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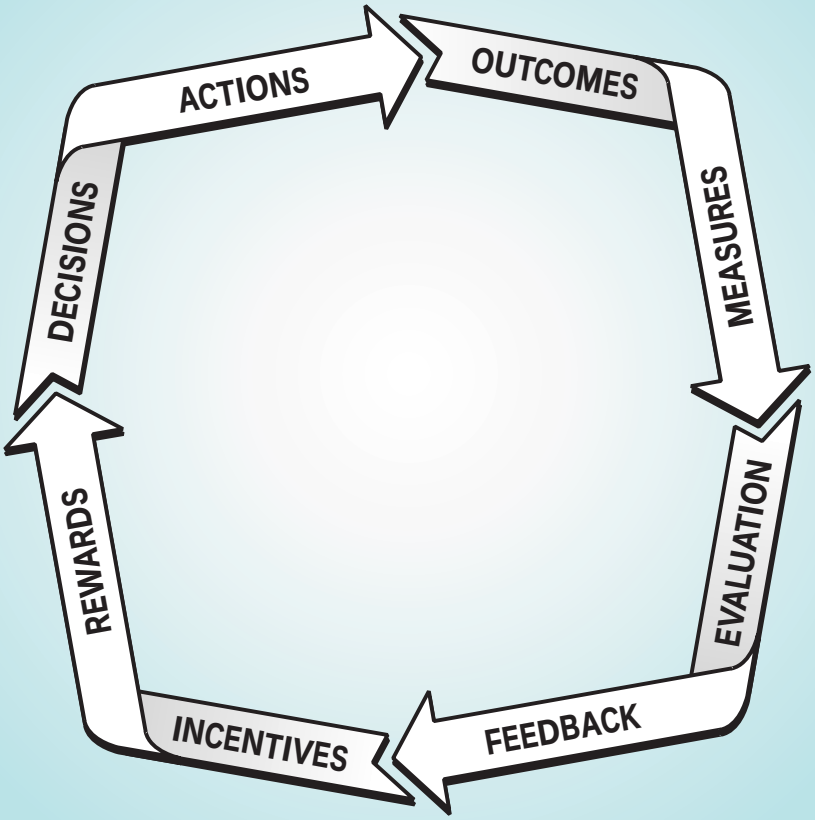
Celebrating Success:

A Self-Regulating Service Delivery System for Children and Youth



A DISCUSSION PAPER

Prepared for

The Federal/Provincial/Territorial Working Group on the Mental Health and Well-Being of Children and Youth

Canada

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Prepared by

The Sub-Committee on Self-Regulating Systems

for the

Federal/Provincial/Territorial Working Group on the Mental Health and Well-Being of Children and Youth

2000

Our mission is to help the people of Canada
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CONTENTS

EXECUTIVE SUMMARY

A SELF-REGULATING SERVICE DELIVERY SYSTEM FOR CHILDREN AND YOUTH

This paper outlines a model for service delivery to children and youth in the general population and those who are "at risk" of not maturing into healthy, well functioning adults. Children and youth at risk presently receive services through a variety of government departments and branches. Many difficulties arise from the present methods of service delivery. Self-regulating service delivery has the potential to address these fundamental difficulties in addition to bringing benefits for all children.

Self-regulating service delivery functions automatically. Once set in motion, this system seeks ever better outcomes for all children and youth. The system has four components.

The first component is a collection of outcome indicators that reflect the well-being of both children and youth in the general population and children and youth who use services. Indicators must be carefully chosen for their ability to reflect meaningful mental health attributes and they must be measured at regular intervals.

The second component is a regular feedback process to ensure that relevant information gets to everyone with a valid interest in children and youth, particularly those who can influence and/or direct services.

The third component consists of the use of powerful incentives contingent upon the outcomes. This action reduces the influence of those factors that deflect an organization's purpose from its stated goals and enhances the focus on beneficial outcomes. The more powerful the incentives and the more they are attached to specific outcomes, the more likely those outcomes will be sought and produced.

The fourth and last necessary component is the capacity for making executive decisions that can keep all relevant organizations focussed on the outcomes.

The whole system functions on a regular cycle. Outcomes are measured and indicator data are produced. The indicator data, along with the earned rewards, are ultimately fed back to the executive. The decision makers adjust organizational functioning in attempts to gain better outcomes, and the consequent incentives, for the next cycle.

As a model, the self-regulating service delivery system is evaluated by comparing system-wide outcomes with previously set system goals. As a system, it is driven by our children's needs in the relentless pursuit of success for our children.

Celebrating Success: A Self-Regulating Service Delivery System for Children and Youth

INTRODUCTION

This paper presents a proposal for a conceptual model of service delivery that is applicable to all children and youth and in particular to children at risk. The phrase "children at risk" is used here to mean children and youth under 19 years of age who are experiencing or who are likely to experience mental, emotional or behavioural difficulties. These children and youth are considered to be "at risk" of not maturing into healthy, well-adjusted and productive adults.

Although the model is applicable in a number of situations, it is described here in a form most suitable for use for a system of care[1] operated by a Canadian province or territory. It assumes that citizens desire that all children and youth achieve optimal functioning and well-being. This serves the dual purpose of making the early years as experientially positive as possible and, in turn, providing a basis for optimal development into adult life.

This model arose to meet the challenges posed by the fundamental problems of present service delivery and attempts at reform.[2-5] In both Canada and the United States, reform has taken the direction of seeking systems integration, accountability, evaluation and cost efficiency.

The paper will cover the following topics:

- present service delivery to children at risk in Canada,
- fundamental problems with present service delivery,
- the self-regulating service delivery system and its four components,
- the dynamics of system action,

- how to develop and monitor the system,
- the role of government,
- evaluation of the model,
- implementation challenges,
- potential benefits and effects,
- implications for mental health service delivery.

PRESENT SERVICE DELIVERY IN CANADA

In Canada, the bulk of service delivery is mandated, funded and regulated by provincial and territorial governments which have created various non-government organizations and government-managed (public service) agencies to help children at risk and their families. The role of the federal government is generally confined to providing a portion of the funding through a variety of federal-provincial transfer agreements, many of which are being amalgamated into a Canada Health and Social Transfer Fund. Private for-profit organizations, foundations, and private practice clinicians who are not funded by government health care plans (e.g. social workers, psychologists) make a relatively small contribution to overall service delivery. All physicians (including child psychiatrists in private practice) are paid through government-funded health care services, usually on a fee-for-service or a contract basis.

Often, the service delivery organizations for children and youth are administered under as many as five general branches (mental health, child welfare, young offender, drug dependency and special education services). These may involve a variety of government departments (e.g. health, justice, education, social services or community services).[6] Together, these organizations and their contracted services form what is referred to as the formal system of care. This grouping is the closest Canadian equivalent to the use of the term in the U.S. Child and Adolescent Services System Program document, *A System of Care for Severely Emotionally Disturbed Children and Youth*.[1]

Two key research observations explain some of the dissatisfaction with the present delivery of services. First, the problems of children do not come as neatly divided as government departments do[7-9]; put another way, children's needs often cut across government departments. Second, the actual numbers of children at

risk[10,11] far exceed the capacity of consumer-centred service delivery. The service delivery system needs to extend beyond any single branch and to extend its reach, through prevention and population health approaches, to children and youth who are not yet registered clients, but who are at risk. The self-regulating service delivery system is designed for these additional requirements.

PROBLEMS WITH THE PRESENT MODE OF SERVICE DELIVERY

Experience with, and observations of, the present mode of service delivery have revealed a number of problems. These have been classified and described in various ways.[3,12] A few fundamental concerns are listed here:

1. The system of care (as opposed to its separate component organizations) often exists without either a mission statement or an understanding of relevant goals. In addition, there are few regular indicators of outcomes relevant to the clients or the general population that would measure some facet of goal attainment. In consequence, the system of care has problems both focussing on where it is going and determining whether it is getting there.
2. In the absence of valid indicators of child health, organizations are left open to many other influences, each of which comes with its own set of incentives and disincentives. As a result, organizations are open to the difficulties associated with serving many purposes that are above and beyond their reason for being — benefiting children at risk. Competing purposes include special interests or dislikes of executive officers, board members and politicians at all levels, as well as influences due to the media, special interest groups and the community's demand that the system provide employment.
3. There is little to no external incentive for efficiency (surplus dollars must often be returned to central coffers rather than be reinvested locally), producing better outcomes (no one knows what the outcomes are), coherent planning, priority setting or action.
4. There is no executive component that can cause the whole system of care to decide, act upon and implement coherent action.

5. It is difficult to judge the best distribution of resources among service delivery, prevention of disorder and promotion of wellness. Public health nurses, primary care physicians and kindergarten teachers are known to see many of these children and are therefore part of the resource expenditure, but little is known about what they do or how to incorporate or coordinate their activities within a system of care.[10]
6. Provincial and territorial governments have key roles, yet are themselves part of the problem. The various departments, subsections and numerous committees created inside government to mandate, fund and regulate services add to the complexity of service delivery.
7. The basic effect of all the above problems is that most existing systems of care are not true systems, but rather "collections of services" (p18).[13]

Although most provincial and territorial governments have recognized the issues and are actively seeking the means to address them, the problems remain.

A SELF-REGULATING SERVICE DELIVERY SYSTEM MODEL

The conceptual model of a self-regulating service delivery system represents an evolutionary step in service delivery. It is derived from the concepts of general systems theory – in particular, the terms and language of Miller's *Living Systems*.[13] This work has been chosen for its comprehensiveness and its internally consistent, integrated and coherent use of terms and definitions throughout.

At its most basic, a living system comprises a number of components that interact with and influence each other to maximize movement toward a predetermined goal. A living system has a number of inherent characteristics (p18),[13] four of which are the key to a self-regulating service delivery system:

- A living system has a purpose and goals.
- It has feedback loops to provide information on current status with reference to the purpose.
- It has an executive component that uses information to calibrate actions as it moves ever closer to attaining its ultimate purpose.

- It is an open system, that is, it is responsive to influences from the environment, particularly rewards, punishments, incentives and disincentives.

These characteristics, adapted and applied to a system of care and service delivery for children at risk, are described more fully in the following sections.

1. PURPOSE AND GOALS

The official purpose of an organization in a system of care is usually mandated by government and embodied in an organizational mission statement. This paper assumes that a mission statement would reflect a desire that all children and youth achieve optimal functioning and well-being as adults. Further steps in this direction require that goals be created from the mission, and that the goals would be measured through appropriate outcome indicators. As Miller notes, "In order to evaluate how well any system is attaining its specific purposes and goals, it is essential to obtain operational measures of performance." (p 651)[13]

The actual purpose of a system is established from observations of what it does (p 39).[13] Organizations may have multiple purposes and seek various goals to satisfy their single or multiple purposes. In a self-regulating service delivery system, the challenge of ensuring that the "official" purpose and the actual purpose are the same is met by demanding that activities be directed toward health status outcomes derived from the purposes noted in the mission statement.

Acting on a mission produces outcomes in two domains. A **consumer benefits** domain notes changes in active registered consumers of service delivery organizations.[14] A **population benefits** domain notes any reduction in deficits (disorders) and any building of assets (knowledge and skills) in the general population of children and youth.[15]

Determining health status outcomes is not a trivial step. If we are concerned about the well-being of all children and youth, not just of those receiving services,[16-18] then data that reflect the health and well-being of all children and youth need to be regularly collected using indicators that are sensitive to both regional and temporal variations.[19,20] Without these data, there is no measurement of the most important product of a system of care: the well-being of children and youth. Until this well-being is measured on a regular basis, governments cannot say for certain that their funding is having the desired effect,[21-23] and they will be likely to continue to focus on organizational interrelationships, services provided, and service utilization statistics at the expense of evidence pertaining to health status. A number of examples of the use of indicators already exist.[24,25] (See Table 1.)

Table 1. **Examples of Missions and Indicators**

MISSION FOR A SYSTEM OF CARE

The mission of a system of care is to reduce the prevalence of children at risk and to ensure that all children and youth reach their 19th birthday as healthy, well-functioning young adults.

CONSUMER BENEFITS

- recidivism rate for young offenders
- post-treatment drug abuse relapse
- number of placements, children in care
- changes in quality of life
- consumer satisfaction
- 5-year follow-up of eight-years-olds with serious disruptive behaviour disorders
- 3-year follow-up of functioning of children who have been sexually abused
- reduced numbers of stressors
- reduced rates of teenage pregnancy

POPULATION BENEFITS

Disability Reduction

- number of young offenders
- rate of child abuse

Asset Production

- school grade completion rates
- quality-of-life changes
- successful phase transitions to: healthy babies, school, teens, work

2. Feedback Loops

A feedback loop is a structure that carries information about a system's output back to the producer of the output to enable the comparison of the actual outcome with the desired outcome (p 36).[13] In other words, this comparison allows the executive to determine whether the production is meeting the desired mission and goals. Feedback requires a comparison level and a time frame for the information to be meaningful. Most importantly, it requires governments, service delivery organizations and the public to attribute high value to it, so that it will be used.

To provide feedback, a process must be developed to collect the relevant and significant outcome indicators, evaluate them, put them into a useable format[24-26] and convey them at regular intervals to the executives of the service organizations, funders, members of the government and the public. Formats should include summarizing statements and graphs. Newly developed indices would also be useful, such as a child and family well-being index comparable to the social problem index used in Alberta.[26] All could be published in a useful format that appears regularly – for example, a yearly "Progress Report on the Well-Being of Children and Youth for the Province of..."

The feedback content of one measurement cycle becomes the baseline data for the next.

3. EXECUTIVE CAPACITY

All living systems must have an executive component – an essential subsystem that controls the entire system.[13] Executive capacity includes four stages:

- establishing purposes and goals,
- analyzing and evaluating feedback on effectiveness, data from the environment (including incentives and disincentives) and information from the system's internal processes,
- developing options for action on the basis of the interpretation of the feedback,
- implementing action.

It is the executive component that enables a system to adapt to the many influences affecting it, maintain its purpose, and assume the responsibility for achieving its goals. If the executive cannot elicit compliance from the other subsystems to implement its decisions, then there is no system.

For most Canadian jurisdictions, when the collection of services directed to the interests of children and youth at risk is considered, no over-arching formal executive component can be found. The service organizations are subdivided into too many subgroups, and under too many different funding and policy authorities, to allow any decision making that binds all into coherent action. This problem has been recognized for decades. See, for example, the history of attempts at service integration as documented by Kagan and Neville in *Integrating Services for Children and Families*.[12] The authors also note the many efforts to address the problem. Articles and books on service delivery have made recommendations that run the gamut from heartfelt pleas to draconian legislation in bids to improve cooperation, coordination, collaboration, integration and amalgamation.[12,27] These various approaches are not reviewed in this paper. Suffice it to say that, for the most part, coherent decision making and action remain a problem.

Uncoordinated action becomes even more obviously troublesome when we consider that we now know that both clinical and prevention programs can make a positive difference in the lives of children.[28-32]

Usually, these observations lead to a recommendation that in a given jurisdiction (province, territory or region), an executive component needs to be created, one that is able to elicit compliance from enough organizations to act in accordance with the mission. However, although this executive component would be

helpful, such a recommendation is not essential to the development of a self-regulating service delivery system. In this model, governments are free to choose from a number of options, ranging from allowing the evolution of community decision-making bodies to legislating and appointing of a single regional authority for all services to children at risk. In all cases, implementation of this model is aided by government creation of an infrastructure to support organizations wishing to take cooperative action (whether client-, program-, policy-, organization-[12] or supra-organization–centred) in the interests of the task of eventually producing well-functioning adults.

4. INCENTIVES AND REWARDS

The challenge in service delivery is to incorporate a component that serves as a powerful inducer of action. Profit serves this function in business. The study of human behaviour has revealed many ways in which action can be induced and perpetuated (many of which are used by all of us as parents with our children). Thus, the fourth component of self-regulating service delivery is a structure of incentives and rewards.

A characteristic of living systems is that they are open systems with significant inputs, throughputs and outputs of information, matter and energy (the organization's resources and products) (p 18).[13] If any given system is to maintain a steady state in accordance with its purpose, then the system must adjust to the open inputs. An important subset of these external influences includes rewards or punishments. These can have a powerful effect on system functioning, indeed, upon the very purpose and existence of the system. As Miller hypothesizes, in reference to system functioning, "A component will comply with a system's purposes and goals to the extent that those functions of the component directed toward the goal are rewarded and those directed away from it are punished." (p 109)[13]

The task of governments, organizations, communities, business and the public is to develop incentives that are powerful, effective and contingent on better outcomes for children.[1,33,34] A transition needs to be made toward rewarding the outcomes instead of the process of delivery (management style, fiscal control, caseload and output counts). Powerful incentives attached to clearly defined outcomes will induce such action.

Consider the potential effect on organizations within a system of care, if, because of their effective work, they were to receive $1,000,000, congratulatory public recognition and highly esteemed awards. (An award of $1,000,000 to a region's

care organizations would be highly motivating, yet it represents a trivial overall cost in comparison to the hundreds of millions spent on at-risk children in many jurisdictions.)[35] Service providers and planners would focus their activities on those endeavours that were deemed most likely to produce good outcomes. Furthermore, communities could incorporate such recognition into their campaigns to attract business development.

If an outcome is the equivalent of a business product, then incentives must be as powerful as profits.

The examples in Table 2 illustrate a range of incentives that could be developed.

Table 2. **Examples of Incentives**

FINANCIAL

- $1,000,000 to region's organizations with the most improved baseline index of child and family well-being from the previous progress report
- $500,000 to the region with the second most improved baseline index
- large cash awards for specific products or indicators
- research funds
- financial savings to remain in a region for reinvestment in children

GOODS AND SERVICES

- computer products and services
- training and educational opportunities

RECOGNITION AND AWARDS

- state dinner and awards presentation (see below)
- volunteer-, child care worker- and clinician-of-the-year awards
- publicity of a region as the best place for families (and thus boosting industry and growth)

CELEBRATING SUCCESS WITH A PUBLIC AWARDS CEREMONY

Political leaders	present awards
Media	broadcast and publicize
Entertainment personalities	emcee and add interest
Business leaders	provide and win awards
Community leaders	receive awards
Service organizations	receive awards
Staff and the public	receive awards and a morale boost

THE DYNAMICS OF SYSTEM ACTION

Self-regulation is not a difficult concept. It works like heat control in a house. In the heat control system, the purpose is to provide warmth in reference to a goal (or standard) of how warm is warm enough. If the room temperature is not warm enough, the action taken is to turn on the furnace. The outcome of this action is measured by a thermometer and fed back to the executive centre (the thermostat). The function of the executive centre is to interpret the feedback (Does the room temperature meet the standard?) and make a decision (in this case, turn the furnace off or leave it on). This self-regulating heat control system operates continuously.

The self-regulating service system delivery model has a circular quality to its functioning such that it can be described starting from any component. Here, our description starts with the purpose and goals.

1. A mission, the purpose of the system of care, is established for children and youth. Goals and indicators are developed for the consumer and population domains.

2. Measurements are taken at regular intervals. At each interval, the raw research data are synthesized into significant outcome data and indices.

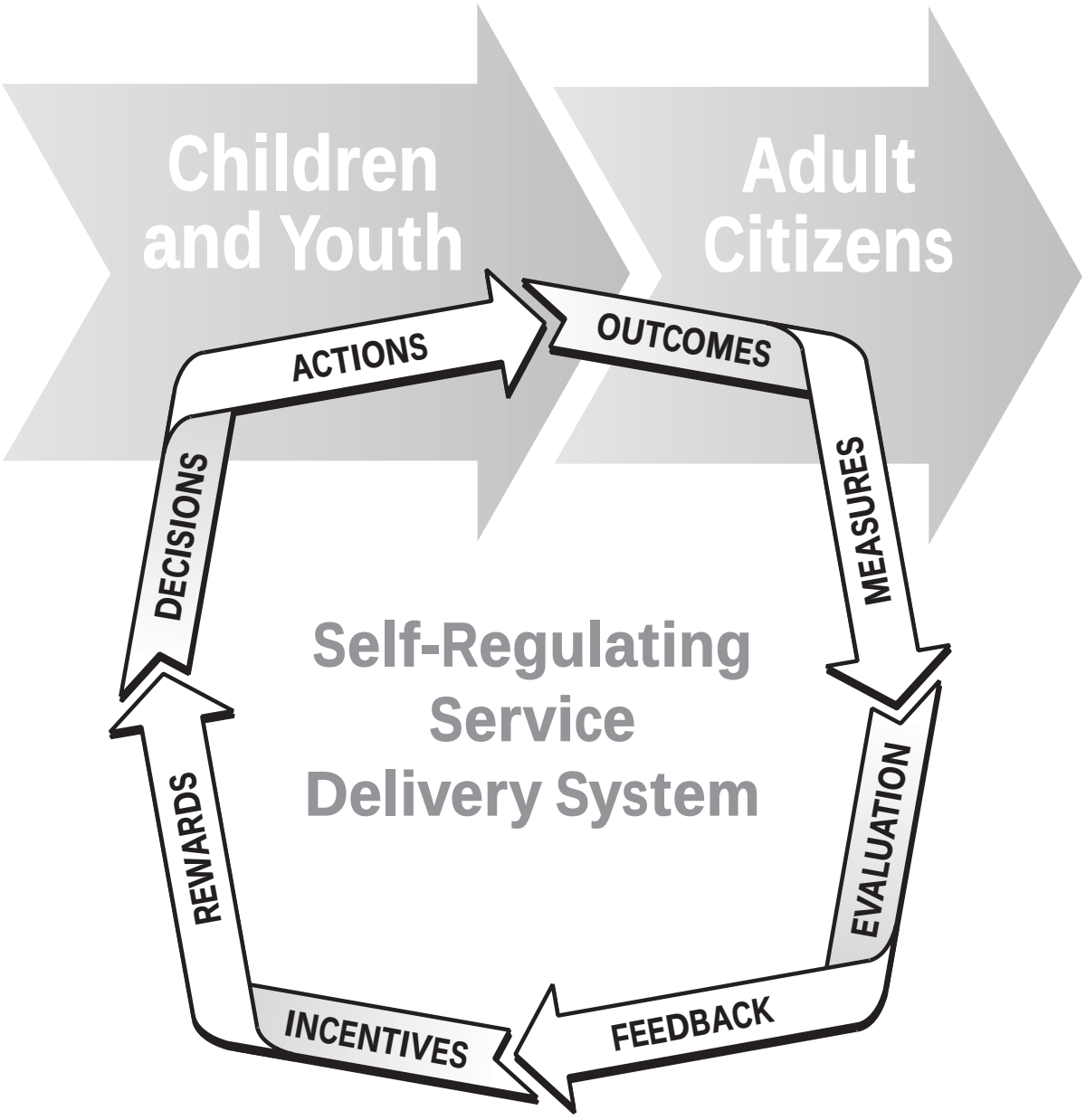
3. The results, representing a progress report of the well-being of children and families, are regularly provided to organizations, regional authorities, government and the public. The results from one cycle form the baseline for the next.

4. The rewards for specific achievements are given to the regions, organizations, communities or individuals in accordance with the incentive structure (e.g. highest prize for the region which has the most improved index of child and family well-being). The periodic and desired rewards become the incentives (e.g. rewards could be attached to reduced young offender recidivism rates and to reduced youth drug abuse rates to induce the decisions to develop effective preventive programs). Not only will the system flounder without strong rewards for achievement, the nature and importance of these rewards will reflect the importance of children in society.

5. The executives of organizations, and of systems of organizations, use the outcome indicators to evaluate progress toward the goals and associated incentives and rewards. The executives will also note that some important goals cannot be

achieved without cooperative action with others in the system of care (e.g. reducing the numbers of young offenders). Their own internal process indicators will help them decide which actions to take to lead to improved outcomes in the following years.

6. The cycle repeats itself, with all players striving to achieve their goals. Thus, each cycle will bring with it continuous improvement in the mental health of children and youth; the adults of the next generation. In the end, all will benefit.



Examples of practical outcomes with indicators that communities could choose and the effect of using the self-regulating service delivery system are listed in Table 3. The accompanying diagram (see previous page) illustrates this cycle superimposed on the mission of optimizing the health and well-being of all children as they move toward adult life.

Table 3. **Examples of the System in Action**

Goal: Reduce the number of young offenders.

Observation: No service organization or community acting alone can change this goal.

In a self-regulating service delivery system, potential steps are...

1. Set and measure the desired outcome (e.g. reduced numbers of new young offenders).
2. Facilitate the development of a regional structure that will ensure collaboration (e.g. a director responsible for all service components or a regional coordinating committee whose mandate is to produce a coordinated plan of action for all service components), allocate resources, and redirect services in response to the offender rates in its jurisdiction.
3. Ensure that all interested parties receive appropriately timed feedback on new young offenders.
4. Institute powerful incentives or rewards that are contingent on reduced delinquencies and other selected measures of well-being.

Goal: Balance clinical and preventive services for drug abuse.

Observation: We have dollars for clinicians but when times are tough, we have fewer dollars for prevention even if we seem to have effective programs.

In a self-regulating service delivery system, the potential steps are...

1. Set and measure the outcomes (i.e. relapse rate for drug treatment programs and rates of drug use in the community).
2. Ensure that the executive director of the drug abuse program has the authority to move resources between prevention and treatment programs in accordance with whatever mix of the two approaches produces the best overall outcomes.
3. Translate both sets of outcomes into a single index that best reflects progress toward the desired outcome, and provide this information to the executive director of the drug abuse program.
4. Institute powerful incentives or rewards that are contingent on movement toward the balanced outcome goal.

DEVELOPING AND MONITORING THE SYSTEM

Governing bodies need to development processes for each of the components deemed to be essential for the functioning of a self-regulating system. For outcomes, the process must result in the development, implementation and monitoring of appropriate indicators and appropriate feedback formats. For incentives, the process must result in the development, implementation and monitoring of powerful incentives to be attached to the most desired goals. Research is necessary for continued improvement in the choice and monitoring of both outcomes and incentives.

The beneficiaries of improved outcomes will be families, organizations delivering services, businesses (which benefit both from a better work force and from less crime), communities, governments and the public. Therefore, the development process should allow for representation from all these groups.

Once these processes have provided initial results and developed a strategy for ongoing monitoring, the self-regulating service delivery system can be put in place.

THE ROLE OF GOVERNMENT AND CONTROL OF THE SYSTEM

In a self-regulating service delivery system, the provincial and territorial governments have a major role in sanctioning and facilitating the development of the system and its control. Each government (in cooperation with organizations and the public) sets the conditions that allow the development of the system by:

- setting the overall mission, goals, indicators and feedback process for a system of care for children;
- creating subregions within its boundaries that are suitably prepared for self-regulation;
- ensuring that within each region, organizations exist that have the potential to implement programs derived from the mandate for all children and youth (no single organization need have the resources or mandate for total accomplishment of the mission);

- providing equitable allocation of resources;
- developing powerful incentives and rewards for successfully achieving the goals that were derived from the mission;
- facilitating cooperative activity by creating a supportive infrastructure and reducing barriers.

In effect, each government provides the dollars and the rules (including purpose and incentives) and the funded organizations produce the product.

In Canada, some of the major preconditions for the development of a self-regulating service delivery system already exist (regionalization, moves to equitable funding, adequate numbers and types of organizations to look after the needs of children at risk). Others are in development (removing barriers to cooperative action, recognizing a need for outcomes). Still others have not been considered at all, or a shift is needed from intention to action (mission statements, goals, outcome indicators and incentives).

EVALUATION

The test of the system lies in its ability to improve outcomes for children and youth in comparison to other models of service delivery management. Obviously, this evaluation cannot take place until the essential elements of a self-regulating system (clear goals with indicators, feedback, executive capacity and adequate incentives) have been in place long enough for the evaluation to be meaningful. In the end, the well-being of children is the decisive gauge of the effectiveness of this, or any other, approach.

IMPLEMENTATION CHALLENGES

Individual components of this conceptual model have appeared in the journal literature (e.g. outcomes,[14,16,17,20] progress reports,[22,25,36] incentives, and various methods of addressing the difficulties of coherent decision making between organizations[12]).

However, integration into an overall abstract conceptual model subject to the creation and testing of hypotheses has not. The first step in implementing a model is to make it available for consideration by interested parties. This paper is designed to meet that end. Furthermore, the model has been published in the scientific literature,[37] conference presentations have been made, and support materials have been made available through Health Canada. Communication about the model aside, there are four other challenges to the implementation of this model.

CONCEPTUAL MODELS AS A FRAMEWORK FOR ACTION

Governments and organizations need to adopt the practice of using conceptual models as a basis for planning. The self-regulating model particularly suits a government jurisdiction such as a province or territory and can be adapted to a large organization or network of organizations whose major mandate involves the care of children and youth. Three difficulties impede this use.

The evolution of service delivery by governments over decades has proceeded more by ad hoc developments to meet changing social circumstances and conditions than through the use of a conceptual model that builds in constant evolution. Many of these emergent situations cannot be ignored, and it is difficult to produce a conceptual plan that has the appropriate contingencies built in.

Governments frequently subdivide responsibilities for children into a number of departments for categories of children at risk and are often without any administrative centre for addressing the broader area of children in the general population. This fragmentation increases the difficulty in developing and adopting broader and more comprehensive policies and plans.

In their quest for accountability, governments often become over-involved in the day-to-day administration and monitoring of organizations that they fund. Governments may find it hard to shift from this micro-management style of control to a model where they exert influence by controlling the choice of outcomes and motivational factors.

THE USE OF OUTCOMES MEASURES

The development and use of outcome measures has mushroomed over the past decade. Despite this, there is much to be done before it can be said that adequate information at an acceptable cost is readily available to those who are responsible for program development and improvement.

If, for instance, the goals are for children to be safe, secure, knowledgeable, responsible, loved and healthy, then what measures currently exist that are

acceptable indicators? Some goals may lend themselves easily to suitable measurement techniques, but for others, as desirable as they might be, measurement techniques have yet to be developed.

Many challenges need to be met, including the choice of outcomes that are sensitive to temporal and regional variations, meaningful to the general public, comprehensive enough to be accepted as relevant to the overall state of children and youth, and independent of self-interested manipulation.

RECOGNIZING AND FOCUSSING MOTIVATION

Although research on outcomes is burgeoning, research on motivational factors influencing health and service delivery organizations is conspicuously underdeveloped. It is clear that financial profits will motivate an organization to provide a service, but tying some form of reward to mental health outcomes has yet to be evaluated. Three challenges are faced in the incorporation of the motivational component in the system:

- The first challenge is to recognize that organizations may have many motivational factors influencing their actions that may be more powerful than those contingent on the well-being of children and youth (making a financial profit, balancing a budget, keeping a government department out of the media, personal relations between executive directors of organizations).
- Once other motivational factors are recognized, those focussing on improved outcomes must be added to newly developed incentives and rewards and all must be strengthened for maximal effect. The influence of factors not focussing on outcomes should be reduced as much aspossible.
- The third challenge is to develop the methods that will ensure that all motivational factors will be focussed on improving outcomes for children.

One could hypothesize that the amount of power inherent in the motivational factors and the degree to which they are harnessed to better outcomes for children will determine the likelihood that children will show benefits over the years.

PARADIGM SHIFTS

The model suggests a different perspective on a number of areas of service delivery:

- the management of service delivery through the use of macro-, as opposed to micro-, management;

- the incorporation of the concept of working for rewards in an area of service delivery that many think should be driven primarily by altruistic motivations;
- the insistence of a focus on the amount of desired product (outcomes for children and youth) instead of on the process of production (various indicators of workload and flow through processes). Differentiating outcome indicators from process indicators is still a difficulty for some administrators.

All the above requires a paradigm shift that many administrators and managers may not yet be prepared for. Furthermore, shifting the momentum of an industry spending billions of dollars yearly[38] may be a bit like untying the Gordian Knot. Changing paradigms is sometimes easier to proselytize about than to practise.

Indeed, as Barker[39] notes, holding a strong belief in a particular paradigm (Kuhn[40]) can lead to a reluctance to give up activities that are believed in and familiar – a condition he termed "a terminal disease of certainty."

MEETING THE CHALLENGES

Despite the difficulties, the model takes a broad enough perspective and is simple enough that it is not only possible to implement it but it can be done in a set of gradual and evolving steps. The developing field of outcomes research is leading to the emergence of government publications on the state of children and youth in various jurisdictions. As these elicit ever better measures of the state of children and youth, more attention will be drawn to the value of having outcomes statistics. The very process of publishing actual outcome data will then drive the public, funding organizations, and governments to demand even greater improvement in outcomes. This development process alone will gradually change the face of service delivery and propel it even more strongly in the direction of self-regulation.

POTENTIAL BENEFITS AND EFFECTS

The most important potential benefit of the self-regulating system is improved functioning and well-being for children and youth. Indeed, this benefit, above all, should be the standard by which all service delivery is judged.

Nonetheless, there are a number of other potential benefits and effects:

- The system is applicable to both children receiving services and children in the general population.
- The system induces, as opposed to demands or pleads for, cooperative planning and actions inside a region. This leaves regions and communities more in control of their organizations and system of care.
- Communities and regions are free to be creative in the partnerships they develop in the pursuit of better outcomes for children.
- The data obtained provide useful information for decisions and action. The system makes it easier to link costs and outcomes. It enables better priority setting and action through choices of indicators and attached incentives. It makes it easier to determine the best balance of resource allocation among clinical, preventive and promotional activities for a region.
- The system can accommodate a variety of conditions regardless of whether these are produced by external factors (high unemployment levels, difficult socio-economic circumstances) or internal factors (resource limitations for service organizations).
- The system relies on basic principles that are similar to those found in business that ensure that profitable enterprises survive and those that lose money do not. The parallel is that organizations that are able to show an improvement in the mental health of children in their sphere of responsibility will continue to be funded. Those that are not able to demonstrate this will either change their approach or lose their financial support. The supposed heartless side of business is avoided because the “bottom line” differs between the two. Business revolves around financial gain, while the purpose of a child and youth organization is to improve the well-being of children and youth.
- The system is compatible with other management tools such as total quality management and continuous improvement systems.
- The system allows attention to specific problem areas by choice of indicators (e.g. three- and five-year follow-up of eight-year-olds with severe disruptive behavioural disorders).
- The outcome data gained will be useful for organizations, governments and the public in understanding children’s issues and advocating for solutions.
- The use of Incentives and rewards is much more likely to boost morale of front-line workers than other approaches that are punitive or unfocussed.

- Politicians supporting the development of and continued participation in this system are placed in a win-win situation: Children benefit and politicians bring positive action in support of communities and families.
- Governing bodies will not have to micro-manage, being freed to focus on "managing outcomes", that is, setting the rules, allocating resources, measuring and monitoring indicators, applying and monitoring incentives and celebrating successes.
- While most service delivery systems have arisen out of historical precedent and ad hoc solutions, as a model, this system is subject to the testing of hypotheses, including those associated with its potential benefits.
- This system is self-regulating and self-perpetuating.

IMPLICATIONS FOR MENTAL HEALTH SERVICE DELIVERY

Mental health services under the self-regulating system would focus more strongly on outcomes. For provincial and territorial governments, a number of problems of present service delivery in this area could be addressed by concentrating efforts on the establishment of the four components, by:

- developing and selecting mental health indicators that would serve for children and youth who are receiving services and for those in the general population, but who may be at risk;
- developing a feedback process that is valued, effective, and produced at regular intervals;
- developing strongly reinforcing incentives attached to the most desired indicators;
- creating, or facilitating the development of, an entity that can influence all mental health treatment, prevention and promotion services for children and youth. This "entity" is best described by its purpose than by its form. That is, its singular purpose is to improve the mental health of young people, but it might be a person, board or inter-agency group, and it could be appointed by edict, selected via competition, or elected. It might function by facilitation, leverage and/or

decree. Regardless of its form, it will be judged in terms of progress toward achievement of its mission.

A second set of implications applies to the research community. Simply put, there is a dearth of research on (1) the development and selection of key indicators of child and youth mental health, and on (2) the selection and application of rewards and incentives for activities that improve health and well-being.

There are a number of implications for mental health service delivery organizations. The desire by governments for accountability can be demonstrated through rewards, which may well provide the organizations the impetus to evaluate effectiveness. Furthermore, a well-chosen outcome goal will often be unattainable by any one agency. Any child and youth organization that wishes to meet its goals, be eligible for rewards, and, in some cases, to receive continued funding, will be highly motivated to join forces with other appropriate organizations in order to improve overall effectiveness.

Finally, there is also an implication for other models of service delivery. They, like this model, should be evaluated to determine effectiveness and benefits.

CONCLUSION

This paper proposes that the many long-standing and fundamental difficulties with service delivery can be addressed by a self-regulating approach. A self-regulating service delivery system places a major emphasis on regular measurements of outcomes in two domains: consumers of services and the general population. It depends on the development and regular use of powerful incentives focussed on the outcome indicators to drive a system of constantly improving outcomes. It suggests that a number of other features naturally evolve from it or are induced by it: better quality, improved accountability, interorganizational cooperation, less duplication, stronger community support, high staff morale, efficiency and better use of resources. As a system, it is driven by our relentless pursuit of success for our children.

"WHAT GETS MEASURED GETS DONE"

(Peters and Waterman [1982] *In Search of Excellence*)[41]

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