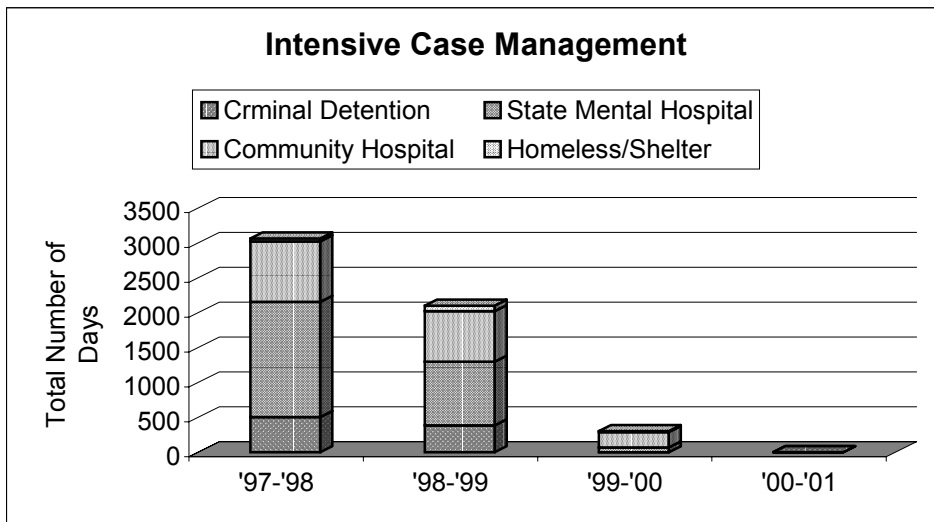


Figure 11

Figure 12 shows the total number of days Resource Coordination consumers were not in 'home settings' over a 4-year period. The figure shows that consumers spent a total of 703 days in either a community hospital, a state mental hospital, a criminal detention facility, or were homeless or living in a shelter during the '97-'98 fiscal year. During '98-'99 consumers spent a total of 1005 days non-home settings. In '99-'00 the total was 725 and in '00-'01 the total had decreased to 194 days.

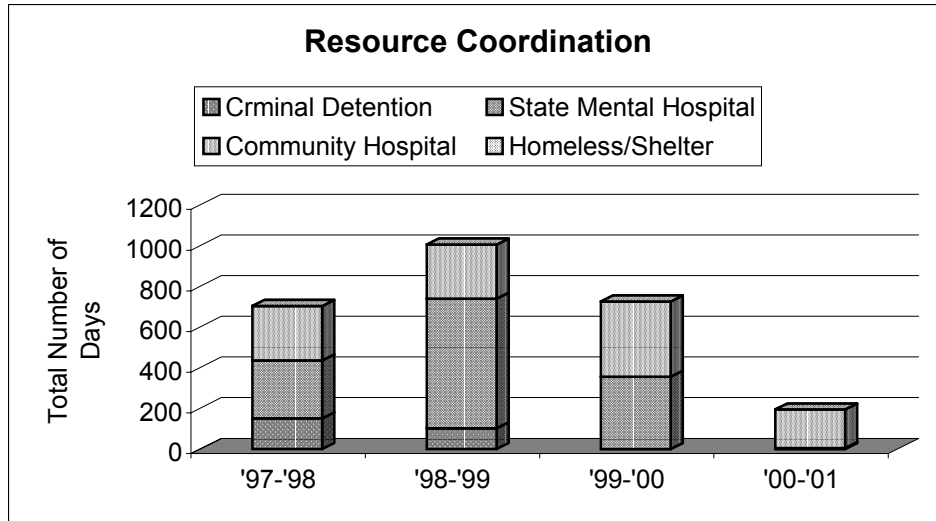


Figure 12

Acute Partial Hospital Program

Inputs and Activities. The program served 81 consumers in 2001. Of those, 70% were diagnosed with mood disorders (bipolar disorder, depression) while another 11% were diagnosed with schizophrenia and related disorders. In addition, 25% of the 81 consumers also had a secondary mental health diagnosis including anxiety and substance abuse disorders, and 22% had personality disorders (borderline personality, antisocial personality disorder, borderline intellectual functioning). Approximately 91% were Caucasian and 70% were female.

Services were provided by a clinical coordinator, a psychiatric nurse and a therapist along with some psychiatrist time, using two group treatment rooms. Treatment included daily group and individual therapy, case management, discharge planning, brief family therapy, psychiatric evaluations and medication checks. The average length of stay in the program was 15.2 days.

Immediate Clinical Outcomes - Functioning. Overall, the program reported a 10-point change on average for Global Assessment of Functioning (GAF) scores. The average GAF at entry was 41 (meaning serious symptoms or serious impairment in social, occupational, or school functioning), while the average GAF at discharge was 51 (meaning moderate symptoms or moderate difficulty in social, occupational, or school functioning).

Immediate Functional Outcomes. It is significant that less than 5% of the consumers were admitted to a psychiatric hospital while enrolled in the program.

Outpatient Psychiatry/Nursing

Inputs and Activities. For the year 2001, the program staff chose to look at adult consumers who had been admitted to the psychiatric hospital serving the Allegheny Valley area between July

2000 and July 20001 and were subsequently discharged to Family Services Outpatient Psychiatry/Nursing Service. Of the 92 people in this group, 38% were diagnosed with mood disorders, and 48% were diagnosed with schizophrenia and related disorders.

Staff included psychiatrists supported by a team of nurses at two outpatient office sites in Tarentum and New Kensington. The psychiatrist and nurses conducted evaluations, prescribed and monitored psychotropic medications, and provided medication injections where needed. In addition, the nursing staff provided psychoeducational groups for consumers on topics relevant to their diagnoses and medications.

Functional Outcomes. Figure 13 shows that 66% consumers with schizophrenia/related disorders did not experience another hospitalization in the year following the initial hospitalization. Likewise, 68% of consumers with mood disorders and 69% of consumers with all other disorders did not experience another hospitalization. The remaining consumers experienced one or more readmissions to a psychiatric hospital during the year following the initial hospitalization.

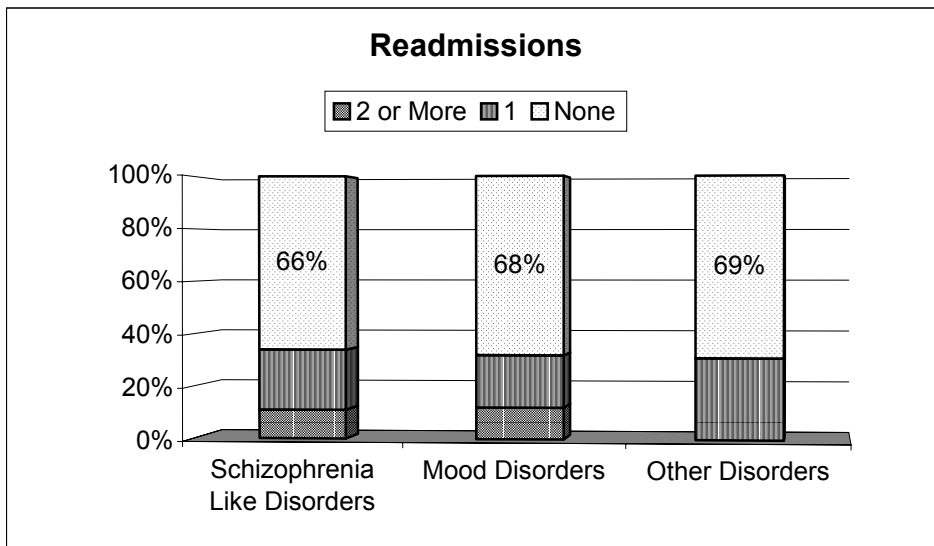


Figure 13

These data show the extent to which Outpatient Psychiatry/Nursing – in collaboration with consumers and other service providers – contributed to supporting people with serious mental health disorders maintain themselves in the community.

Community Employment Center

Inputs and Activities. The Community Employment Center, (CEC) provides vocational rehabilitation services for persons with disabilities. It is geared towards skill acquisition and job search training for eventual competitive employment. Services include vocational evaluations, personal work adjustment training, progressive employment and education opportunities, mobile work crews, and job coaching. There are 13 full-time employees.

Immediate Outcomes. During fiscal year 2000/2001, 29 new people were referred to CEC for vocational services. Figure 14 shows that 14% ‘graduated’ by obtaining competitive employment.

Another 24% made some type of progress into a higher level of vocational rehabilitation including stepping up through the CEC service options while an additional 34% were showing improvement within the CEC program options. The remaining consumers did not achieve work readiness and ended their involvement with CEC.

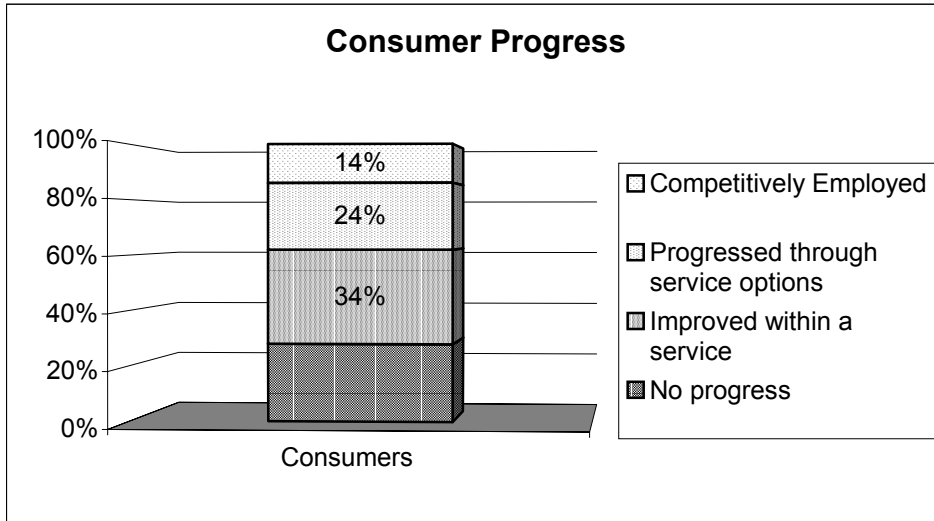


Figure 14

Adult Developmental Training Center

Inputs and Activities. The Adult Developmental Training Center at NorthCo provides support services to individuals with physical and developmental disabilities in a day program setting.

The 13 staff of ADTC assist participants with developmental training to maximize self-determination, choice and control in their daily lives. The program teaches skills in daily living (personal hygiene, eating, cooking), community inclusion, self-preservation, safety awareness, gross/fine motor skills, social interactions, communication skills, and vocational assembly packaging skills. There were 29 consumers during the 2000/2001 fiscal year.

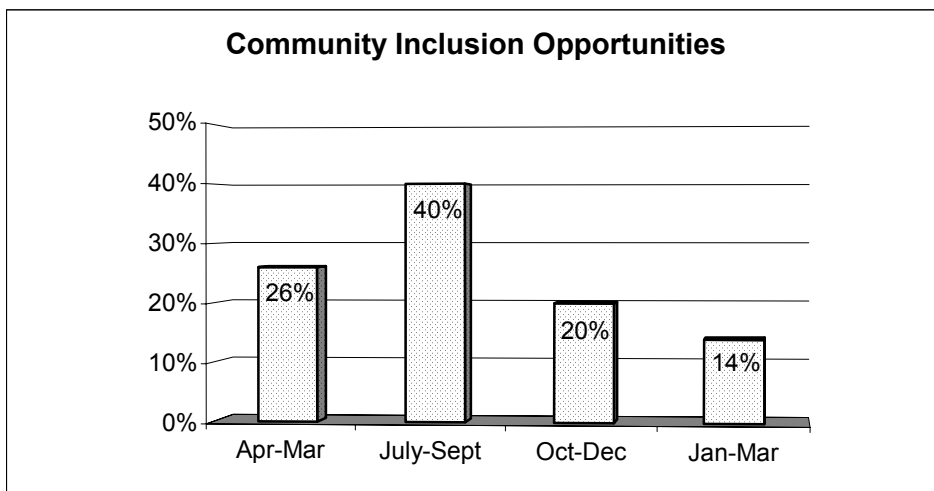


Figure 15

Immediate Functional Outcomes – Quality of Life – Community Inclusion. The ADTC program provides each consumer with the opportunity to enhance participation in community events and to build relationships with community establishments. Figure 15 shows the percent of community-based events in which consumers were involved on a quarterly basis.

Immediate Functional Outcomes – Quality of Life – Meaningful Work. The ADTC program supports and coaches consumers in assembly packaging work, opportunities for which the consumers are paid. Out of twenty-nine individuals, eleven (28%) participated in the vocational work.

Work Adjustment Center

Inputs and Activities

The Work Adjustment Center at NorthCo assists program participants in attaining the technical, behavioral, social and other work readiness skills necessary to advance to other vocational rehabilitation and training programs. During the period covered by this report, 73 adult consumers worked on contract jobs that involved activities such as sorting, packaging, simple assembly, and mailing for which they were paid based on prevailing wage rates in the region. Specialized training programs in the areas of custodial, warehouse material handling, and clerical were also provided.

Immediate Functional Outcomes – Quality of Life – Meaningful Work. During the period covered by this report, program participants were engaged in productive, paid work 78% of the time.

Immediate Functional Outcomes – Quality of Life – Meaningful Work. In addition to productive work, program participants and staff focus on the safety skills of the participants. Figure 16 shows the number of work related injuries over four quarters.

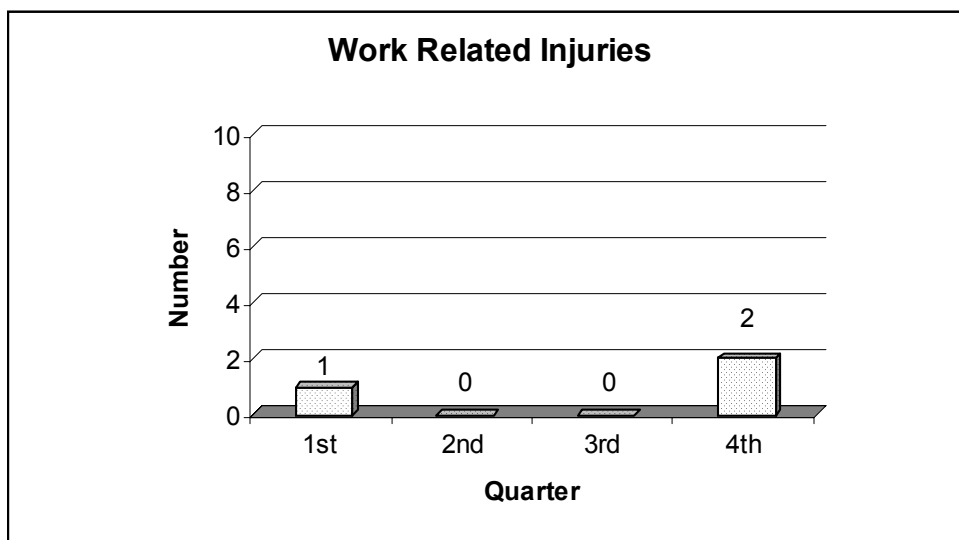


Figure 16

Supported Living Program

Inputs and Activities. During the period covered by this report, the three program staff provided support and skill teaching to 45 adults with mental illness living in a community setting within Allegheny or Westmoreland county. The focus of the program was to teach people the specific self-selected skills needed to be successful in an independent living situation so that they could live in integrated settings in the community. The skill teaching occurred on a 1:1 basis in the consumers' homes and communities, and included skills such as medication compliance, renter skills, budgeting, public transportation, housekeeping, cooking, and socialization skills.

Immediate Clinical Outcomes. During the period covered by this report, 20 consumers were discharged. Figure 17 shows the reasons why consumers ended their use of Mobile Housing Support services. The figure shows that 42% of the consumers completed the program of services.

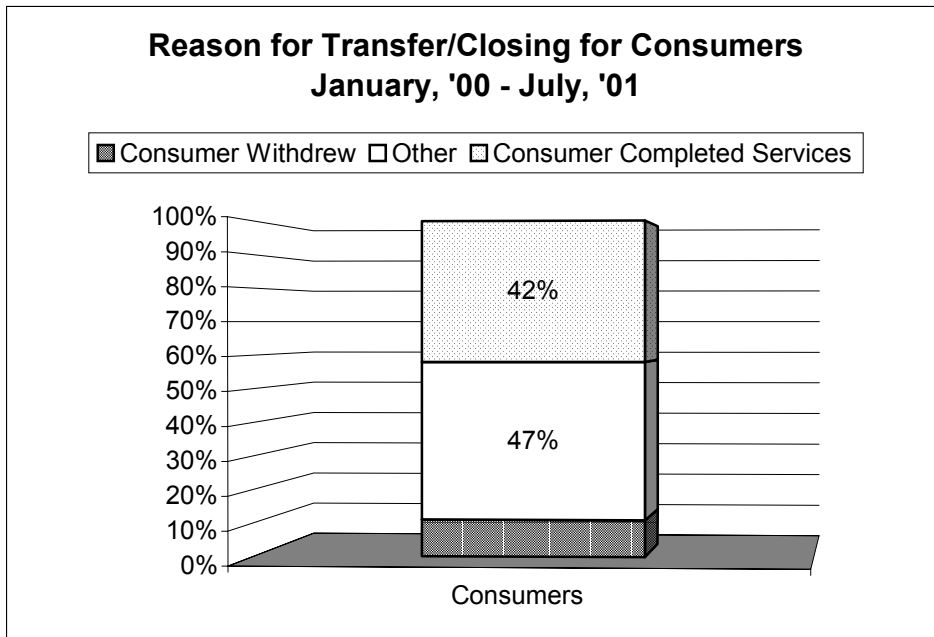


Figure 17

Figure 18 shows consumers' goal attainment at the time of discharge from Mobile Housing Supports. The figure shows that 50% attained their goals while an additional 18% made some improvement.

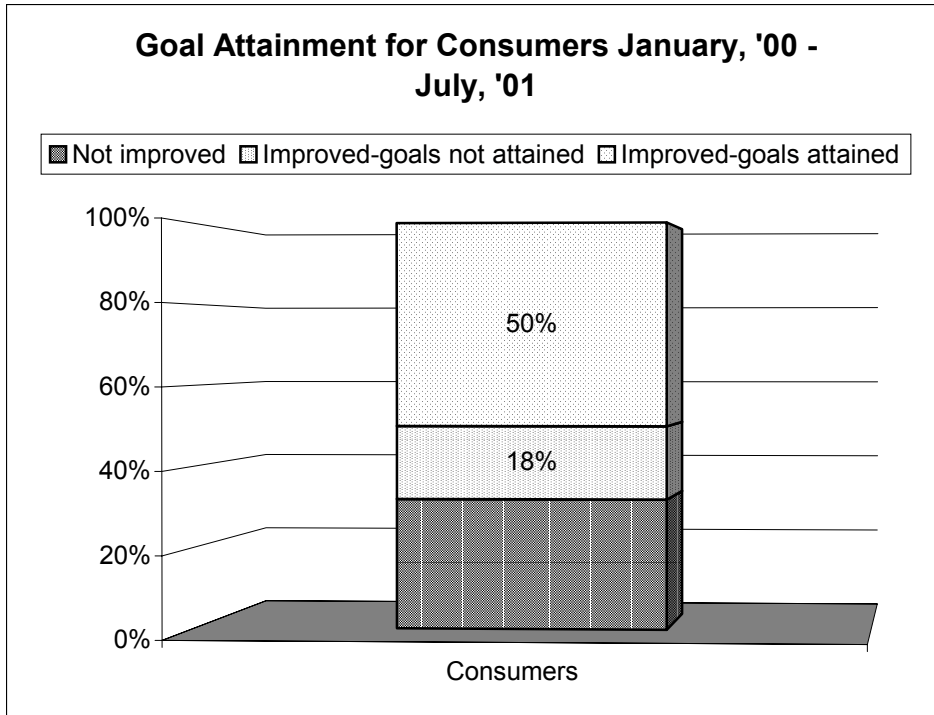


Figure 18

Immediate Functional Outcomes. Figure 19 shows the work status of consumers at the time of discharge from Mobile Housing Supports. The figure shows that all of the consumers were

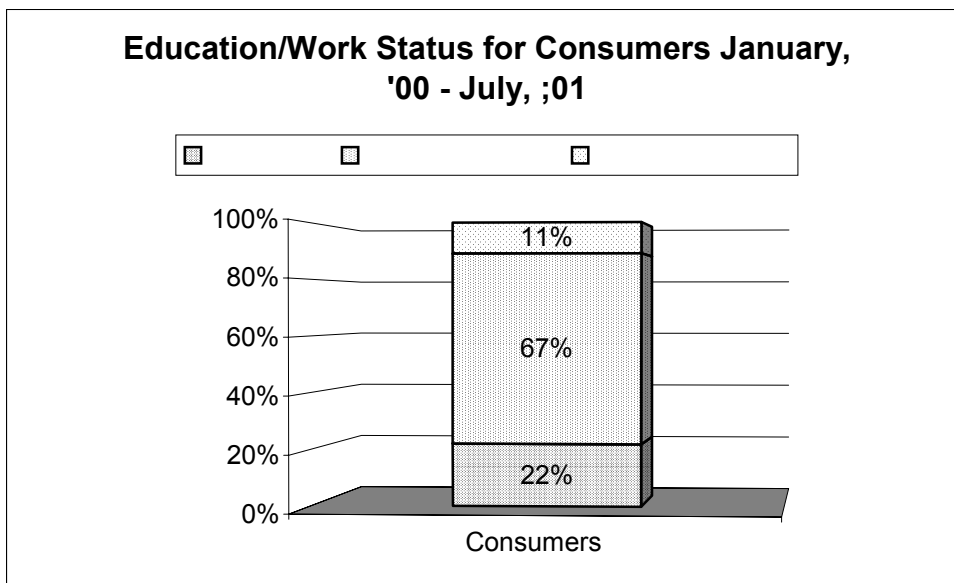


Figure 19

involved in some form of meaningful work. There were 11% who had obtained full-time employment, and 67% who had obtained part-time employment. Another 11% were volunteering at activities that were meaningful to them.



Family-Based Mental Health

Inputs and Activities. The Family Based Mental Health (FBMH) program, provides in-home treatment services for families with children and adolescents who are seriously mentally ill or emotionally disturbed. FBMH Services are provided by 11 teams, each composed of a children’s mental health professional (a master’s level clinician, or a certified family based clinician) and a mental health worker (a bachelor’s level clinician). These teams provide crisis stabilization, therapy, psychoeducation and case management services under the supervision of clinical managers.

Enduring Functional Outcomes. Most of the families who receive FBMH services have at least one child who is in imminent danger of being removed from the home due to the child’s mental illness or serious emotional disturbance. In fact, ‘imminent danger of removal’ is one of the criteria used in deciding whether FBMH is the appropriate level of service for a family. Therefore, it is important to know how many children continue to live with their families after services end. Figure 20 shows the percent of children who were living in out-of-home placements by 3-4 months after FBMH services had ended. Data covering two years are presented. The left side of Figure 20 shows data for 2000 while the right side shows data for 2001.

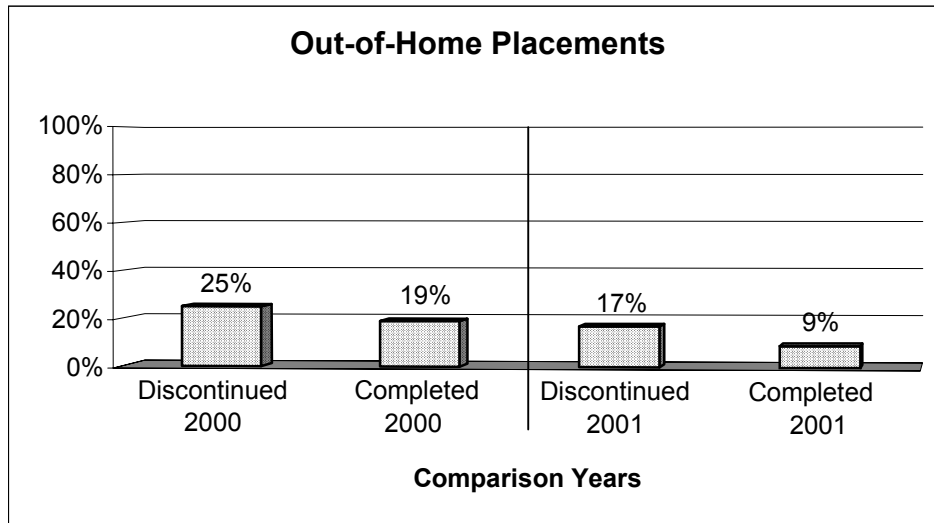


Figure 20

Figure 16 shows that less than 25% of the children had been placed out of their homes. In fact, for families who completed the FBMH treatment in 2000 (‘Completed 2000’) only 19% were placed out of their homes, while in 2001 (‘Completed 2001’) only 9% were placed out of their homes. This can be compared to the fact that almost 100% of the children were ‘at imminent risk of out-of-home placement’ when FSWP initiated FBMH services.

The bars for “Discontinued” show outcomes for families who accepted FBMH services, but then chose to discontinue the service because it was not the kind of service they then wanted. Usually families chose to discontinue in the first month of two of service. Some of these families accepted alternative services such as Behavioral Health Rehabilitation Services, or outpatient therapy. As the figure shows, “Discontinued” families experienced only slightly more out-of-home placements suggesting that either the brief FBMH service was effective, that an alternative

service was being effective, or that some of the “Discontinued” families actually did not have a child in imminent risk of out-of-home placement.

Another indication of family progress can be seen in the education domain. Partial Hospital/Day Treatment is an alternative, less restrictive form of treatment compared to a full hospitalization for children, adolescents and their families. However it is still much more intensive and restrictive than attending classes in neighborhood schools. Figure 21 shows the percent of families whose children were attending partial hospital/day treatment programs 3-4 months after FBMH services had been ended.

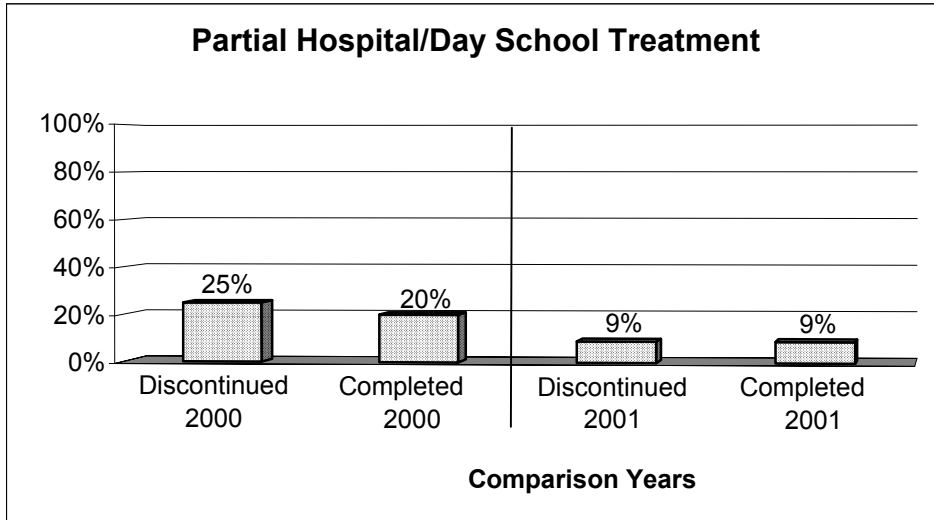


Figure 21

These results are similar to the out-of-home placement results. The figure shows that less than 25% of the children had been placed in partial hospital/day treatment programs. Of the families who completed the FBMH treatment in 2000 (‘Completed 2000’) only 20% had a child placed in a partial hospital/day treatment program. In 2001 (‘Completed 2001’) the percent decreased to 9%. The percentages for “Discontinued” families was only slightly higher in 2000 and the same in 2001.

When the families were contacted 3-4 months following the end of treatment, they are asked whether anyone in the family had been taken to a hospital emergency room for mental or behavioral problems, threatened or tried to commit suicide, been involved with the police, or entered a treatment program for drug and alcohol abuse. Figure 22 shows the percent of families who reported any of these problems. As can be seen very few families reported emergency room visits, suicide threats, police contacts, or drug and alcohol treatment. No group was above 20% and less than 9% of the ‘Completed 2001’ families reported these critical events. Of the families who did report one or another event, the most common answers were police contact for drug and alcohol related problems.

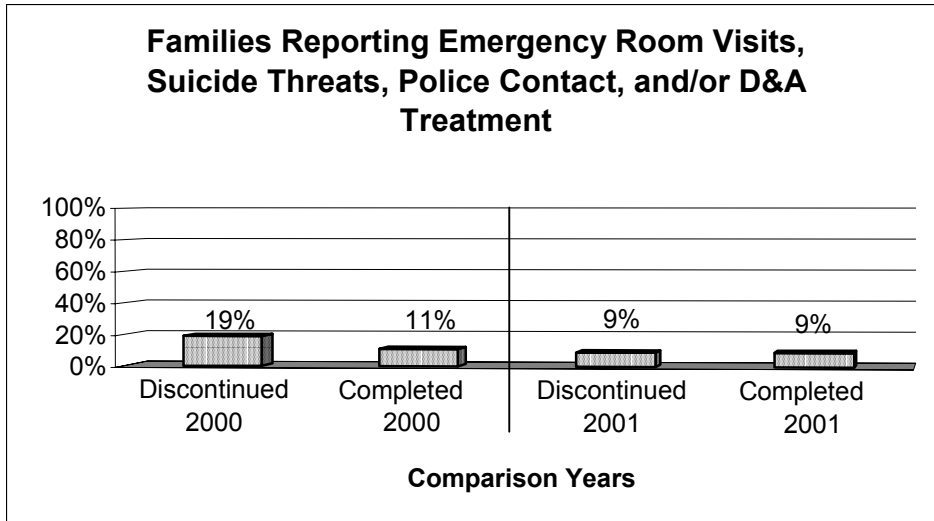


Figure 22

Perceptions of Outcomes. The families also were asked to reflect on whether they felt that FBMH helped them. They were asked overall, how much they felt their family was helped.

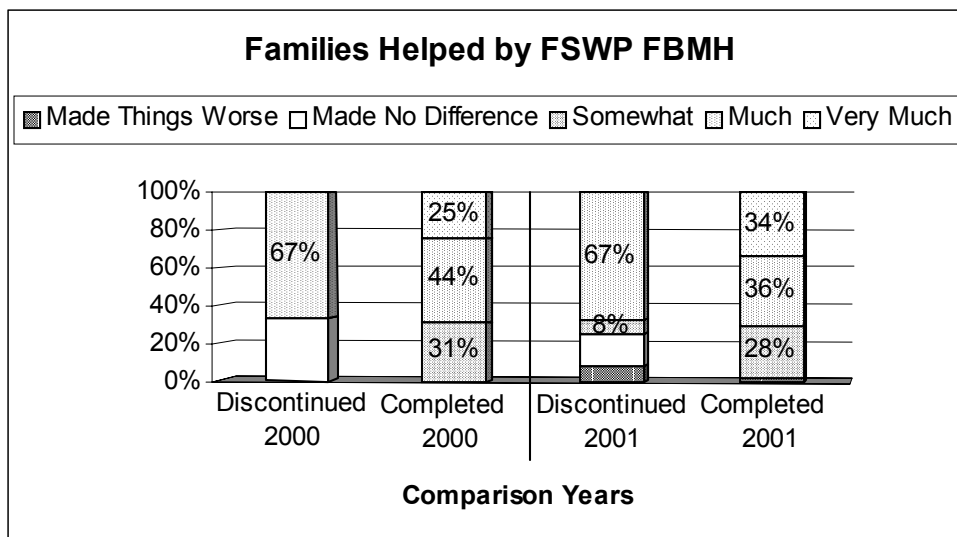


Figure 23

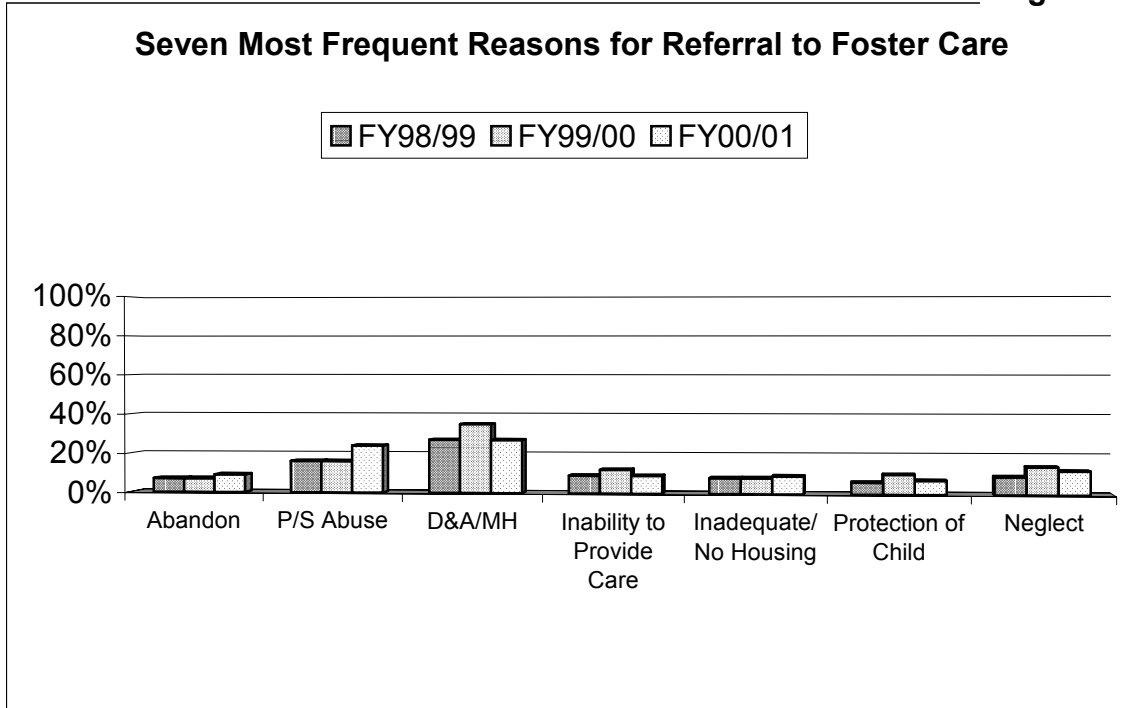
The rating scale went from ‘Very Much’ to ‘Much,’ ‘Somewhat,’ ‘Made no Difference,’ and to ‘Made Things Worse.’ Figure 23 shows the families’ ratings. These data can be compared with the overall agency consumer survey data for helpfulness (the middle bar of the third figure on page 4 of this report). As might be expected, more “Discontinued” families reported that FBMH services were not helpful.

Foster Care

Inputs and Activities. The Foster Care program serves a number of children and adolescents in foster homes located primarily in Allegheny County. There are approximately 80 foster homes

that provide foster care for children who range in age from newborns up to the age of 20. The foster families are trained, coached, and supervised by a team of 14 aides, workers, and supervisors. Children are referred from the county office of Children, Youth & Families for various reasons. Figure 24 shows the seven most frequent reasons why children were referred over the past three years.

Figure 24



Immediate Functional Outcomes. A total of 73 children who were in care for more than three months were discharged during the report period. Figure 25 shows that 50% were returned to their natural parents, 29% were placed in a pre-adoptive foster home, and 4% left their foster homes for independent living situations. These are the children counted as successful outcomes because they moved to situations less restrictive than Family Services foster homes. The total percent of successful discharges was 83%.

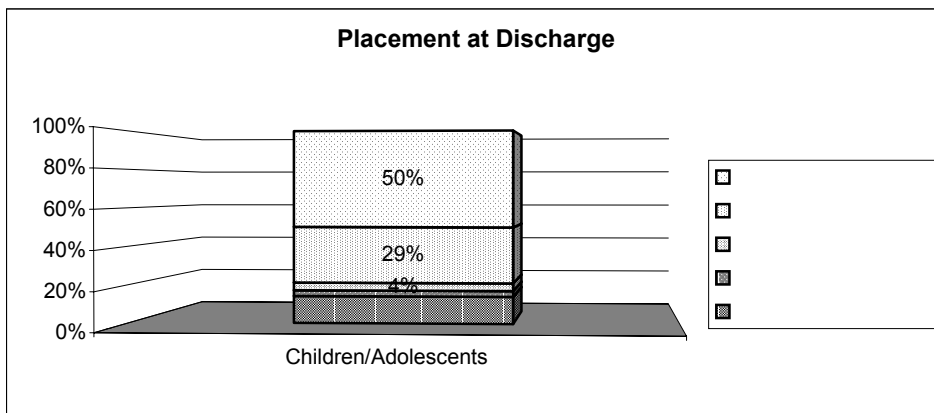


Figure 25

The remaining 17% are considered unsuccessful because they moved to equally restrictive or more restrictive living situations when discharged. Specifically, 3% were placed in another foster care home and 14% were placed in a group or residential setting.

Enduring Functional Outcomes. The Foster Care Program has been making follow-up contacts six months post discharge. At the time of the follow up call, all of the children who left care and were placed in a less restrictive setting continued to reside in less restrictive settings. In other words, 83% of children discharged continued to live with parents, relatives, adoptive parents, or independently up to six months after discharge.

MH Residential Program

Inputs and Activities. The Mental Health Residential Program is made up of three levels of residential services: an emergency respite option, an intensive community rehabilitation residence (intensive CRR) and a full care community rehabilitation residence (full care CRR). At each level, consumers are supported in setting, prioritizing, and working toward short-term objectives and long-term goals. The goals can focus on daily living skills, financial management, community integration and mobility skills, interpersonal skills, physical health and symptom management skills. In addition, psychoeducational groups are provided along with vocational referrals.

From May 2001 to April 2002, 148 consumers used the emergency respite program, 17 used the intensive CRR and 18 used the full care CRR. During that same time period, 143 people were discharged from the emergency respite program, and 17 were discharged from the full care and intensive CRR programs. While all of the consumers had a mental health diagnosis, the majority was diagnosed with mood disorders or schizophrenia and related disorders.

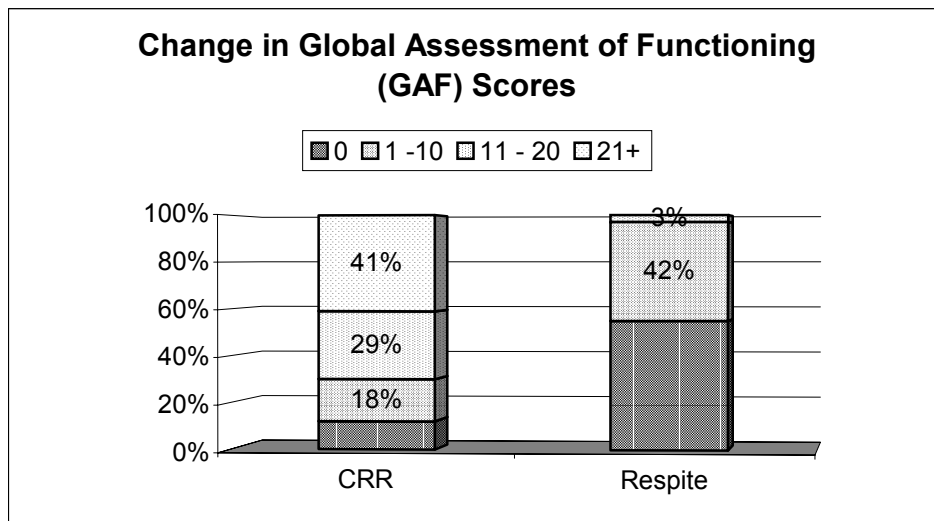


Figure 26

Immediate Clinical Outcomes - Functioning. Staff recorded Global Assessment of Functioning (GAF) scores at admission to each program and again at the time of discharge from each program. Figure 26 shows the percent of consumers who experienced changes in their GAF scores ranging from no change (0) to a 1 to 10 point change, an 11 to 20 point change, or a

change of more than 20 points from the GAF score at admission to the GAF score at discharge. In the CRR programs 70% (41% + 29%) of consumers experienced a change of 11 or more points. In the Respite program, a brief acute setting, 42% of the consumers experienced a change of 1 to 10 points.

Immediate Functional Outcomes. Figure 27 shows where consumers went to live when discharged from the CRR programs and the Respite program. Following a brief stay in the Respite program, 61% (47% + 14%) of the consumers went to natural settings like independent living in an apartment or went to live with family or friends. A few consumers (9%) experienced a worsening of their conditions and were discharged to a psychiatric hospital.

For consumers leaving the CRR programs, 86% (59% + 17%) went to natural settings like independent living in an apartment or went to live with family or friends.

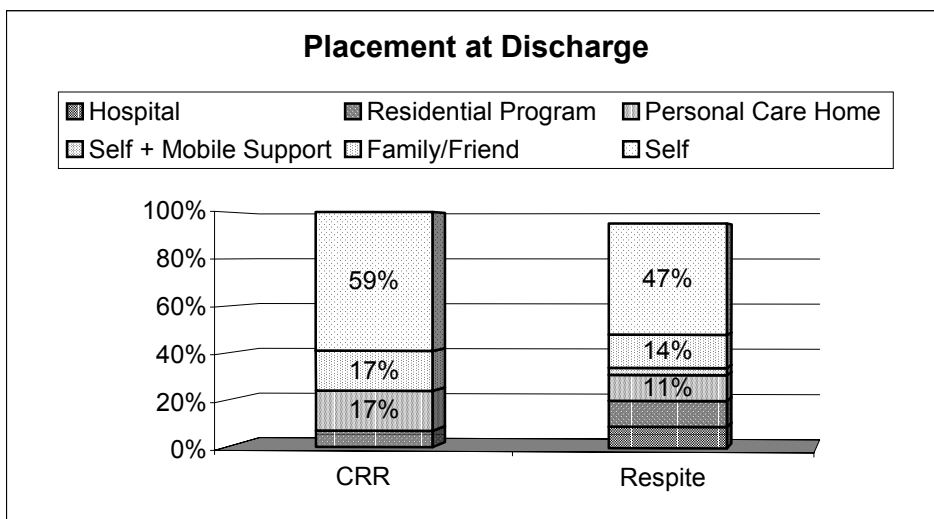


Figure 27

Mental Retardation Residential

Inputs and Activities. The Mental Retardation Residential Program consists of 14 homes for 42 consumers. Staff include 60 full-time and part-time direct care staff guided by 13 managerial staff. The program provides 24 hour supervised living for persons with mental retardation, or in-home supports to people living in their own homes. Training and support is provided to maximize independence in activities of daily living, participation in integrated community activities, and assistance with medical and psychiatric needs.

Functional Outcomes – Quality of Life. Eighty-eight percent (88%) of the residents were surveyed to assess their life circumstances in terms of what they actually do and experience (objective quality of life) and their feelings about these experiences (perception of quality of life). Objective quality of life was assessed by posing a number of questions to consumers or for consumers unable to answer, another person who knew the individual best. The questions were grouped into nine domains: residential goals, consumer’s choice, social inclusion, consumer’s relationships, individual’s rights, consumer’s dignity and respect, consumer’s health, consumer’s

environment, and consumer's security. One additional domain, consumer satisfaction, assessed consumers' perception of quality of life.

Figure 28 shows for each domain the percent of questions that were endorsed, or answered, in a positive direction. Eighty percent (80%) of the consumers endorsed all of the domains in a positive direction, and 100% of the consumers endorsed two domains – Dignity & Respect and Health – in a positive direction.

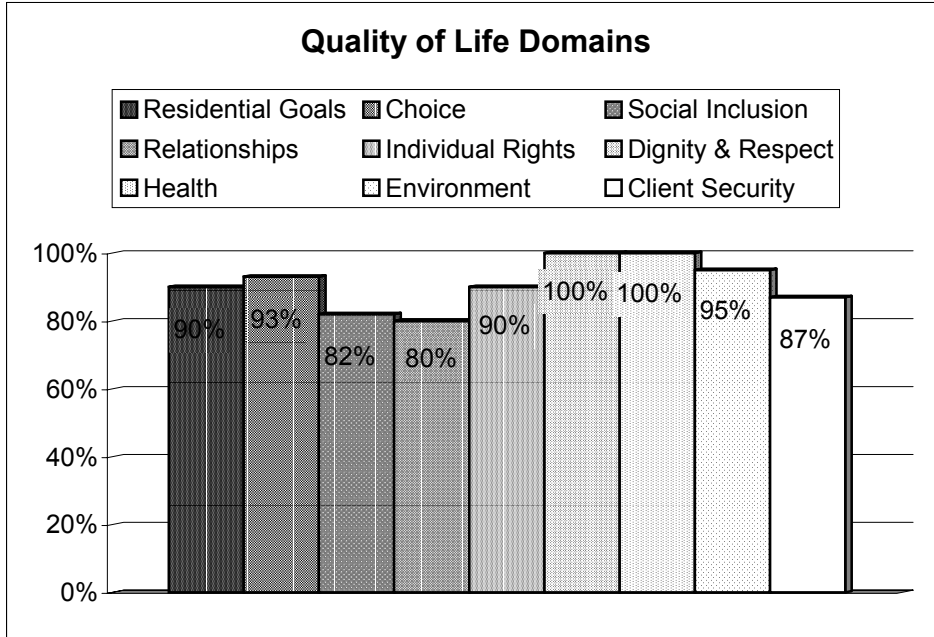


Figure 28

Perceptions of Process. Consumer satisfaction was measured with 4 questions. Figure 29 shows that the four questions were endorsed, or agreed with, in the positive direction 91% of the time.

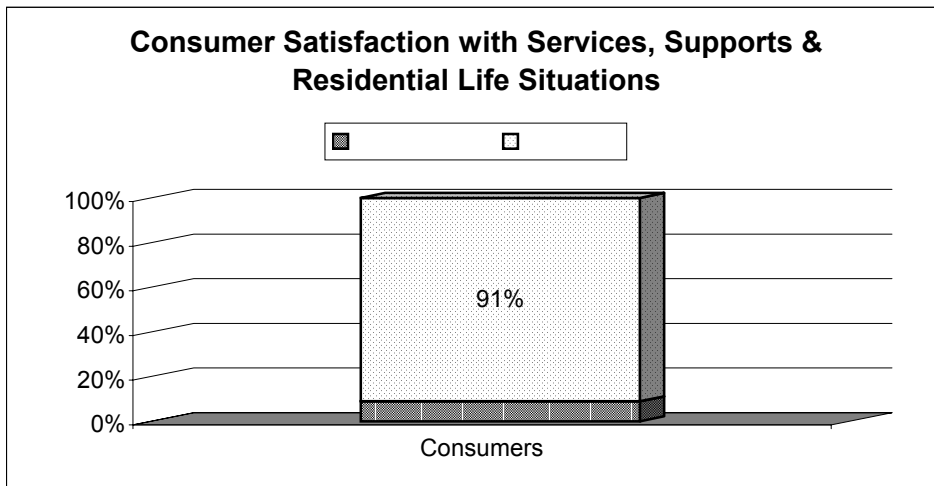


Figure 29

Future Directions

The data presented in this report serve two general purposes:

First, the data document the extent to which Family Services programs have been providing quality services. Without such data it is difficult to see what we have accomplished for the people who use our services. These data hold us accountable and ought to be shared with consumers and other stakeholders.

Second, the data provide feedback for future quality improvement. All of the effort put forth to collect these data will have been to no avail unless each program reviews its data and commits to improvement goals over the next year. Improvement goals should reflect improvement in the delivery of service and improvement in the data collection process.

Anything we can do, We can do better
