

Families & Communities Together

An Evaluation of Delaware's Child Mental Health Grant Initiative: Interim Data Report

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Executive Summary

Delaware's Families & Communities Together (F.A.C.T.) project is a six-year effort to establish a system of care for children with serious emotional disturbances and their families. Delaware is one of 60 sites that have received grants from the federal Substance Abuse and Mental Health Administration's Center for Mental Health Services to establish such systems of care. To date, F.A.C.T. has served 76 children. This report summarizes the evaluation data collected on the F.A.C.T. project through November 2003.

F.A.C.T. Participants

F.A.C.T. is intended to serve children aged 3 to 18 years (with a focus on those aged 9 to 14 years) who: are receiving special education services, *and* have mental, emotional, and/or behavioral problems, *and* are not functioning well in school, home, and/or community, *and* require the services of multiple state agencies. The evidence suggests that F.A.C.T. is serving its intended target group. The high proportion of children who received school-based services prior to enrollment in F.A.C.T. indicates that the special education criterion is being met. In addition, there are indications that the project is serving children with severe combinations of problems. Specifically, children have a pattern of risk factors indicating a greater potential for developing psychosocial problems. (For more information on the characteristics of F.A.C.T. participants, see pp. 3-9.)

F.A.C.T. Length of Stay and Service Costs

- The average length of stay in F.A.C.T. for the 33 children who have been discharged was a little over 16 months and ranged from less than 4 months to almost 2 ½ years.
- The total service costs for the project were approximately \$3.712 million in FY02 (for 45 clients) and \$4.290 million in FY03 (for 63 clients). The average cost per child was \$82,486 in FY02 and \$68,102 in FY03.
- F.A.C.T.'s FY03 average monthly cost of mental health services (services + case management) was \$3,084, \$1,155 less than the \$4,239 that is the monthly Medicaid Bundled Rate CMH receives for each child served.
- F.A.C.T.'s average total monthly service costs (services + case management + special education) were \$6,874 in FY02 and \$5,675 in FY03. The average monthly ICT residential placement cost in FY02 was \$13,333.
- F.A.C.T. expenditures on 24 hour services comprised 49% of its total mental health services expenditures (24 service costs + non-24 hour service costs) in FY02 and 32% in FY03. CMH expenditures on 24 hour services comprised 55% and 53% of its total mental health services expenditures in FY02 and FY03, respectively.

Child and Family Functioning

At the national level, children across the grant sites who have been participating in the national evaluation study for two years, the trend is that reported problems and levels of impairment decrease over time, although gradually and slowly, and for many children

there are still substantial areas of clinical concern. While some children show improvement in behavioral and emotional strengths, most either remain stable or decline.

The F.A.C.T. evaluation needs to increase the participation in the national evaluation interviews, conduct more sensitive analyses on current data, and obtain data from educational records before it will be able to report meaningfully about the trends in these variables for Delaware. (Discussion of the data that are currently available can be found on pp. 13-21.)

Satisfaction with Planning and Services

High levels of satisfaction with planning and services were reported by family members and other participants in clinical services planning meetings in three different types of assessments of satisfaction. However, satisfaction with services has not necessarily translated into satisfaction with the progress their children are making. Considering that many children in F.A.C.T. appear to have multiple, complex, and challenging needs, the disparity between satisfaction with services and progress is not necessarily surprising or problematic, as progress might be expected to be slow and gradual. (See pages 21-22 for more information.)

Implementation of the System of Care

One of F.A.C.T.'s objectives is to successfully establish a "system of care" for the target population. To achieve this success, F.A.C.T. must (1) enhance family involvement in the service system, (2) provide a complete array of community-based, family-focused, and culturally-competent services in the least restrictive environment that is clinically appropriate, (3) apply a validated clinical services management model, and (4) sustain the system of care for the target population after the grant ends. According to two external assessments, F.A.C.T. has had some success in involving families in project governance as well as in service planning and provision. Its major challenge has been the development of a partnership with a family support and advocacy organization, a challenge that is being addressed. One of these external assessments also reported that a well developed service array is available in most parts of the state to meet most needs. Concerns about the services raised in this assessment were the limited access to respite care and therapeutic foster care, along with geographic issues which limit other service availability and/or accessibility in parts of the state, and case load size. (See pages 22-25 for more detail.)

Acronym Glossary

ADHD	Attention Deficit Hyperactivity Disorder
CMH	Delaware Division of Child Mental Health Services
CSC	Clinical Service Coordinators
DSCYF	Department of Services for Children, Youth & Their Families
F.A.C.T.	Families and Communities Together
FACTS	Families and Child Tracking System
HSO	Human Systems and Outcomes
ICT	Interagency Collaborative Team
ICST	Interagency Child Service Teams
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
QSR	Quality Services Review
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMHSA/CMHS	Substance Abuse and Mental Health Services Administration/Center for Mental Health Services
SOCA	Systems of Care Assessment

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Families & Communities Together

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Introduction

Delaware's Families & Communities Together (F.A.C.T.) project is a six-year effort to establish a system of care for children with serious emotional disturbances and their families. Delaware is one of 60 sites that have received grants from the federal Substance Abuse and Mental Health Services Administration's Center for Mental Health Services (SAMHSA/CMHS) to establish such systems of care. This report summarizes the evaluation data collected on the F.A.C.T. project through November 2003.

The F.A.C.T. Project

The goal of F.A.C.T. is to create a comprehensive, coordinated spectrum of behavioral and other services for children aged 3 to 18 years (with a focus on those aged 9 to 14 years) who:

1. are receiving special education services locally and/or through the State Interagency Collaborative Team (ICT) (see Appendix B for a description of the ICT) *and*
2. have mental, emotional, and/or behavioral problems *and*
3. are not functioning well in school, home, and/or community *and*
4. require the services of multiple state agencies.

F.A.C.T. is a statewide effort originally designed to serve 15 children each in Sussex and Kent Counties and 20 children in New Castle County. In December 2003, the project expanded its capacity in New Castle County by 15 families.

F.A.C.T.'s objectives are to:

1. Successfully establish a "system of care" for the target population.
2. Enhance family involvement to establish a full family-professional partnership.
3. Enhance the service system by adding new, appropriate services to provide a complete array of community-based, family-focused, culturally-competent services in the least restrictive environment that is clinically appropriate.
4. Apply a validated clinical services management model, creating Interagency Child Service Teams (ICSTs) to work with each child and family locally to ensure individualized assessment, service planning, clinically appropriate services, and on-going care management.
5. Sustain the system of care for the target population after the grant ends by reducing utilization of deep-end and out-of-state services, creating less intensive/restrictive services in Delaware, utilizing care management practices, and optimizing federal cost recovery to support the service system.

F.A.C.T. is coordinated by Delaware's Division of Child Mental Health Services (CMH) in the Department of Services for Children, Youth, & Their Families (DSCYF). The project

involves collaboration among other state agencies, community partners and Delaware families. The other state agencies involved are DSCYF's Divisions of Youth Rehabilitation Services and Family Services, the Department of Education, and the Division of Developmental Disabilities Services of the Department of Health and Social Services. In addition, F.A.C.T. currently partners with Children and Families First to foster the development of the Delaware Chapter of the Federation of Families for Children's Mental Health, a family-run support and advocacy organization for families of children with mental health issues.

Evaluation Methods and Data Sources

The evaluation data summarized in this report come from a combination of interviews, surveys, and analyses of secondary data. The specific sources of data are:

- *F.A.C.T. national evaluation interviews.* The F.A.C.T. project participates in the national evaluation of the federal grant program. At the time of enrollment into F.A.C.T. families are invited to participate in the national evaluation study, which involves interviewing families shortly after entry into F.A.C.T. and every 6 months after that. The interviews consist of a battery of questions that gather detailed information from children (if eligible to participate) and their parents, caregivers, or primary staff caregivers (depending on the child's living situation at the time of each interview) on child and family outcomes. (See Appendix C for brief descriptions of the instruments used in the national evaluation interviews.) As of July 2003 (the cutoff date for the analyses of data collected from this method), 18 families had participated in baseline interviews, 14 in the 6 month follow-up interviews, and 10 at the 12 month follow-ups. Because of the low participation rate, the interview data cannot be generalized to the F.A.C.T. project as a whole and are also not sufficient to support conclusions about the effectiveness of F.A.C.T.
- *National comparison data.* The federal Center for Mental Health Services contracts with ORC MACRO International to coordinate the overall national evaluation effort and compile national evaluation interview data from all grant sites. This report uses the data to compare F.A.C.T. participants to participants in similar projects across the nation.
- *FACTS information system.* DSCYF's management information system, known as *FACTS* (Family and Child Tracking System), provides data on F.A.C.T. participants' demographic characteristics, service use, and involvement across DSCYF Divisions. *FACTS* data come from DSCYF staff and contracted providers.
- *F.A.C.T. records.* In addition to the data kept in the *FACTS* system, the F.A.C.T. project keeps records on client characteristics and functioning, service use, service costs, and satisfaction.
- *Quality Services Review (QSR case studies).* In December 2002 and January 2003, the consulting firm Human Systems and Outcomes (HSO) reviewed the quality of the ICT, CMH, and F.A.C.T. systems. The assessment was based on two dimensions of the system, child status and service performance. These dimensions were examined in detail in intensive case studies of 39 individual children (16 ICT cases, 15 ICT/F.A.C.T. cases, and 8 CMH cases), selected to ensure diversity across age, sex, and county. The ICT cases were also selected to ensure diversity of placements. The acceptability of the cases on indicators of

child status and service performance was rated using a 6 point scale, with 6 = optimal functioning and 1 = worsening problems. The case reviews also provided qualitative information about what was working and not working in the child's current situation, and a six-month prognosis.

- *MACRO Systems of Care Assessment (SOCA) Report.* At 18 month intervals, ORC MACRO, as part of its work related to the national evaluation of the SAMHSA/CMHS systems of care grant program, conducts site visits to examine whether individual grant programs have been implemented in accordance with systems of care principles and documents how systems develop over time to meet the needs of children and families. These visits involve interviews with staff, various grant stakeholders, service providers, and families and reviews of case records. On March 11-13, 2003, F.A.C.T. participated in its second SOCA visit and the highlights of the findings of that visit are included in this report.
- *F.A.C.T. Federal Site Visit Presentation.* On September 3-4, 2003, F.A.C.T. participated in its regularly scheduled site visit by representatives of SAMHSA/CMHS. These visits focus on the implementation of SOC grants, project strengths, and challenges faced. A final report from this site visit is not yet available. Information regarding F.A.C.T. project activities was presented to the site visit team. This documentation of project activities was reviewed as part of this report.
- *ICST Satisfaction Survey.* A survey administered at the end of each ICST meeting gauged the extent to which meeting participants felt the meeting and plans generated were consistent with system of care principles. Surveys were administered between early 2001 and the fall of 2003. Data were provided by 247 meeting attendees. However, the response rate cannot be determined as information about the overall number of meeting attendees was not collected.
- *FY2003 Division of Child Mental Health Services Service Provider Survey.* A survey administered August - October 2003 asked service providers for their perspectives on the CMH managed care system, including the F.A.C.T. project. Thirty-four providers responded. The response rate cannot be determined because the survey was open to all levels of providers, from Chief Executive Officers to clinical staff, in the 31 agencies in the CMH system.

Who does F.A.C.T. serve?

As described above, F.A.C.T. is intended to serve children who are now being served through special education and/or the State ICT, have mental, emotional, and/or behavioral problems, are not functioning well in school, home, and/or community, and require the services of multiple state agencies. This section presents information about the children and families the F.A.C.T. project serves. Included in this section are basic demographic data, information about child and family history and risk factors, previous service use, and psychiatric diagnosis. Sample sizes for the different variables change because the data come from different data collection instruments and different sources (parent/caregiver or staff person).

Demographic Information

Data sources: F.A.C.T. records, FACTS, and national comparison data

As of August 31, 2003, 74 children had been served by the F.A.C.T. project. Table 1 describes the 71 of these children for whom we have reliable demographic data. The table also provides comparable information for CMH as a whole and the national study sample of children involved in other grant projects. (See Figure A-1 for more information on the age of F.A.C.T. children at intake.)

Table 1. Gender, age, race/ethnicity, and custody status

	F.A.C.T.	DSCYF	National Study Sample
<i>Gender</i>			
Male	86%	61%	67%
Female	13%	39%	33%
<i>Average Age</i>	12.4 years	12 years	12.1 years
<i>Race/Ethnicity</i>			
Black or African American	45%	52%	33%
Hispanic	4%	.3%	10%
White	51%	48%	50%
<i>Custody Status at Intake</i>			
Parents	55%	n/a	67%
Relative	21%	n/a	13%
State custody	23%	n/a	9%
Sample size	71	7,832	3,821 to 4,028

Child and Family History of Risk Factors

Data sources: F.A.C.T. records and national comparison data

More than one-third of the children served by the F.A.C.T. project have had a previous psychiatric hospitalization (42%), run away without the caregiver knowing their whereabouts (37%), and/or been physically abused (36%). As shown in Figure 1, the F.A.C.T. children are more likely than the national comparison sample to have these experiences that place children at risk for negative mental health and/or developmental outcomes. F.A.C.T. children are also more likely to have experienced sexual abuse or to have been sexually abusive. Relative to the national comparison sample, the smaller proportion of F.A.C.T. children with a history of substance abuse may reflect F.A.C.T.'s recruitment of children through the special education system instead of through a variety of systems (e.g., juvenile justice, child welfare), as is the case in many of the other grant sites, and may also be function of the high proportion of children who have a mental retardation or developmental disability-related diagnosis.

Figure 1. % of F.A.C.T. Children Experiencing Risk Factors, Compared to National Sample

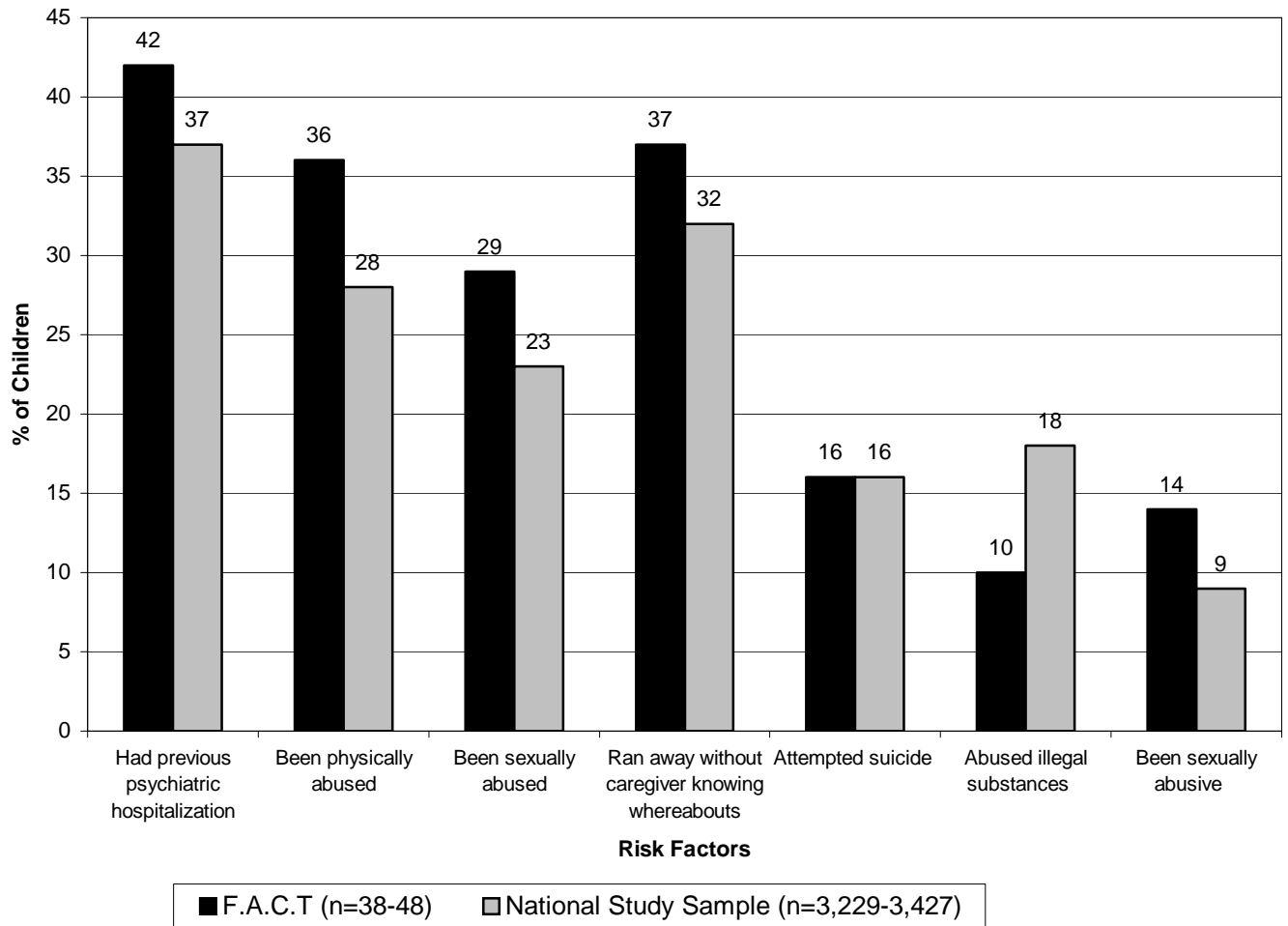
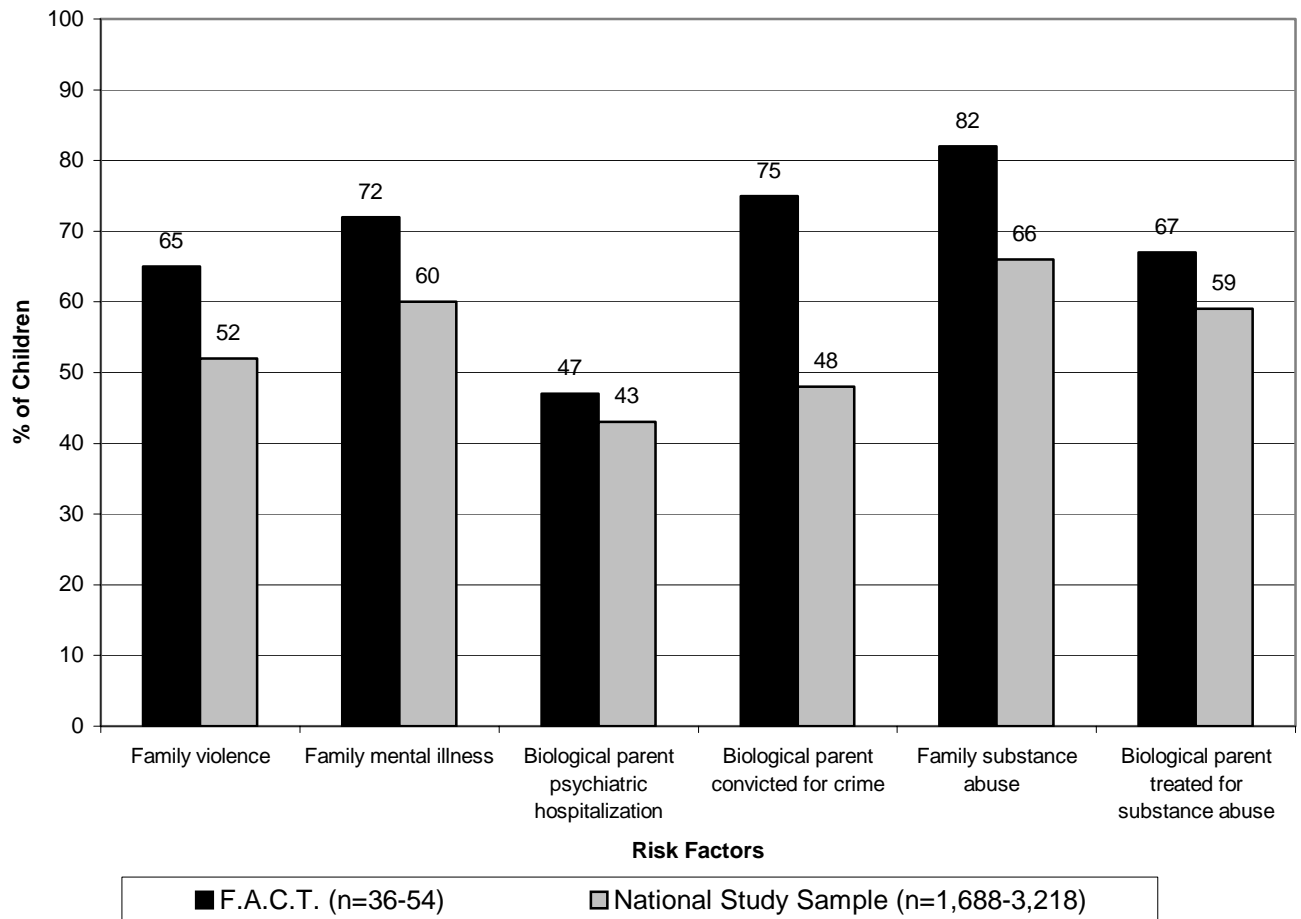


Figure 2 presents a picture of risk factors reported to be present in F.A.C.T. children's biological families (includes parents, siblings and other blood relatives). Most of the families have had experiences that are generally considered to be risk factors for the development of a variety of problems among children. Compared to the larger national comparison sample, the biological families of F.A.C.T. children have higher levels of these risk factors.

Figure 2. % of F.A.C.T. Children with Family Risk Factors, Compared to National Sample



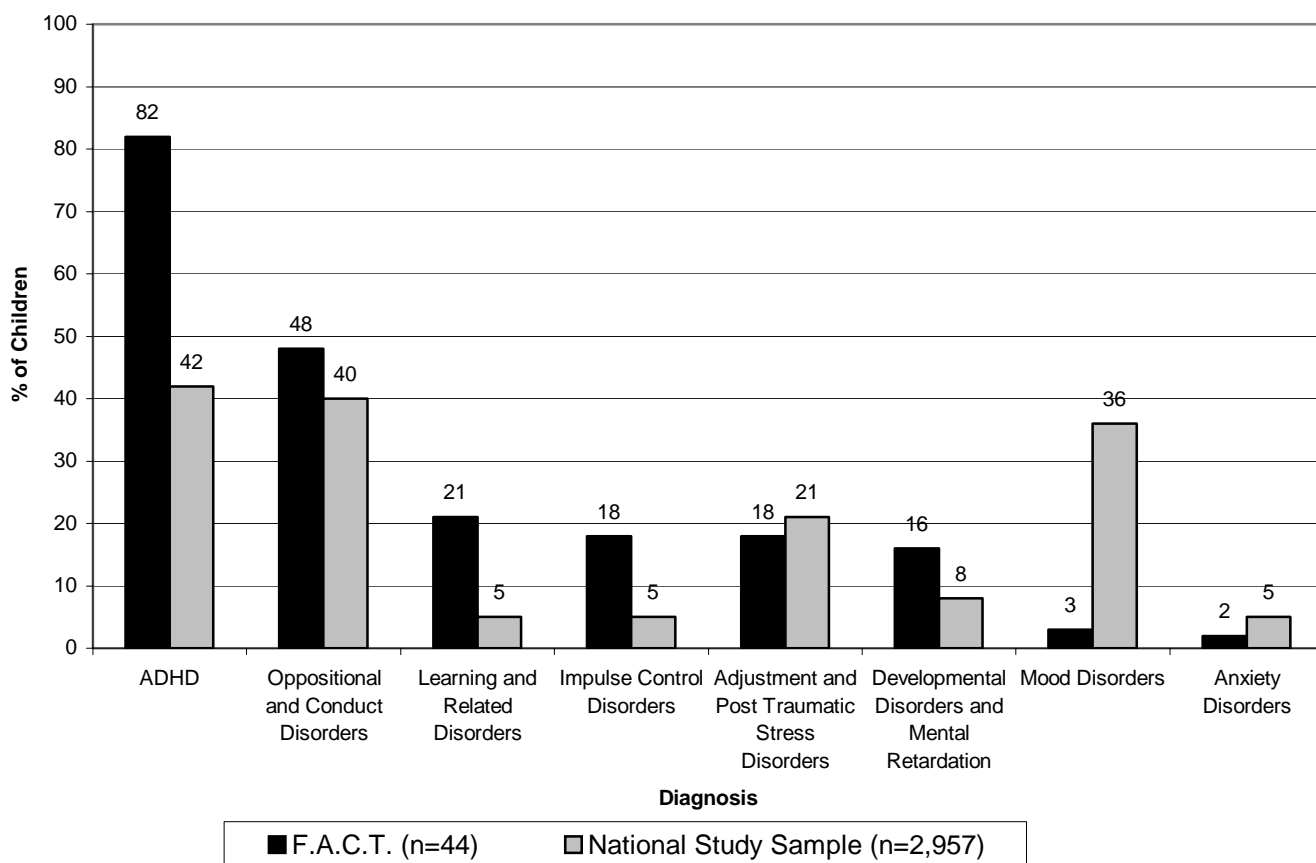
Psychiatric Diagnoses

Data sources: F.A.C.T. records and national comparison data

Of the 44 children for whom this data was collected with a standard data collection instrument, most (84%) had more than one diagnosis at the time of entry into F.A.C.T. Over 80% had been diagnosed with ADHD and close to half had been diagnosed with oppositional and conduct disorders. As shown in Figure 3, compared to the national comparison sample, F.A.C.T. children were:

- Four times as likely to have a diagnosis of a learning and/or related disorder,
- Three and a half times more likely to have a diagnosis of an impulse control disorder, and
- Two times more likely to have a diagnosis of a developmental disorder and mental retardation.

Figure 3. Psychiatric Diagnoses of F.A.C.T. Children, Compared to National Sample



The higher proportions of learning and impulse control disorders among F.A.C.T. children are probably a function of F.A.C.T.'s partnership with the education system. The higher proportion of developmental disorders and mental retardation among the F.A.C.T. children reflects the project's emphasis on the children most at risk of being placed in residential treatment.

Reviews of case records were conducted for all children served by F.A.C.T. (N = 76) as of November 2003 to determine the percentage with at least one mental retardation/developmental disability diagnosis.¹ Forty-six children (61%) had at least one diagnosis on DSM-IV Axes I, II, or III indicating mental retardation or a developmental disability, with 10 children (13%) having more than one such diagnosis. (See Figures A-2 and A-3 for more detail.) The most common diagnoses were those related to mental retardation.

¹ Other DSM-IV Axis I and Axis II diagnoses were not reviewed at that time. A decision was made that it was necessary first to explore issues of diagnostic practices before a reliable report could be provided. DD/MR diagnoses were judged to be more independent of these issues. Sources of these diagnoses, in order of preference, were neuropsychological evaluations, CAS evaluations, and most recent Service Admission Forms. Where conflicts were evident, preference was given to diagnoses made based on thorough assessments.

Service Use Prior to Enrollment in F.A.C.T.

Data sources: F.A.C.T. records

In the 12 months prior to entry into F.A.C.T., the 58-59 F.A.C.T. children for whom intake demographic questionnaire data were available used services in the following proportions:

- 97% used school-based services;
- 72% used outpatient services;
- 43% received day treatment;
- 39% received residential or inpatient treatment;
- 5% received treatment for alcohol or substance abuse.

Summary: Is F.A.C.T. Serving the Children it Set Out to Serve?

The evidence suggests that F.A.C.T. is serving its intended target group. The high proportion of children who received school-based services prior to enrollment in F.A.C.T. indicates that the special education criterion is being met. In addition, there are indications that the project is serving children with severe combinations of problems. Specifically, children have a pattern of risk factors indicating a greater potential for developing psychosocial problems. Information about diagnoses suggests that some children may present more demands on the service system because of the combination of developmental disabilities/mental retardation issues and other problems. Comparison data are needed, however, about children from the body of the CMH population before a more complete answer can be given about the extent to which the F.A.C.T. project is serving the children most at risk of residential care.

Patterns of Service Use

This section describes the F.A.C.T. project in terms of the amount of time that children are enrolled, the kinds of services that the children and their families use and the rates at which they use them, and the reasons for and types of involvement in special education. The information is related to the F.A.C.T. project goals of keeping children with severe emotional and behavioral problems in the least restrictive environments possible.

Children's Length of Stay in F.A.C.T.

Data sources: F.A.C.T. records

The amount of time that children stayed in the F.A.C.T. project was calculated using data from the 33 children whose cases had been discharged as of June 30, 2003 and the 38 children whose cases were active on that date.

For active cases:

- The average length of stay was almost 18 months
- As of the date of analysis, stays ranged from almost 3.5 months to more than 2 years 10 months.
- About 63% were enrolled in F.A.C.T. less than 2 years; 13% more than 2½ years.

For discharged cases:

- Nearly 95% of these children had been discharged in less than 2 years.
- The average length of stay was a little over 16 months.
- The shortest stay was less than 4 months and the longest was almost 2 ½ years.

Rates of Service Use

Data sources: F.A.C.T. records, FACTS

One goal of F.A.C.T. is to reduce the use of more restrictive services in favor of more community-based, family-focused services, such as behavioral aides and respite care. Tables 2 and 3 show service use as measured by average length of stay/service event for light, mid-range, and more restrictive services for the 12 months before enrollment in F.A.C.T. and the period in F.A.C.T. up to either discharge or the most recent updating of the service history record. The comparison shows that, on average, the children have used outpatient, wraparound and day hospital services for shorter periods during F.A.C.T. than before F.A.C.T. However, given the variability of the data, the patterns shown in these tables are not reliable.

Table 2. Average Length of Stay for Light and Mid-Range Services, Before and During F.A.C.T.

Service Type	12 months before enrollment in F.A.C.T.			During F.A.C.T. Enrollment		
	Average LOS (days)	Standard deviation	Min-Max	Average LOS (days)	Standard deviation	Min-Max
Crisis Bed (n=19)	6.9	12.7	Min – 0 Max – 54	10.5	24.8	Min – 0 Max – 166
Crisis Intervention (n=76)	18.3	23.4	Min – 0 Max – 147	17.4	35.6	Min – 0 Max - 373
Day Treatment (Mental Health) (n=15)	135.0	130.9	Min – 9 Max – 527	134.2	116.8	Min – 2 Max – 644
Intensive Outpatient (Mental Health) (n=10)	229.0	244.2	Min – 1 Max – 760	272.3	277.6	Min – 14 Max – 1492
Outpatient (Mental Health) (n=12)	309.9	317	Min – 19 Max – 1173	207.8	156.8	Min – 4 Max – 635
Wraparound Services (n=14)	303.6	211	Min – 0 Max - 651	261.1	257	Min – 0 Max - 1373

Table 3. Average Length of Stay for More Restrictive Services, Before and During F.A.C.T.

Service Type	12 months before enrollment in F.A.C.T.			During F.A.C.T. Enrollment		
	Average LOS (days)	Standard deviation	Min-Max	Average LOS (days)	Standard deviation	Min-Max
Day Hospital (n=11)	94.7	77.8	Min – 5 Max – 256	62.1	51.7	Min – 0 Max – 256
Psychiatric Hospital (n=24)	12.08	9.9	Min – 0 Max – 40	30.9	69.3	Min – 0 Max – 483
Residential Treatment Center (Mental Health) (n=5)	251.60	231	Min – 4 Max – 603	209.2	202	Min – 5 Max – 1015
Treatment Group Home (n=2)	372.00	288.5	Min – 168 Max - 576	372.0	288.5	Min – 168 Max - 576

Children's Involvement in Special Education

Data source: F.A.C.T. records and F.A.C.T. national evaluation interviews

Records were reviewed for all children served by F.A.C.T. as of November 2003 (N = 76) to determine special education classification, if applicable.² Of these children, six either had no special education classification or no information was available in the child's mental health records pertaining to this issue. For children receiving special education services, eligibility is determined under one of the IDEA-defined classifications. The most common classifications were Emotional Disturbance (48%) and Learning Disability (27%). The remaining 24% were distributed across the categories of Autism, Educable Mentally Disabled, Hard of Hearing/Partially Deaf, Physical Impairment, and Trainable Mentally Disabled. See Figure A-4 for more information.

Sixteen F.A.C.T. caregivers involved in the national evaluation at baseline reported the reasons their children had an Individualized Education Plan (IEP). Although an IEP gives a single special education classification at a time, the caregivers reported multiple reasons. The most common reasons the caregivers gave for their child's IEP when they enrolled in F.A.C.T. were behavioral and/or emotional problems (85%), learning disabilities (64%), and developmental disabilities and/or mental retardation (42%). Speech impairments, physical disabilities, and vision or hearing impairments comprised the rest of the reasons for having an IEP. More than 75% of the caregivers gave more than one reason that their child had an IEP.

The interviews conducted for the national evaluation also ask about the proportion of time that children spend in different levels of intensity of special education. Table 4 shows that

² Documents reviewed to determine classification, in order of preference, were IEPs, other educational record documents, and information about educational classification from the FACTS database. IEPs were not on file at F.A.C.T. for all children, necessitating a review of these secondary sources in many cases.

most of the parents and caregivers participating in the national evaluation interviews report that their child spends more than 75% of their school day in special education classes.

Table 4. Types of Special Education Placements per F.A.C.T. National Evaluation Participant Report

Special Education Placements	Baseline (n=16)	6 months (n=13)	12 months (n=10)
Spending more than 75% of their school day in special education classes	70%	76%	80%
In a class with at least some children who were not involved in special education	50%	36%	10%
In at least one class where all children were involved in special education	75%	79%	80%

Service Costs

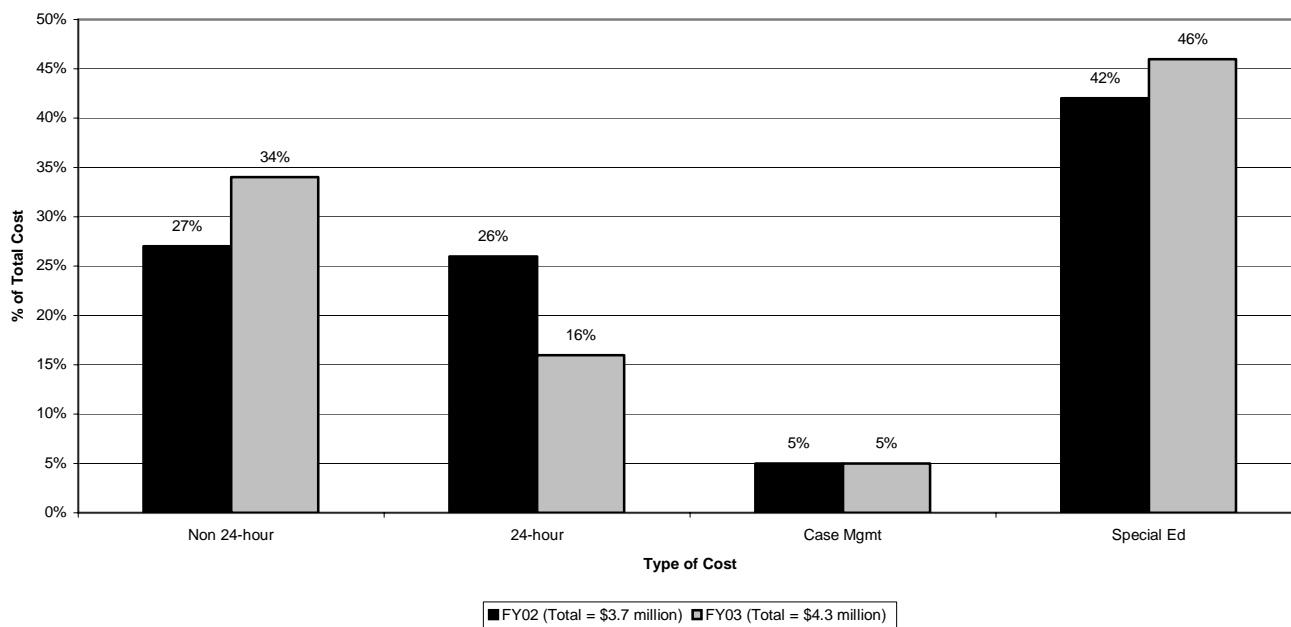
Data source: F.A.C.T. records

The F.A.C.T. project compiled data on the cost of services received by children in the project in fiscal years 2002 and 2003 from project records, the CMH data unit, and the Department of Education. Based on this data, the total service costs for the project were approximately \$3.712 million in FY02 (for 45 clients) and \$4.290 million in FY03 (for 63 clients). The average cost per child was \$82,486 in FY02 and \$68,102 in FY03. As shown in Figure 4, the proportion of the total spent on 24-hour services decreased. Although we do not know if we can attribute the decrease to the F.A.C.T. project itself or the specific children served, a decrease in the costs of 24-hour services is one of the goals of the F.A.C.T. project.

Comparisons of the costs of F.A.C.T. services to data on other costs show that:

- F.A.C.T.'s FY03 average monthly cost of mental health services (services + case management) was \$3,084, \$1,155 less than the \$4,239 that is the monthly Medicaid Bundled Rate CMH receives for each child served.
- F.A.C.T.'s average total monthly service costs (services + case management + special education) were \$6,874 in FY02 and \$5,675 in FY03. The average monthly ICT residential placement cost in FY02 was \$13,333.
- F.A.C.T. expenditures on 24 hour services comprised 49% of its total mental health services expenditures (24 service costs + non-24 hour service costs) in FY02 and 32% in FY03. CMH expenditures on 24 hour services comprised 55% and 53% of its total mental health services expenditures for FY02 and FY03, respectively.

Figure 4. FY02-FY03 Comparison of Costs for All F.A.C.T. Children



Stability of Living and Educational Environments

Data sources: F.A.C.T. national evaluation interviews, QSR case studies

By providing community-based and family-focused services, F.A.C.T.'s system of care effort is intended to support more stable lives for the children it serves. Data on the stability of children's living and educational environments are available from the national evaluation component of the project evaluation. Relevant results from the Quality Services Review (QSR) are also provided.

Many children participating in the F.A.C.T. national evaluation interviews have experienced instability in their living and educational environments. (The reader is reminded that the small sample sizes for the interviews -- 18 at baseline, 14 at 6 months, and 10 at 12 months -- mean that the results are not generalizable to all F.A.C.T. participants.) Specific results are:

- At the time of the baseline interviews, fewer than 40% of children in the F.A.C.T. national evaluation had been in a single living situation in the previous 6 months, with an average of 2.9 living situations per child. At the 6 and 12 month follow up points 50% and 80%, respectively, had been in a single living situation, with averages of 2.1 and 1.7 living situations, respectively.
- At baseline, home (i.e., living with any combination of parents, living with friends or relatives, or living alone and independently) was the most commonly reported living situation (60%) followed by psychiatric hospital (30%). At 6 and 12 months, home (70% and 65%) and psychiatric hospital (20% and 29%) were still the most commonly reported situations.
- According to the parents and caregivers participating in the F.A.C.T. national evaluation interviews, their children are most commonly schooled at alternative

day schools across all data collection points (baseline – 76%; 6 months – 64%; 12 months – 60%). Public schools were the second most common school placement (30%, 42%, and 30%, respectively).

The F.A.C.T. cases included in the QSR were rated on four variables related to the child's living environment: school placement, home/residential placement, stability and safety. School placement indicates the extent to which the child was in the least restrictive educational environment consistent with his/her needs, age, ability, culture, and peer group. Home/residential placement refers to whether the child is in the least restrictive environment consistent with the child's needs, age, ability, culture, religion, and peer group. Stability refers to the number and type of transitions the child has experienced. Safety was assessed by considering family history, neighborhood, supervision, and risky behaviors. As shown in Table 5, safety had both the highest average rating and the largest proportion of acceptable cases. While school placement had the lowest average rating, stability had the lowest proportion of acceptable cases.

Table 5. QSR Ratings of Variables Related to Living Environment*

QSR Variable	Acceptable	Average rating
Safety (n=15)	87%	4.3
School placement (n=11)	82%	3.1
Home/residential placement (n=15)	73%	4.1
Stability (n=15)	60%	3.5

*Variables were rated on a 6 point scale, with 6 = an optimal condition and 1 = a bad and worsening condition. A case was considered to have an acceptable condition if it received a rating of 4 or higher.

Child Functioning, Problems, and Strengths

An overarching goal of the F.A.C.T. project is to decrease problematic behaviors while enhancing positive behaviors to produce better functioning across children's life domains. This section provides information related to this goal, drawing primarily on the F.A.C.T. national evaluation interview data. Where possible, data from F.A.C.T. program records and the QSR are also presented.

General Considerations

Clinical problems and outcomes can be assessed using a variety of approaches. One way is to examine problem behaviors and symptoms, with desirable outcomes equaling fewer problems/symptoms. Another way is to examine both problem behaviors and behaviors which reflect competencies and strengths, with improvement marked by a decline in problematic behavior *and* increases in positive behaviors. Yet another way is to assess a child's ability to function effectively in different life areas or domains, such as at home, at school, and with friends with improved functioning as the desired outcome.

Generally, the process of assessing outcomes is improved by using some combination of these or other methods. In recognition of this, the F.A.C.T. national evaluation interviews employ all three of these types of outcome assessment strategies. Functioning is assessed by the Child and Adolescent Functional Assessment Scale (CAFAS), problem behaviors are primarily examined by the Child Behavior Check List (CBCL) and the Youth

Self Report (YSR - the child version of the CBCL), and strengths primarily by the Behavioral and Emotional Rating Scale (BERS). Brief descriptions of these instruments are provided below; for more detail, see Appendix C.

This section presents data from these different scales. Please note that the results presented in this section are preliminary. Reliability assessments and more detailed analyses are needed to assess the extent to which outcome patterns can be attributed to F.A.C.T. instead of to the number of other factors not related to services received. At this time, conclusions cannot be made about the data or the effectiveness of the project.

Child Functioning

Data sources: F.A.C.T. project records, F.A.C.T. national evaluation interviews

The CAFAS provides ratings for children on eight life domains: School or Work, Home, Community, Behavior toward Others, Moods and Emotions, Self-Harm, Substance Use, and Thinking/Communication. On each domain, children receive a rating of:

- 0 (Minimal or No Impairment)
- 10 (Mild Impairment)
- 20 (Moderate Impairment), or
- 30 (Severe Impairment)

Average CAFAS scores based on ratings made by the F.A.C.T. Clinical Service Coordinators (CSCs) are presented in Figure 5. Average CAFAS scores based on ratings made as part of the F.A.C.T. national evaluation interviews are presented in Figure 6.

These two sets of CAFAS scores are presented separately because each set uses a different group of raters and different methods of gathering information on which to base the ratings. CSC CAFAS ratings are made based on the totality of information in the possession of a CSC (e.g., case records, direct contacts with families). F.A.C.T. national evaluation interview CAFAS ratings are derived from data collected during a structured interview with caregivers specific to the CAFAS, with ratings made by the interviewer conducting the interview or another member of the evaluation team. In Figure 5, scores are compared at four time points. These are not labeled by months passed because the intervals between ratings varied by individual case. The CAFAS scores presented in Figure 6 were collected at regular 6 month intervals for each case.

According to both sources of data, children in the F.A.C.T. project are most impaired in the life domains of School, Home, Behavior toward Others, and Moods and Emotions. The charts show a discrepancy between the CSC and F.A.C.T. evaluation team ratings of impairment in the Thinking/Communication domain. The procedural differences, in combination with the issues raised in the General Considerations section, may account for this and other differences seen in some scales between these two sets of scores. More detailed information on the CAFAS scores can be found in Tables A-1 and A-2.

Figure 5. Average CAFAS Scores - CSC Administration

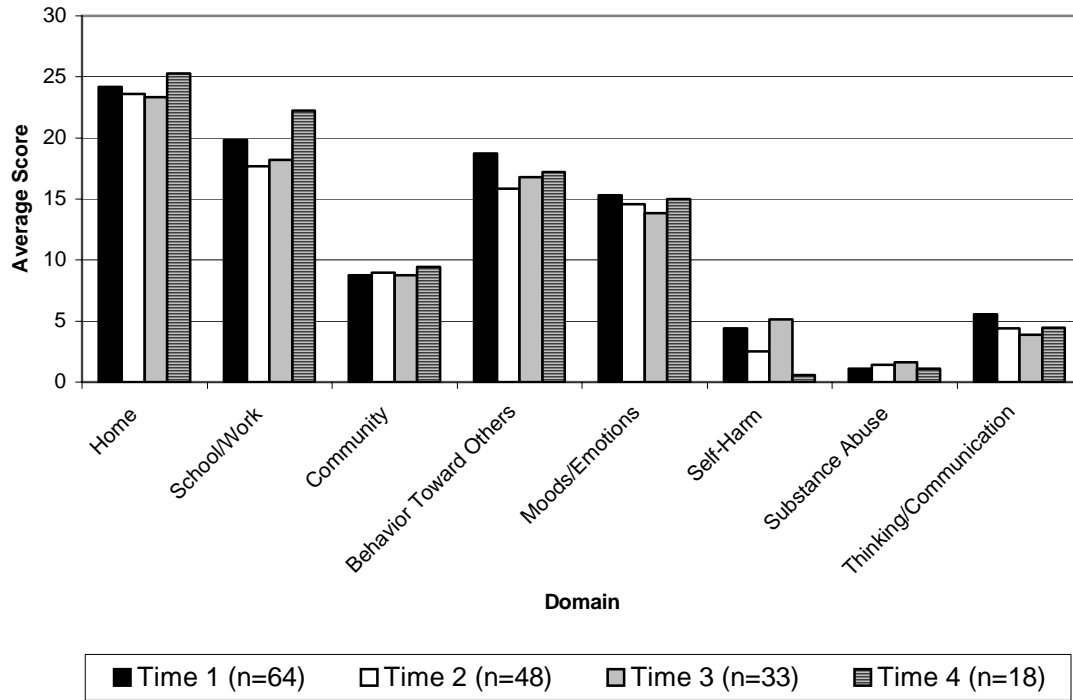
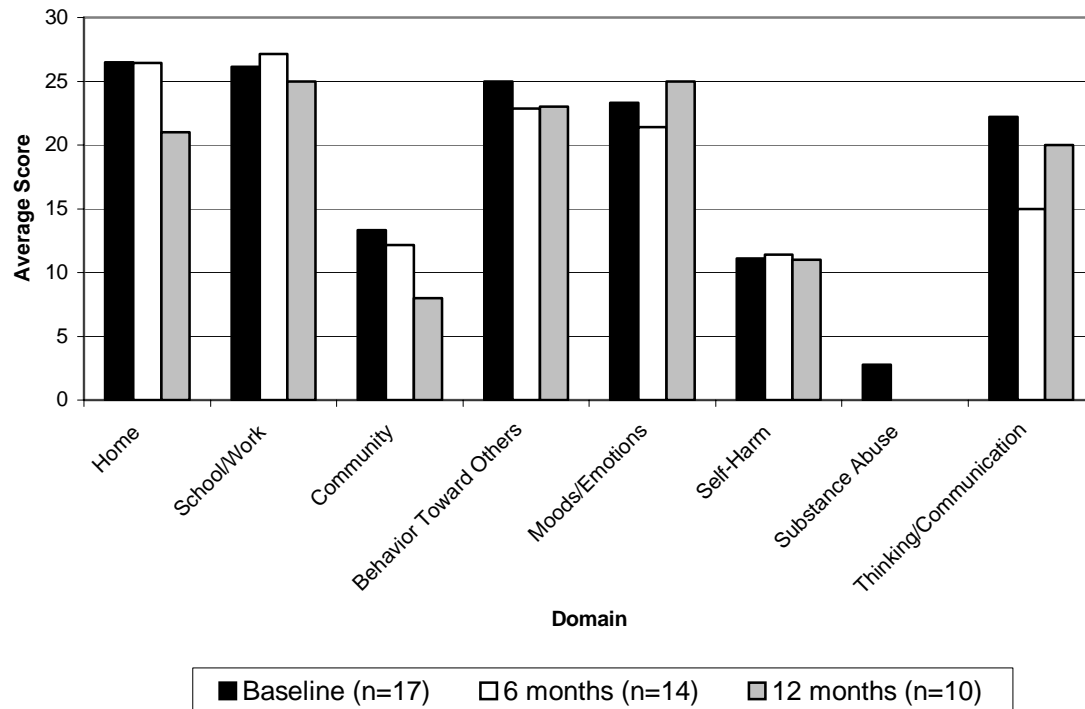


Figure 6: Average CAFAS Scores - National Evaluation Interview Administration



Problems & Strengths

Data source: F.A.C.T. national evaluation interviews, QSR case studies

The CBCL is a measure of problems and competencies and is completed by caregivers as part of the national evaluation interview. The YSR is the youth version of the CBCL and is completed through a youth interview. Both measures provide scores on a number of classes of behaviors/symptoms (e.g., anxiety, acting out, school competence). Based on the scores, children are classified as being in the normal range (scores less than 67) for a behavior class, the clinical range (scores greater than 70), meaning the behavior is at a level typically seen in children with behavioral and/or emotional problems, or on the border between these two ranges, called the borderline clinical range (scores from 67-70).

The BERS measures a variety of behavioral and emotional strengths children may have (e.g., sharing with others, interacting positively with others) and is completed via interview as part of the F.A.C.T. national evaluation interviews. The BERS also provides standardized scores for a number of different types of strengths.

For the CBCL, 18 caregivers were interviewed at baseline, 14 at 6 months, and 10 at 12 months. For the YSR, 14, 11, and 9 youth were interviewed at the respective data collection points. For the BERS, complete data are available for 17, 13, and 9 caregivers.

Analyses of the CBCL, YSR, and BERS data indicate the following:

- At baseline for the CBCL, total problems reported by the caregivers were in the clinical range (average score of 70.4). The average score did not differ much at the two follow up points (70.5 and 71.7 respectively).
- Caregivers indicated Internalizing Problems (e.g., anxiety, depression) were a moderate concern at baseline and 6 months, with the average score just above and just below the clinical range cut point. At 12 months, the average was nearly 5 points above the cut for the clinical range.
- Externalizing problems (e.g., acting out) were in the borderline clinical range at all three data collection periods (68.1, 67.7, and 67.1)
- Youth reported substantially fewer problems on average than did caregivers. No scores were in the clinical range with only 2 inside the borderline range. Average scores at follow up were consistently lower than baseline scores. (Note - marked differences between CBCL and YSR scores are not unusual. Youth in clinical populations generally tend to under-report problem behavior and over report strengths on the YSR.)
- The average BERS Strengths Quotient (an overall measure of strengths) at baseline was 89.6, just below the average range of 90 to 100. At the 6 and 12 month follow up points, average scores were 91.3 and 91.0.

Data related to child functioning, problems, and strengths are also available from the QSR. The QSR's case studies examined child status in terms of physical well-being, emotional/behavioral well-being, and evidence of progress in behavioral patterns, responsible behavior, risk reduction, developing meaningful relations, transition goals, and symptom reduction. As described in the methodology section above, each variable was rated on a 6 point scale, with 6 = an optimal condition and 1 = a bad or worsening condition. A case was considered to have an acceptable condition if it received a rating of 4 or higher. Results for the 15 children whose cases were included in the QSR are summarized below. More detail can be found in Table A-3.

- Physical health had the highest average rating (4.8) and the largest proportion of acceptable cases (87%).
- Progress toward behavioral goals had the second highest rating (3.9) and second largest proportion of acceptable cases (86%). The other variables with average ratings above 3.5 are emotional well-being (3.8) and responsible behavior (3.7). The other variable with a proportion of acceptable cases above 80% was progress toward risk reduction.
- Symptom reduction had the lowest average rating (2.5), and progress toward meaningful relations had the lowest proportion of acceptable cases (55%).
- The other variables with average ratings below 3.0 are progress in transition goals (2.7) and progress toward meaningful relations (2.7). The other variable with fewer than 70% acceptable cases is progress toward transition goals (64%).

Summary

The data on child problems, strengths, and functioning indicate that F.A.C.T. is serving a challenging group of children. Many children served by the project have marked impairments in multiple life domains. Data from the F.A.C.T. national evaluation interviews show higher levels of problem behaviors and somewhat lower levels of emotional and behavioral strengths than the average child. Levels of impairment, problems, and strengths are similar at follow up periods, but conclusions cannot yet be drawn about the impact of F.A.C.T. on these areas.

While it is premature to discuss the issue of progress or decline among children served by the F.A.C.T. project, it may be helpful to mention trends seen in the data from the larger national study sample. Baseline data indicate that F.A.C.T. children are similar to those in the large national sample with respect to reported problems, strengths, and primary areas of impaired functioning. For children across the grant sites who have been participating in the national evaluation study for two years, the trend is that reported problems and levels of impairment decrease over time, although gradually and slowly, and for many children there are still substantial areas of clinical concern. While some children show improvement in behavioral and emotional strengths, most either remain stable or decline.

School Performance and Behavior

Data sources: F.A.C.T. national evaluation interviews, QSR case studies

The F.A.C.T. national evaluation interviews provide a variety of data about school performance and behavior. Presented below are the results of analyses for attendance, academic performance, and disciplinary actions. Given the small number of families participating in the interviews, this information is not generalizable to all the families that F.A.C.T. serves.

The proportion of caregivers participating in the F.A.C.T. national evaluation interviews that reported that their child had been absent more than one day/month in the 6 months prior to the interview ranged from 60% of the 18 caregivers at baseline, 40% of the 14 caregivers at the 6 month follow-up, and 33% of the 10 caregivers at the 12 month interview. (See Figure A-5.) The national evaluation interviews assess school performance through parent report of grades using the traditional letter-grade system or through a determination of whether progress is satisfactory or not. At baseline, just over 50% of children in the F.A.C.T. national evaluation interviews were reported to have been graded using the traditional approach, more than 75% at the 2 follow up periods. The

following summarizes the data for both groups, those receiving a traditional letter grade and those receiving a determination of satisfactory or unsatisfactory progress:

- At baseline, no child received a grade below a “C”, with more than 40% receiving a “B” or better (Figure A-8). At 6 and 12 month follow ups, no child received a grade below “C”, and about 40% had grades of “B” or better.
- Of the second group of children, 50% were described as having made satisfactory progress at baseline. The 6 month data mirror the pattern at baseline, but at 12 months all children were reported as having made satisfactory progress.
- At baseline and 12 months approximately 60% of caregivers felt their children’s academic performance matched their abilities. At 6 months, this rate was just over 45% (see Figure A-6).

Parents participating in the F.A.C.T. national evaluation interviews were also asked whether their children had been suspended from school, been in after-school detention, or been expelled in the 6 months preceding the interview (see Figure A-7). The results of their answers are:

- At baseline, almost 60% of caregivers reported their children had been suspended, almost 30% had been in detention, and almost 20% had been expelled.
- At the 6 and 12 month follow up interviews, suspension rates were 8% and 30%, detention rates were somewhat lower than baseline, and expulsion rates were 14% and 0%.

Any trends observed in the data on school performance and behavior could be the result of those caregivers who had reported the highest number of absences and/or disciplinary actions at baseline dropping out before the follow-up interviews at 6 or 12 months. These data still need to be compared to data from school records before any conclusion can be made.

The QSR also examined evidence about the placement and performance of children in school. Table 6 provides the percentage and average rating of the applicable cases that were considered acceptable on school attendance, class participation, parent participation in education, and progress in assigned curriculum.

Table 6. QSR Ratings of Variables Relevant to Child Educational Services and Academic Performance*

QSR Variable	Acceptable	Average rating
School attendance (n=15)	93%	5.3
Class participation (n=15)	80%	4.2
Parent participation in education (n=15)	80%	4.8
Progress in assigned curriculum (n=14)	79%	3.9

*Variables were rated on a 6 point scale, with 6 = an optimal condition and 1 = a bad and worsening condition. A case was considered to have an acceptable condition if it received a rating of 4 or higher.

Family Functioning and Resources

Data source: F.A.C.T. national evaluation interviews

Having a child with a serious emotional and/or behavioral disturbance can place considerable stress on families and caregivers, and can strain family relationships and the resources (financial and non-financial) necessary for families to function effectively. In recognition of these potential impacts, the F.A.C.T. national evaluation interviews also contain questionnaires to assess caregiver strain, family functioning, and resources available to the family. Following are the summaries of the data on these issues provided by the F.A.C.T. national evaluation interview participants.

Caregivers were asked about the strain they experience day to day related to caring for their children served by the F.A.C.T. project. Three kinds of strain are measured:

- Internalized Strain, which includes worry, guilt, and fatigue caregivers may experience;
- Objective Strain, which focuses on things like trouble with neighbors, disrupted family relationships, and loss of personal time; and
- Externalized Strain, which includes caregiver anger and resentment toward the child.

Across all three data collection points, the F.A.C.T. caregivers participating in the national evaluation interviews reported higher levels of internalized strain (“quite a bit” of strain) than objective or externalized strain (strain was “somewhat” of a problem. Levels of each of these types of strain at the follow up points were similar to baseline levels. (See Figure A-11.) Data from the larger national comparison sample indicate that the F.A.C.T. caregivers participating in the national evaluation report similar levels of strain compared to other caregivers nationally.

Both caregivers and youth participating in the F.A.C.T. national evaluation interviews were asked about their family relationships, communication, the family’s ability to solve problems, and related issues as part of the Family Assessment Device (FAD). The FAD provides an overall score regarding family functioning. Overall scores for caregivers were roughly the same across the baseline and follow up points ranging from 2.7 to 2.9 (on a 4 point scale), indicating that caregivers thought their families were functioning relatively well overall. Youth ratings were similar to those provided by the caregivers (Figure A-12).

F.A.C.T. national interview data also provides data on the resource needs and challenges of families. The Family Resource Scale (FRS) asks about the following types of resources:

- Cash and Recreation, which includes money for necessities (e.g., monthly bills, special equipment), saving, and discretionary expenses (e.g., things for one’s self, family entertainment, toys, travel or vacation);
- Time and Social Support, including time for self care (sleep, rest, exercise, alone time), time with significant adults (partner, friends), and time with family;
- Basic Needs, which focuses on the adequacy of housing, food, clothing, and utilities, and money for necessities;
- Health Care/Social Services, which includes medical and dental care and public assistance; and

- Secondary Needs, like transportation, phone access, and a good job.

Results for the caregivers participating in the national evaluation interviews (17 at baseline, 13 at 6 months, and 9 and 12 months) indicate that at the first interviews:

- Basic Needs, Health Care/Social Services, and Secondary Needs were rated, on average, as “usually adequate.”
- Ratings for Time and Social Support and Cash and Recreation ranged between “seldom adequate” and “sometimes adequate.”

At the 6 and 12 month follow up periods, ratings of the adequacy of these resource categories were similar to their respective levels at baseline. (Figure A-12 shows the overall FRS score at the three data points.)

Satisfaction with Planning and Services

Data sources: F.A.C.T. national evaluation interviews, ICST survey, QSR case studies

This section presents data on satisfaction with planning and services. Since F.A.C.T. emphasizes family-centered, team-oriented, and strengths-based planning, understanding perceptions regarding involvement in the service planning process is essential to understanding satisfaction overall. The data comes from three sources -- the F.A.C.T. national evaluation interviews, F.A.C.T.’s Individualized Child Service Team (ICST) Satisfaction Survey, and the QSR case studies.

The ICST Survey was developed for the F.A.C.T. project and is a short measure of participants’ satisfaction with different aspects of the planning meetings. The survey was designed to be completed at the end of each ICST meeting by every meeting participant, including Clinical Services Coordinators, representatives from the schools, providers, representatives from other state agencies with which children may be involved, caregivers and youth, and family support resource people chosen by the family (e.g., a friend, family member, minister). Since families have a choice about who attends a given meeting and not every family will be involved with all partners, the number of actual meeting participants can vary greatly.

In response to the ICST Survey, at least 95% of the 247 meeting attendees who completed the survey (including parents and caregivers) indicated they ‘agreed’ or ‘strongly agreed’ that:

- The right people were on the team and at the meeting.
- The meeting was at a convenient time and place.
- Communication was open and honest.
- The meeting was conducted in accordance with System of Care principles. (strengths-based, respected and incorporated family views, customs, and beliefs).
- Necessary issues were discussed and plans updated as needed.
- The plan was a good one.
- Their input and contributions was respected and valued.

The only items receiving “agree” or “strongly agree” responses from fewer than 95% of the respondents are:

- I feel this is a good plan to support this child. (94% agree or strongly agree)

- The plan reflects customs and beliefs of the child and family. (94% agree or strongly agree)
- The team reviewed progress and implementation of the plan in terms of the long range goals. (93% agree or strong agree)
- The action plans to meet the long range goals were updated as needed. (91% agree or strongly agree)
- The safety of the child, family, and community was discussed and crisis plans reviewed if needed. (88% agree or strongly agree)

Details of the ICST results are presented in Table A-4.

Satisfaction with services is measured by the F.A.C.T. national evaluation interviews only at follow up interview points. Data for this group of families are as follows:

- Five (39%) of the 13 caregivers responding to the 6 month follow-up interview said that they were 'satisfied' or 'very satisfied' with the number of times they were asked to participate in meetings where services for their children were planned. Eight (62%) were 'satisfied' or 'very satisfied' when asked about their involvement in such planning meetings. Of the nine caregivers responding at 12 months, eight (89%) were satisfied with the frequency of invitations and seven (80%) were satisfied with their involvement.
- Ten (78%) of 13 of caregivers at 6 months and 7 (77%) of 9 at 12 months indicated they were 'satisfied' or 'very satisfied' with the services their children had been receiving in the previous 6 months.
- 12 of 13 (92%) caregivers at 6 months and 8 of 9 (89%) at 12 months felt that services had been helpful for their children.
- The level of satisfaction with their children's progress was lower than that for other satisfaction questions, with 5 of 13 (38%) of caregivers indicating they were 'satisfied' or 'very satisfied' at 6 months, 6 of 9 (67%) at 12 months.

The high levels of satisfaction reported in the ICST survey and the F.A.C.T. national evaluation interviews were also found in the QSR case studies. Twelve (86%) of the 14 parents/caregivers who participated in the case reviews indicated that they were at least minimally satisfied and eight of these were rated as either "substantially" or "optimally" satisfied. The average rating on the QSR's 6-point scale for satisfaction was 4.4. As the interview data provided above indicates, satisfaction with services does not necessarily translate into satisfaction with the progress their children are making. Considering that many children in F.A.C.T. appear to have multiple, complex, and challenging needs, the disparity between satisfaction with services and progress is not necessarily surprising or problematic, as progress might be expected to be slow and gradual.

Implementation of the System of Care

As described in the introduction to this report, one of F.A.C.T.'s objectives is to successfully establish a "system of care" for the target population. To achieve this success, F.A.C.T. must (1) enhance family involvement in the service system, (2) provide a complete array of community-based, family-focused, and culturally-competent services in the least restrictive environment that is clinically appropriate, (3) apply a validated clinical services management model, and (4) sustain the system of care for the target population after the grant ends. Although the evaluation activities have focused on gathering information on service use, satisfaction, and child and family outcomes, some

information on F.A.C.T.'s progress toward establishing a system of care is available. The sources for this information are the Systems of Care Assessment report based on a March 2003 site visit by federal evaluators, the QSR case studies conducted in December 2002 and January 2003, the presentation of the F.A.C.T. project to federal grant administrators in September 2003, and a survey of service providers conducted in August-September 2003.

Family Involvement

Data sources: F.A.C.T. Federal Site Visit Presentation, MACRO System of Care Assessment, QSR case studies, CMH Service Provider Survey

In March 2003, the MACRO System of Care Assessment report indicated that families are included in the governance and operations of F.A.C.T. The report also found that service planning and services are strength-based and family-focused and that families are actively involved in planning and driving services for their children. This assessment is consistent with the findings from the QSR case studies which found that 12 (80%) of the 15 cases had an acceptable level of family participation in service decisions. The average rating of family participation was 4.8 in a 6 point scale, with 6=optimal participation and 1=no participation. Somewhat less positively, a little over half (56%) of the 17 services providers who responded to questions about the F.A.C.T. project stated that F.A.C.T. had focused on full family involvement to a great or very great extent. However, the extent to which the views of these 17 providers represent the views of service providers participating in F.A.C.T. generally is unknown. (See Table A-5 for QSR results on all the system performance variables and Table A-6 for details on the responses of the service providers to the questions about the F.A.C.T. project in the CMH survey.)

Although generally positive about family involvement, the MACRO report noted that when families are involved with the Division of Family Services for family protection issues, family involvement faces some challenges. MACRO also identified the lack of a family support and advocacy organization as a challenge to the success of the system of care in Delaware. However, in September, the project reported that they had entered into a contract with Children and Families First to facilitate and support the development of the Delaware Chapter of the Federation of Families for Children's Mental Health. F.A.C.T. also reported that families continue to participate in various project committees and on the Child Mental Health Community Advisory Council. In addition, the project has funded family participation in national grant conferences and local, state, and national training around a variety of topics.

Array of Community-Based, Family-Focused, and Culturally Competent Services

Data Sources: F.A.C.T. Federal Site Visit Presentation, MACRO System of Care Assessment, QSR case studies, CMH Service Provider Survey

Having an array of services requires both the presence of appropriate services and coordination between services. According to the MACRO site visit report, a well developed service array is available in most parts of the state to meet most needs, and creative use of services to best meet family needs is evident. The MACRO report also states that F.A.C.T. has strived to make services more accessible by engaging in outreach activities and attempting to fill service gaps and expand service capacity. In addition, there is collaboration among project partners at the governance and service delivery levels, and that the CSCs play a central role in coordinating service delivery.

Of all the system performance variables assessed in the QSR, service coordination and availability of planning supports and services had the lowest rates of acceptable cases. For service coordination, 60% of the 15 cases were rated as having acceptable levels of

service coordination and (67%) were rated as having acceptable levels of planning supports and services. In addition, the proportion of service providers who said that F.A.C.T. focused on collaboration among agencies to at least some extent was not notably different from the proportion who said that CMH focused on collaboration to at least some extent (94% of 17 compared to 97% of 33, respectively).

Limited access to respite care and therapeutic foster care, along with geographic issues which limit other service availability and/or accessibility in parts of the state, are concerns raised by MACRO about the project's array of services. The report also noted that case load size is a barrier to better service and transition coordination. More work needs to be done with respect to coordinating the activities of other agencies with a child's overall service plan. Recently, however, according to the project's September report, it has added Individualized Residential Treatment to the service array and is working to further expand available services by developing Requests for Proposals for Respite Care and Intensive In-Home Outpatient Therapy. Since the MACRO site visit, F.A.C.T. has expanded its capacity from 50 to 65 families by adding a fifth CSC to its staff, but this will not reduce case loads. The QSR found that 87% of the 15 cases had acceptable levels of resources for treatment services and 82% (9 out of 11 applicable cases) had acceptable levels of wraparound service resources. Eighty-one percent of 17 CMH service providers reported that F.A.C.T. supported youth in community-based treatment to a great or very great extent, 20% more than the 61% of 33 who said that CMH supported community-based treatment to a great or very great extent.

According to both MACRO and the project's September report, F.A.C.T. has engaged in efforts to enhance the cultural awareness and competence of staff and the broader system through training, awareness activities, and case management practices. Fifty-three percent of the 17 respondents to the CMH service provider survey stated that F.A.C.T. had focused on family culture to a great or very great extent, and 36% of 33 respondents said that CMH in general had that focus to a great or very great extent. However, the MACRO site visit report also indicated that staff diversity is minimal and outreach doesn't target cultural groups (the latter due to caseload capacity issues).

Use of a Validated Clinical Model

Data Sources: MACRO System of Care Assessment, QSR case studies, CMH Service Provider Survey

F.A.C.T. is based on a strengths-based, family-focused, and individualized clinical model. Evidence related to the use of such a model includes:

- The MACRO site visit report found that service planning and services are strength-based and family-focused.
- All 17 (100%) of the service providers that responded to questions about F.A.C.T. stated that the project focused on full family involvement to at least some extent, compared to 80% of the 33 service providers responding to questions about CMH in general. Differences in the distribution of answers to questions about F.A.C.T. or CMH focus on child and family strengths, individualized service planning, and multiple life areas were negligible. (See Table A-6.)
- In ratings of the characteristics of F.A.C.T. CSCs and CMH Clinical Services Treatment Leaders, F.A.C.T. CSCs received somewhat higher ratings for accessibility, professionalism, helpfulness, and willingness to explain their decisions. (See Table A-6.)
- Among the system performance variables rated in the QSR, the adequacy of the treatment plan and the adequacy of the service plan had the lowest rates of acceptable cases, with 62% (8 out of 13 cases) and 64% (7 out of 11 cases)

respectively. The highest rates of acceptable cases were found in the adequacy of the IEP (86%, or 12 out of 14) and IEP implementation (87%, or 13 out of 15). (See Table A-5.)

Sustaining the System

Data Sources: F.A.C.T. Federal Site Visit Presentation, CMH Service Provider Survey

The effect of the F.A.C.T. project on the child mental health system as a whole is one way to look at the likelihood that the system of care will be sustained beyond the end of the grant initiative. Ways in which the project is trying to spread the system of care philosophy include entering into a social marketing campaign partnership with Delaware's Mental Health Association, initiating the Positive Behavior Supports/Functional Behavior Analyst Certificate program and sponsoring a statewide PBS conference, and participating in the Interagency Collaborative Team, the Delaware Developmental Disabilities Council, the Behavioral Health Consortium, the DSCYF/DOE/DHSS Coordination Group for enhancing mental services in schools, and DSCYF's system of care deployment effort. The perspectives of the 17 service providers on the impact of F.A.C.T. on the traditional children's mental health system were mixed: Four (24%) said that F.A.C.T. had had little or no impact on the traditional children's mental health system; nine (53%) said that the project had had some or moderate impact; and four (24%) said great or very great impact. As the project enters its fifth year, more attention is likely to be paid to sustaining the system of care beyond the grant initiative.

Next Steps

This report has described the kinds of children being served by the F.A.C.T. project and provided information about the kinds and costs of services that they have received and the implementation of the system of care. At this point, evidence about the effects of F.A.C.T. on the children and families that it serves is insufficient to support any claims about project outcomes. Rather than restate information already provided in the summaries throughout the report, this section describes the steps that the evaluation team are taking to improve the information about the effects of F.A.C.T. on participating families and children.

A major weakness of the current evidence about F.A.C.T. is the small number of families participating in the national evaluation. The F.A.C.T. project evaluation team has taken several measures to increase participation. To improve recruitment, the materials used by the CSCs to describe the evaluation have been redesigned to be easier to read and understand, and the stipend provided to those who participate in the evaluation has been increased. In order to retain more of the families who agree to the baseline interview, the time that the interviews take has been reduced by using teams of interviewers. In addition, communication with the participating families has been increased by sending thank you and birthday cards. The evaluation team has also hired more interviewers to ensure the availability of an interview team at the time most convenient for the participating family. Once the sample sizes increase, more sensitive analyses will be warranted. However, with a capacity of 65 families at any one time and an average length of stay of around 1 ½ years, sample sizes will never be large.

The evaluation team has two kinds of tasks for strengthening the data used to evaluate the project beyond the national evaluation interviews. The first task is to use existing data more completely. The Department of Education records on school attendance, performance, and disciplinary problems will be obtained and used to improve the evidence about children's academic experiences. In addition, the *FACTS* management information

system data will be used to obtain data on children served by the Division of Child Mental Health, but not by F.A.C.T... This data will help us understand the extent to which the F.A.C.T. project is serving the children with the most difficult problems and provide a context for interpreting outcome data on the F.A.C.T. clients.

Collecting new data is the second kind of task the evaluation team has planned for strengthening the local evaluation data. Specifically, assessments of parent perspectives on child progress, fidelity of the service planning meetings held with families to the principles of a system of care, and other data collection activities, such as parent focus groups, interviews with project managers and CSCs, and surveys of service providers, are being considered.

A. APPENDIX A
SUPPLEMENTARY CHARTS AND TABLES

Table A-1: CAFAS Data from Clinical Service Coordinators (CSCs)

Domain	Rating	Rating Period			
		Time 1 (n=64)	Time 2 (n=48)	Time 3 (n=33)	Time 4 (n=18)
School/Work	Severe	64.1%	64.6%	36.6%	66.7%
	Moderate	17.2%	10.4%	15.2%	16.7%
	Mild	7.8%	16.7%	12.1%	5.6%
	Minimal	3.1%	2.1%		5.6%
	Could Not Score	3.1%	2.1%		5.6%
	Avg. Score	24.2	23.6	23.3	25.3
Home	Severe	50.0%	35.4%	45.5%	50.0%
	Moderate	15.6%	14.6%	6.1%	27.8%
	Mild	17.2%	37.5%	33.3%	16.7%
	Minimal	17.2%	10.4%	15.2%	5.6%
	Could Not Score		2.1%		
	Avg. Score	19.8	17.7	18.2	22.2
Community	Severe	9.4%	6.3%	3.1%	5.6%
	Moderate	26.6%	33.3%	34.4%	38.9%
	Mild	6.3%	4.2%	9.4%	
	Minimal	57.8%	56.3%	53.1%	55.6%
	Avg. Score	8.75	8.96	8.75	9.44
Behavior with others	Severe	21.9%	8.3%	22.6%	
	Moderate	45.3%	47.9%	32.3%	50.0%
	Mild	31.3%	37.5%	35.5%	22.2%
	Minimal	1.6%	6.3%	9.7%	11.1%
	Avg. Score	18.8	15.8	16.8	17.2
Moods	Severe	20.3%	8.3%	22.6%	11.1%
	Moderate	31.3%	41.7%	12.9%	44.4%
	Mild	29.7%	37.5%	45.2%	27.8%
	Minimal	18.8%	12.5%	19.4%	16.7%
	Avg. Score	15.3	14.6	13.9	15.0
Self-Harm	Severe	7.8%	2.1%	6.5%	
	Moderate	4.7%	6.3%	12.9%	
	Mild	10.9%	6.3%	6.5%	5.6%
	Minimal	76.6%	85.4%	74.2%	94.4%
	Avg. Score	4.38	2.5	5.2	.6

Table A-1 (continued)

Substance abuse	Severe	20.3%	8.3%	22.6%	11.1%
	Moderate	31.3%	41.7%	12.9%	44.4%
	Mild	29.7%	37.5%	45.2%	27.8%
	Minimal	18.8%	12.5%	19.4%	16.7%
	Avg. Score	1.09	1.4	1.61	1.11
Thinking	Severe	8.2%	4.7%	3.2%	5.6%
	Moderate	11.5%	11.6%	9.7%	11.1%
	Mild	8.2%	7.0%	9.7%	5.6%
	Minimal	72.1%	76.7%	77.4%	77.8%
	Avg. Score	5.6	4.4	3.9	4.4

Table A-2: CAFAS Data from National Evaluation Interviews

Domain	Rating	Rating Period		
		Baseline (n=17)	6 Months (n=14)	12 Months (n=10)
School/Work	Severe	82.4%	85.7%	60.0%
	Moderate	5.9%		
	Mild	5.9%	7.1%	30.0%
	Minimal	5.9%	7.1%	10.0%
	Avg. Score	26.5	26.4	21.0
Home	Severe	83.3%	78.6%	70.0%
	Moderate		14.3%	10.0%
	Mild	11.1%	7.1%	20.0%
	Minimal	5.6%		
	Avg. Score	26.11	27.14	25.0
Community	Severe	16.7%	28.6%	10.0%
	Moderate	27.8%	14.3%	20.0%
	Mild	27.8%	7.1%	10.0%
	Minimal	27.8%	50.0%	60.0%
	Avg. Score	13.3	12.1	8.0
Behavior with others	Severe	61.1%	64.3%	50.0%
	Moderate	27.8%	7.1%	40.0%
	Mild	11.1%	21.4%	
	Minimal		7.1%	10.0%
	Avg. Score	25.0	22.9	23.0

Table A-2 (continued)

Moods	Severe	55.6%	50.0%	70.0%
	Moderate	27.8%	28.6%	20.0%
	Mild	11.1%	7.1%	
	Minimal	5.6%	14.3%	10.0%
	Avg. Score	23.3	21.4	25.0
Self-Harm	Severe	27.8%	35.7%	30.0%
	Moderate	11.1%		10.0%
	Mild	5.6%	7.1%	
	Minimal	55.6%	57.1%	60.0%
	Avg. Score	11.1	11.4	11.0
Substance abuse	Severe	5.6%		
	Moderate	5.6%		
	Mild			
	Minimal	88.9%	100.0%	100.0%
	Avg. Score	2.78		
Thinking	Severe	66.7%	42.9%	30.0%
	Moderate	11.1%	7.1%	50.0%
	Mild		7.1%	10.0%
	Minimal	22.2%	42.9%	10.0%
	Avg. Score	22.2	15.0	20.0

Table A-3. QSR Ratings of Variables Related to Child Functioning*

QSR Variable	Description of Variables**	% Acceptable	Average rating
Physical well-being (n=15)	Good health; basic physical needs met; access to health care services, as needed	87%	4.8
Emotional/behavioral well-being (n=15)	Free of symptoms of anxiety, mood, thought, or behavioral disorders that interfere with capacity to participate in and benefit from education Progress toward normal functioning	73%	3.8
Progress in behavioral patterns (n=14)	Adequate behavioral progress, consistent with the student's age and ability, in presenting appropriate daily behavior patterns in school and home activities. Increased resiliency in meeting daily life challenges.	86%	3.9
Responsible behavior in school and other daily settings (n=15)	Improved levels of personal responsibility; absence of high risk behaviors; evidence of the development of character, conscience, caring, and social competence	60%	3.7
Progress in risk reduction (n=12)	Adequate progress, consistent with the child's life circumstances and functional abilities, in reducing specific risks identified for the child	83%	3.3
Progress in developing meaningful relations (n=11)	Development and maintenance of positive relationships with various family members (or substitute caregivers), non-disabled age peers, and adults.	55%	2.7
Progress toward transition goals (n=11)	Adequate progress, consistent with an appropriate timeline, toward achievement of transition goals in the IEP and/or long-term transition goals	64%	2.7
Progress in symptom reduction (n=10)	Reduction of psychiatric symptoms which resulted in DSM-IV-R diagnoses and treatment	70%	2.5

*Variables were rated on a 6 point scale, with 6 = an optimal condition and 1 = a bad and worsening condition. A case was considered to have an acceptable condition if it received a rating of 4 or higher.

**Source: Coordinated Services Review: Protocol for review of services provided to children and youth served through the Interagency Collaborative Team [ICT] and the Families And Communities Together [FACT] Project, Version 1.0. Human Systems and Outcomes, Inc., December 2002.

Table A-4. ICST Survey Results*

Survey Item***	Average	% Agree and Strongly Agree Responses By Type of Respondent**					
		Total	Youth	Parents	Coordinators	School Staff	Other
4	3.7	98%	100%	100%	100%	100%	100 %
5	3.7	98%	100%	100%	100%	98 %	98%
7	3.7	97%	100%	100%	100%	95%	100%
3	3.7	98%	75%	100%	100%	100%	100%
6	3.7	97%	100%	100%	100%	96%	98%
1	3.6	98%	100%	95%	100%	100%	100%
13	3.6	97%	100%	100%	100%	100%	100%
2	3.6	97%	100%	100%	100%	100%	98%
12	3.6	94%	100%	98%	90%	96%	98%
9	3.6	93%	100%	100%	100%	96%	98%
8	3.5	94%	100%	98%	100%	98%	98%
11	3.4	91%	100%	100%	100%	96%	98%
10	3.3	88%	100%	100%	100%	96%	96%

*Results are based on data collected through 6/30/03.

**Responses are based on a 4 point scale (1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree).

**See below for the full text of survey items.

Full Text of ICST Satisfaction Survey Items

1. The right people were included on the ICST.
2. The right people were here for this meeting.
3. The team was able to find a good time for all members to meet.
4. The team was able to find a good place for all members to meet.
5. Team members were able to be open with each other and have an honest discussion.
6. The meeting was conducted in a strength-based (no shame no blame) manner.
7. The child and family were heard and their views were important for the plan that was developed.
8. The plan reflects customs and beliefs of the child and family.
9. The team reviewed progress and implementation of the plan in terms of the long range goals.
10. The safety of the child, family, and community was discussed and crisis plans reviewed if needed.
11. The action plans to meet the long range goals were updated as needed.
12. I feel that this is a good plan to support this child.
13. I feel that my input and contribution to this team was respected and valued.

Table A-5. QSR Ratings of Variables Related to System Functioning*

QSR Variable	Description of Variables**	% Acceptable	Average rating
Understanding the situation (n=15)	Clear identification of physical, emotional, and educational needs; sufficient scope and depth of knowledge to determine a workable plan of action for resolving the child's needs and problems	80%	4.5
Planning supports and services (n=15)	Priority concerns and needs of the child and family addressed through unified efforts of agencies; individualized services; plan based on a long-term view for child outcomes	67%	3.7
Adequacy of IEP (n=14)	Input of all members of the IEP team reflected; strengths and needs identified; impact of disability on child's progress specified; annual goals and benchmarks clearly stated	86%	4.3
Implementation of IEP (n=15)	Timely, competent, and coordination implementation of IEP plans; appropriate intensity and consistency of services and activities	87%	4.3
Adequacy of treatment plan (n=13)	Same as "adequacy of IEP" variable	62%	3.6
Implementation of treatment plan (n=10)	Same as for IEP plan	70%	3.8
Adequacy of service plan (n=11)	Individualized and flexible supports provided; comprehensive -- related to adequacy of IEP and treatment plan	64%	3.5
Implementation of service plan (n=11)	Same as for IEP plan	73%	3.5
Resources available for placement (n=15)	Availability of supports, services, and resources needed by child and family; steps taken to identify or develop needed resources.	87%	4.3
Resources available for flex/wraparound (n=11)	Same as for placement resources	82%	4.4
Coordination of services (n=15)	Single point of coordination and accountability for the organization, delivery, and results of the plan	60%	3.5
Monitoring and adjustment (n=15)	Tracking of academic and treatment progress, family conditions and supports, and results; frequent meetings to discuss implementation; adjustment of plan as needed	67%	3.0
Effective results (n=15)		67%	3.9

*Variables were rated on a 6 point scale, with 6 = an optimal condition and 1 = a bad and worsening condition. A case was considered to have an acceptable condition if it received a rating of 4 or higher.

**Source: Coordinated Services Review: Protocol for review of services provided to children and youth served through the Interagency Collaborative Team [ICT] and the Families And Communities Together [FACT] Project, Version 1.0. Human Systems and Outcomes, Inc., December 2002.

Table A-6. Results from CMH Service Provider Survey

	FACT*			CMH**		
	Little/not at all	Some/moderate	Great/very great	Little/not at all	Some/Moderate	Great/Very great
<i>To what extent has F.A.C.T./CMH focused on:</i>						
Child & family strengths		41%	59%	9%	33%	58%
Individualized treatment planning		24%	76%	6%	25%	69%
Family culture		47%	53%	6%	58%	36%
Full family involvement		44%	56%	19%	31%	50%
Multiple life areas		41%	59%		48%	52%
Community-based treatment	6%	13%	81%	3%	36%	61%
Collaboration among different agencies	7%	47%	47%	3%	52%	45%
<i>To what extent are F.A.C.T. Clinical Service Coordinators/CMH Clinical Services Treatment Leaders:</i>						
Accessible		38%	63%		53%	47%
Professional		25%	75%		38%	63%
Helpful	13%	25%	63%		44%	56%
Willing to explain		31%	69%	3%	44%	53%
<i>To what extent has F.A.C.T. impacted the traditional system?</i>						
	24%	53%	24%			

*n=15-17

**n=32-33

Figure A-1. Age Distribution of F.A.C.T. Children at Intake

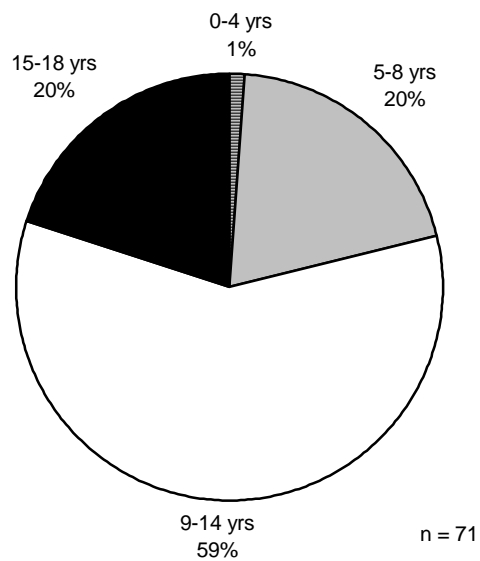


Figure A-2. Developmental Disability and Mental Retardation Diagnoses

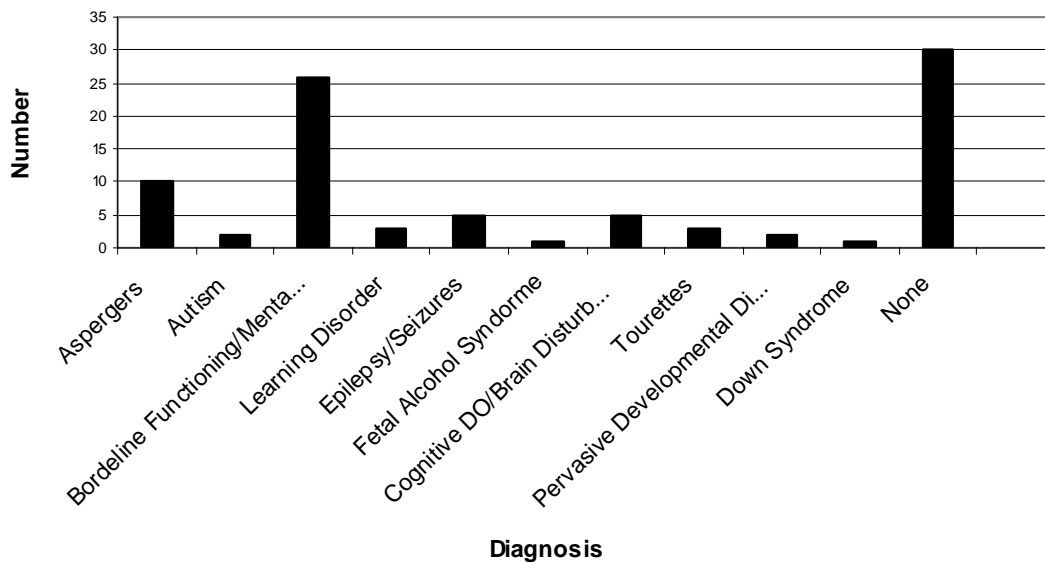


Figure A-3. Mental Retardation-Related Psychiatric Diagnoses

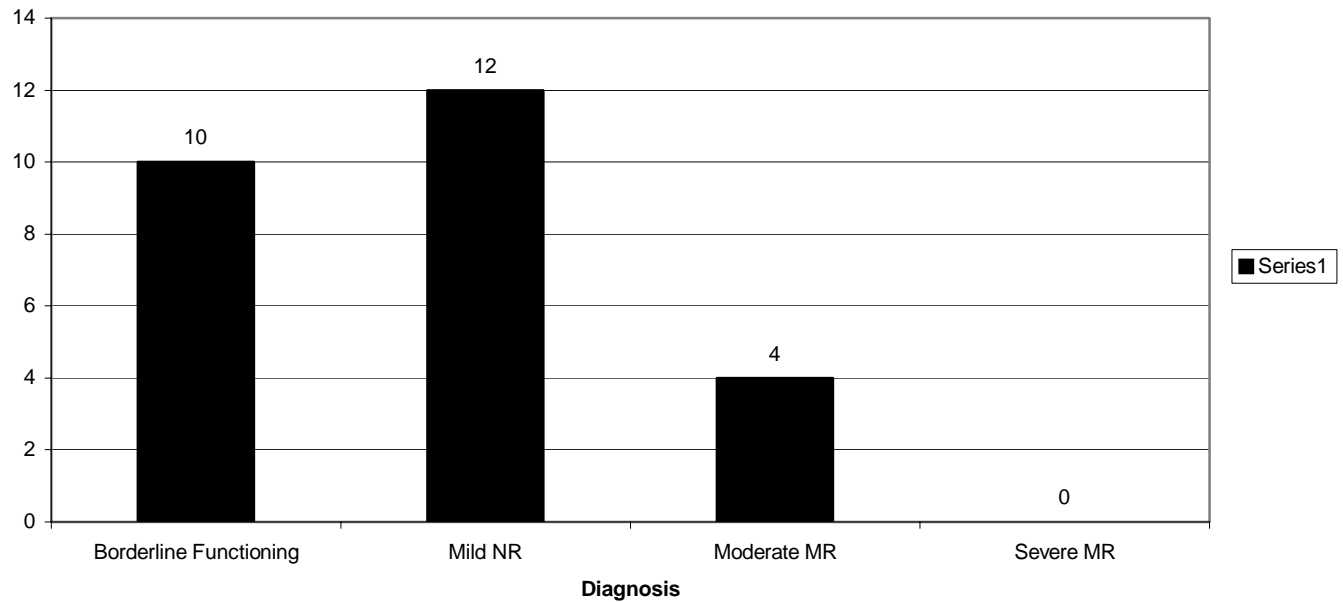


Figure A-4. Special Education Classification

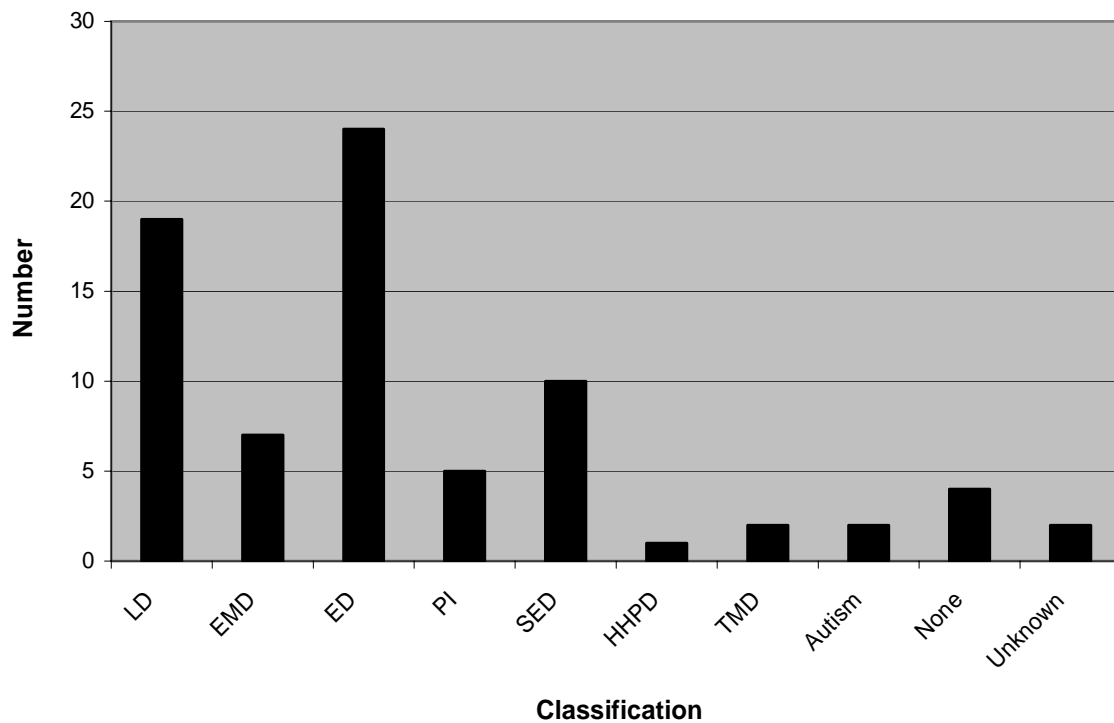


Figure A-5. Problem Scores From Parent Report on Child Behavior Check List

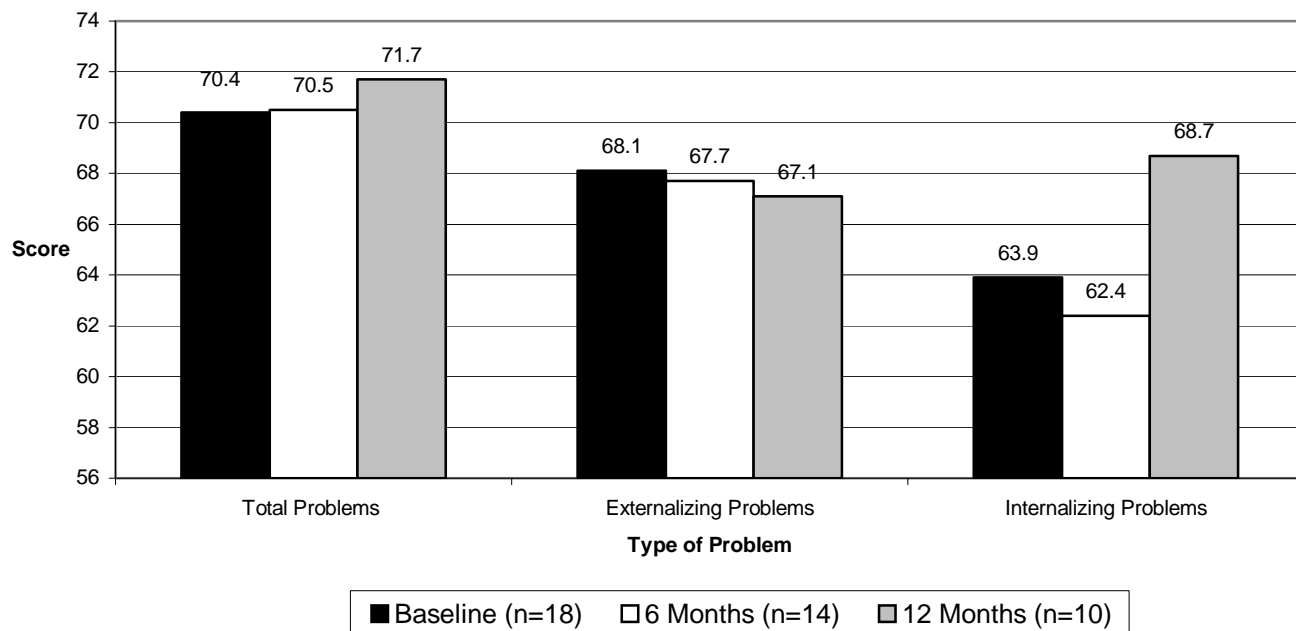


Figure A-6. Problem Scores From Youth Self Report

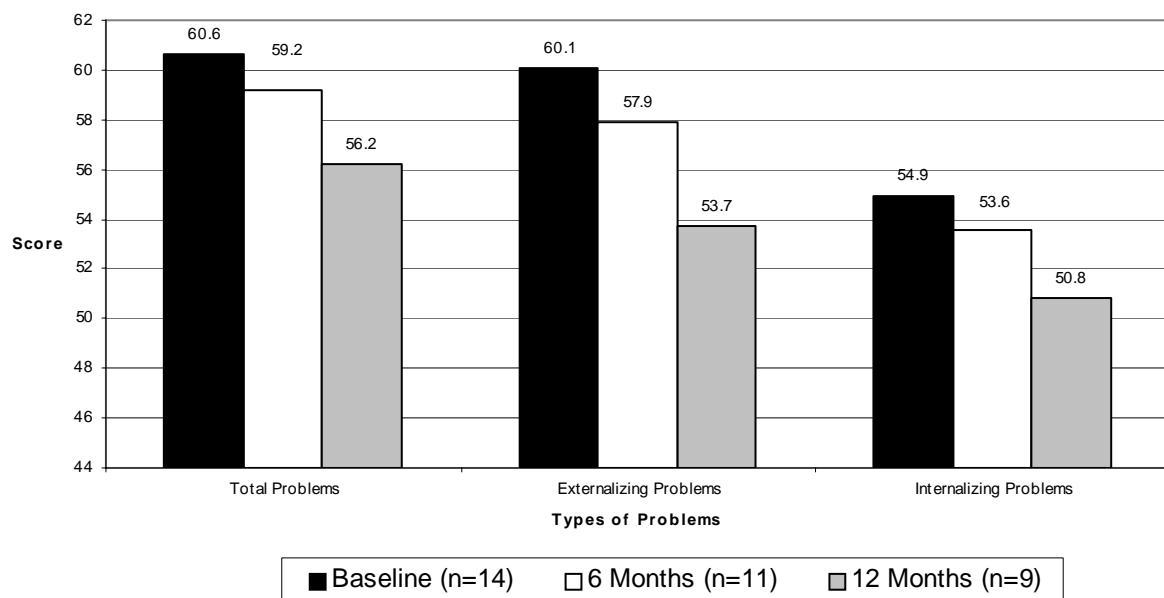


Figure A-7. Rate of Absences per Parent Report

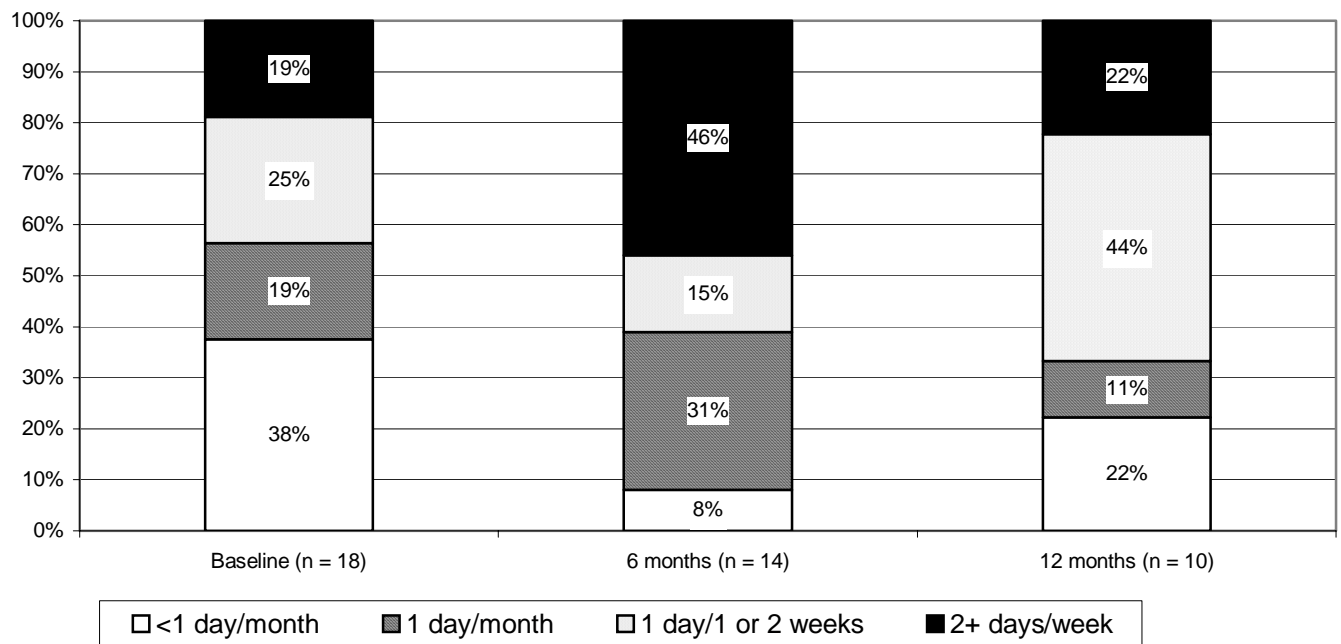


Figure A-8. Children's Academic Performance

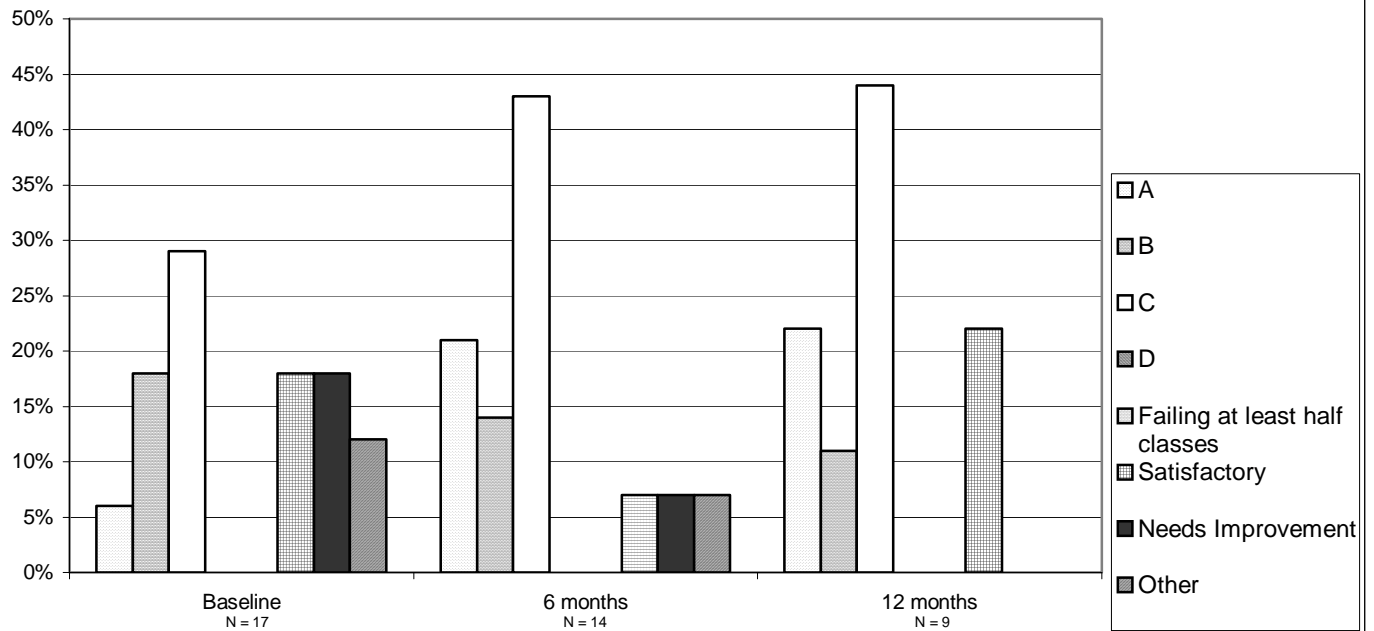


Figure A-9. Parent Ratings of School Performance and Need for Additional Help

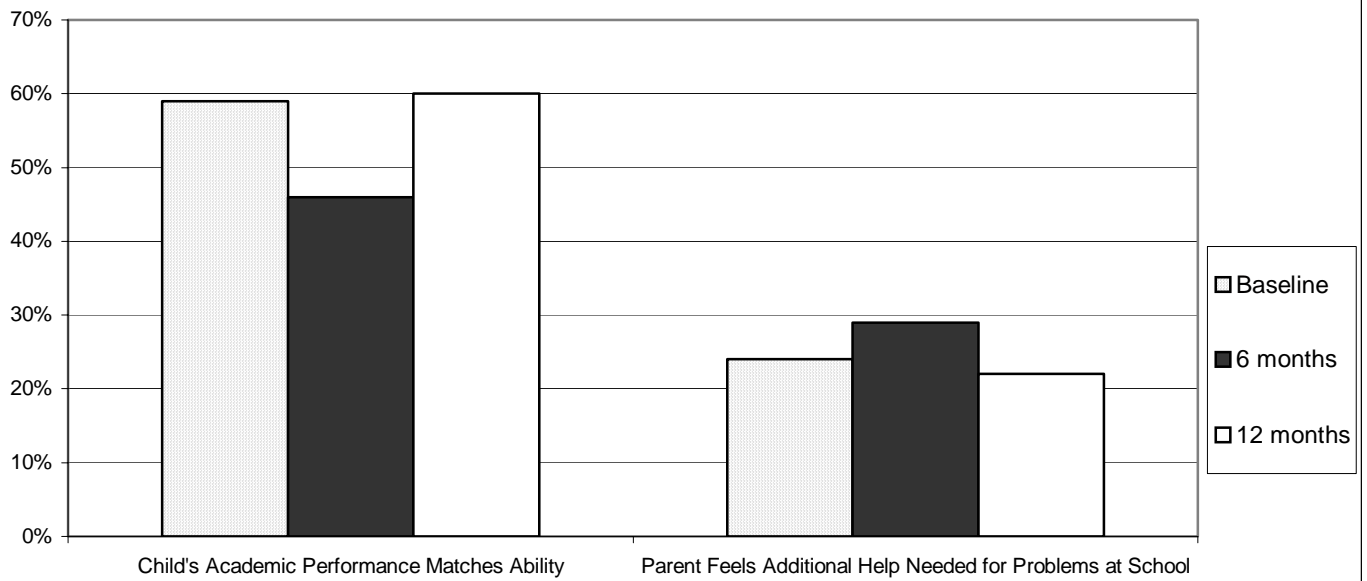


Figure A-10. Parent Report of School Disciplinary Actions

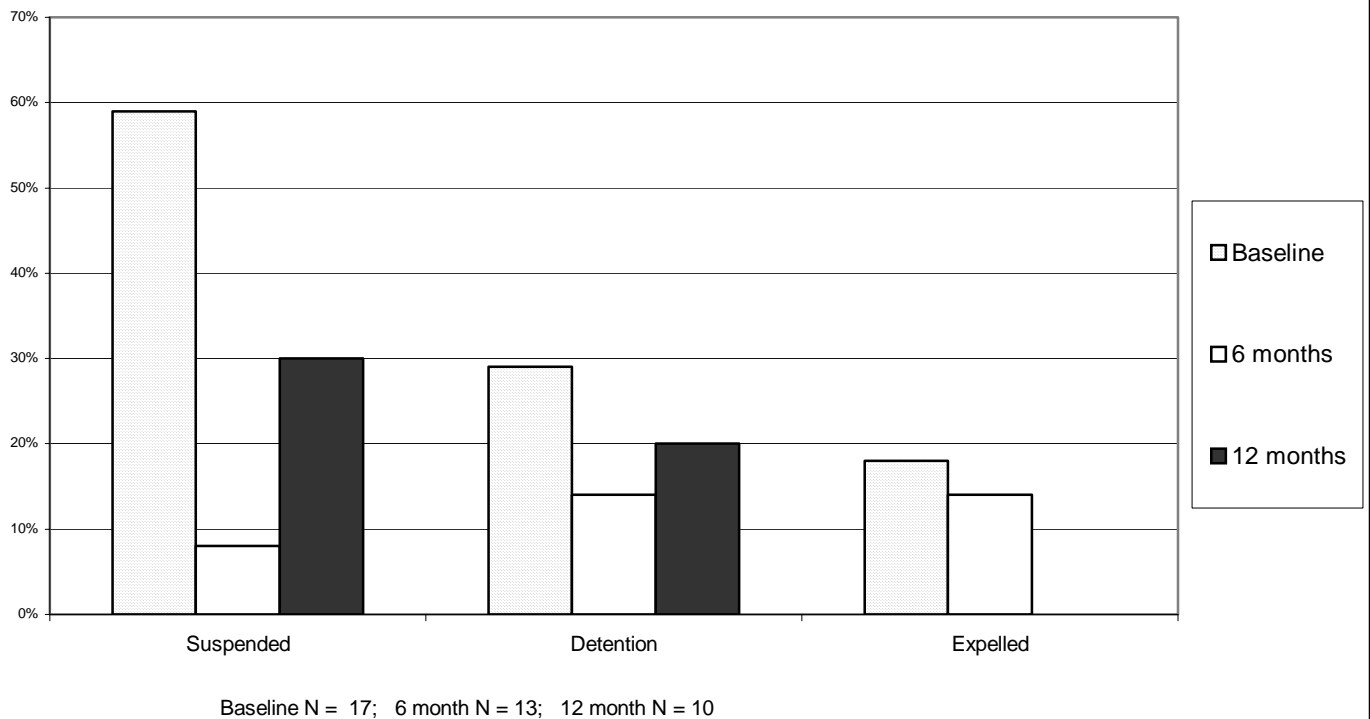
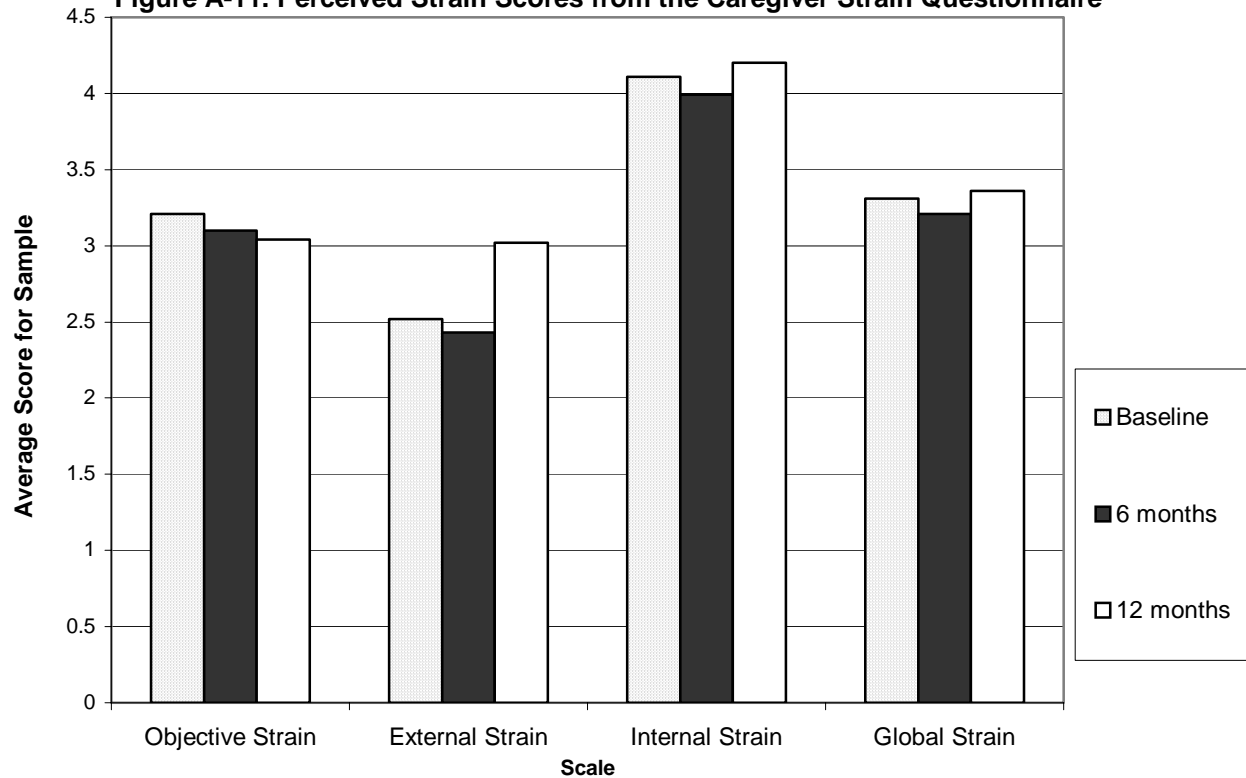


Figure A-11. Perceived Strain Scores from the Caregiver Strain Questionnaire



Baseline N = 17; 6 month N = 13; 12 month N = 9

The CGSQ is a caregiver report (1-5 rating scale) to assess the effects of the special demands associated with caring for children with emotional and behavior problems on caregivers. Higher scores on scales indicate greater strain on caregivers.

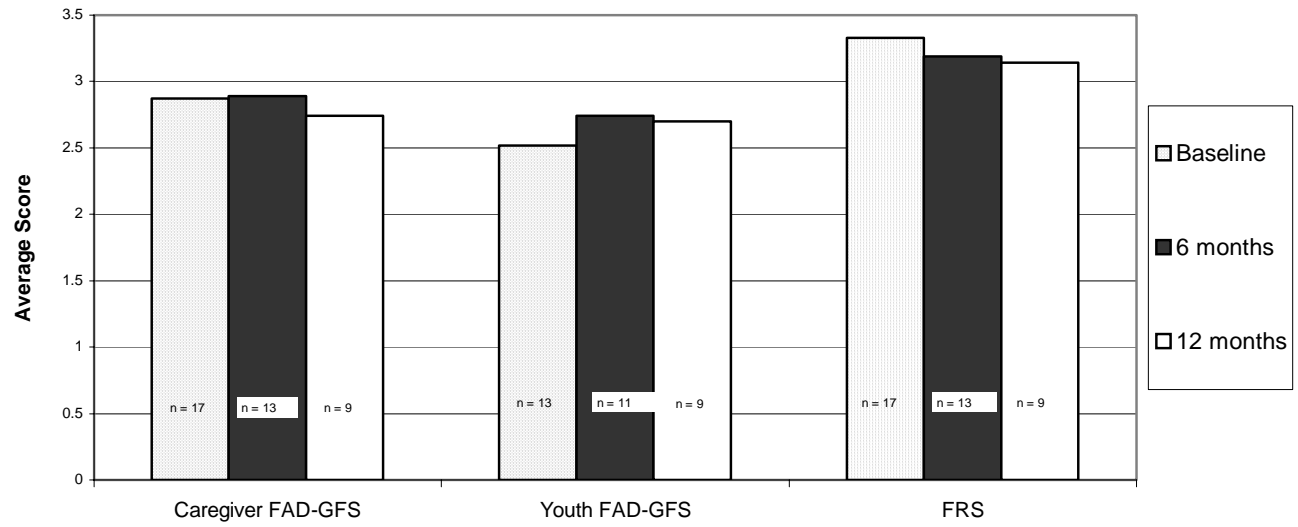
Objective Strain - assesses effect of observable negative events/consequences related to child's disorder affect family.

Subjective-Externalized Strain - related to negative feelings about the child.

Subjective-Internalized Strain - negative feelings caregivers experience, such as worry, guilt, and fatigue.

Global Strain - indication of total impact on family.

Figure A-12. Perceptions of Family Functioning and Adequacy of Resources



FAD-GFS - Family Assessment Device-General Functioning Scale (1-4 rating scale - higher scores indicate higher levels of family functioning)

FRS - Family Resource Scale - (1-5 rating scale - higher scores indicate more family resources)

APPENDIX B

THE INTERAGENCY COLLABORATIVE TEAM

Source: ICT Annual Report, FY02.

The Interagency Collaborative Team (ICT) is authorized in 14 Del. Code Section 3124. The purpose of the Team is to develop a collaborative interagency approach to service delivery for children and youth with disabilities who present needs that cannot be addressed through the existing resources of a single agency. In addition to planning for individual children, the Team identifies impediments to collaborative service delivery and recommends strategies to remove them. The Team consists of the following members as established in legislation:

Susan Ccyk, Director, Division of Child Mental Health, DSCYF
(David Lindemer, designated representative)

Carlyse Giddins, Director, Division of Family Services, DSCYF
(Malisa Knox, designated representative)

Nancy Pearsall, Director, Division of Youth Rehabilitation Services, DSCYF
(Gail Crowell, designated representative)

Marianne Smith, Director, Division of Developmental Disabilities Services, DHSS
(Warren Ellis, designated representative)

Renata Henry, Director, Division of Substance Abuse and Mental Health, DHSS
(Pat Pheris, designated representative)

Jennifer Davis, Director, Office of the Budget
(Michael Jackson, designated representative)

Russell Larson, Controller General
(John Frazer, designated representative)

Martha Brooks, Chair, Director, Exceptional Children and Early Childhood Group, DOE

Nancy Wilson, Associate Secretary, Curriculum and Instructional Improvement, DOE

In addition, representatives of the responsible school district, the parent/guardian, and other persons working with, and/or having knowledge about individual cases, are invited to participate on those specific cases.

The ICT has two charges under the legislation. The first is to review all new and renewal unique alternative applications prior to approval by the Secretary of Education. The ICT reviews existing assessment information and proposed treatment plans. It makes recommendations for alternatives and ensures coordinated interagency delivery of services, including funding.

The second charge is to develop a report that summarizes the experiences of the Team and which provides information on the items reported in the previous year's Annual Report. The legislation mandates that a report be submitted to the Governor, Budget Director, President Pro-Tempore, Speaker of the House and the Controller General by February 15, 2003.

APPENDIX C

NATIONAL EVALUATION INSTRUMENTS

This appendix presents descriptive information about the instruments in the national evaluation for which data have been presented in this report.

Behavior and Emotional Rating Scale (BERS)

The BERS is designed to be completed by caregivers or professionals (e.g. teachers) to identify the emotional and behavioral strengths of children aged 5 to 18 years. It has 52 statements about a child's behaviors and emotions in the last 6 months. For example, Statement #1 is "Demonstrates a sense of belonging to family." Each item is rated on a 4-point scale with the following response options: 0=Not at all like the child; 1=Not much like the child; 2=Like the child; and 3=Very much like the child. The BERS is comprised of 5 domains of behavioral and emotional strengths. The five subscales are mutually exclusive, i.e., one item contributes to one and only one subscale. The scales are described below. Higher scores on any of the scales indicate greater strength.

Calculation of each BERS scale score involves calculating a raw score for each scale by taking the sum of valid responses across items that make up that scale; then the raw scores are converted into standardized scores using a look-up table. Finally, using a different look-up table, the sum of the standardized scores is converted into an overall strength quotient.

The five subscales have a standardized-score range from 1 to 17, with scores below 10 indicating below average strength, a score of 10 indicating average strength, and scores above 10 indicating above average strength. The overall strength quotient has a range from 34 to 164, with scores below 90 indicating below average strength, scores between 90 and 110 indicating average strength, and scores above 110 indicating above average strength.

Child and Adolescent Functional Assessment Scale (CAFAS)

The CAFAS originally was designed to be completed by a clinician who obtained information from multiple informants such as the child, caregivers, schools, and official records. For the purposes of the national evaluation, information to score the CAFAS may also be obtained through a structured interview with the caregiver. Completed CAFAS forms are rated by clinicians or interviewers who have been established as reliable raters by a standardized reliability assessment.

The CAFAS is comprised of 8 domains. The CAFAS rater determines the level of a youth's functional impairment by reviewing specific identifiers across levels of severity in each of the 8 domains and assigns the highest level of impairment based on available information. The CAFAS is rated on 4 levels of impairment: 0=Minimal or no impairment (no disruption of functioning); 10=Mild impairment (Significant problems or distress); 20=Moderate impairment (Major or persistent disruption); 30=Severe impairment (Severe disruption of incapacitation). The eight subscale scores are then summed to produce a total CAFAS scale score with a range from 0 to 240. Total scores of 40 or below indicate minimal impairment; scores from 50 to 90 indicate moderate impairment, scores from 100 to 130 indicate marked impairment and those 140 or higher indicate severe impairment. In addition, the score of 40 is the clinical cutoff, with scores above considered to indicate impairment in social functioning at a level requiring clinical care. The eight subscales are described below.

- **School Role:** Rates poor attendance, unsafe or disrespectful behavior, inattention and hyperactive behavior, and poor academic work.
- **Home Role:** Rates unsafe or potentially unsafe behavior, general disobedience, and runaway behavior.

- **Community Role:** Rates delinquency and/or negative impact of youth's behavior on other people or their property.
- **Behavior Towards Others:** Rates youth's patterns of behavior in social or interpersonal interactions.
- **Moods/emotions:** Rates emotions related to trauma or stress, anxiety, depression. Not rating anger and hostility.
- **Self-harmful Behaviors:** Rates behaviors that are intended to hurt self.
- **Substance Use:** Rates the following substance use—alcohol, street drugs, inhalants, misuse of prescription or over-the-counter drugs.
- **Thinking:** Infers thinking from communications. Identifies relatively severe thinking problems which interfere with functioning and are "pathological."

Child Behavior Checklist (CBCL)

The CBCL is a caregiver report to measure competencies and behavioral and emotional problems among children aged 4 through 18 years. It has 20 competence items and 118 problem behavior items to assess children's competencies and symptoms in the last 6 months. Response options for the 20 competence items vary based on the types of questions asked. For example, the item on time spent in each sport is rated on a 4-point scale: don't know, less than average, average, and more than average. The 118 problem behavior items are rated on a 3-point scale with the following response options: 0=Not true; 1=Somewhat or sometimes true; 2=Very true or often true.

The CBCL is comprised of 3 competency subscales, as well as a total competency scale; 8 narrow band syndrome scales, 2 broadband syndrome scales, and a total problem scale. The scales are not mutually exclusive, i.e., one item may contribute to more than one scale. Higher scores on the competency scales indicate greater competence, while higher scores on the problem behavior scales indicate higher level of problems.

To calculate each CBCL scale score, first a raw score is calculated by taking the sum of valid responses across items that make up that scale; then the raw scores are converted into standardized T-scores using a look-up table. The three competence subscales have a T-score range from 20 to 55, with scores under 30 in the clinical range (i.e. less competence), scores between 30 and 33 in the borderline clinical range, and scores over 33 below in the clinical range (i.e. greater competence). The total competence has a T-score range from 10 to 80, with scores under 37 in the clinical range (i.e. less competence), scores between 37 and 40 in the borderline clinical range, and scores over 40 below the clinical range (i.e. greater competence).

The 8 narrow band syndrome scales have a T-score range from 50 to 100, with scores under 67 below the clinical range (i.e. fewer problems), scores between 67 and 70 in the borderline clinical range, and scores over 70 in the clinical range (i.e. more problems). The Internalizing scale has a T-score range from 31 to 100, the Externalizing scale has a T-score range from 30 to 100, and the Total Problem scale has a T-score range from 23 to 100. All three scales have scores under 60 below the clinical range (i.e. fewer problems), scores between 60 and 63 in the borderline clinical range, and scores over 63 in the clinical range (i.e. more problems).

Caregiver Strain Questionnaire (CGSQ)

The CGSQ is a caregiver report to assess the extent to which caregivers are affected by the special demands associated with caring for a child with emotional and behavioral problems. It contains 21 items that assess strain experienced by caregivers in the last 6 months related to the care of a child with emotional and behavioral challenges. For example, Item 2 asks "How much of a problem was your missing work or neglecting other duties because of your child's emotional or

behavioral problem?” Items on the CGSQ are rated on a 5-point scale with the following response options: 1=Not at all; 2=A little; 3=Somewhat; 4=Quite a bit; and 5=Very much.

The CGSQ is comprised of three domains of caregiver strain, as well as a global strain scale to assess the overall strain experienced by caregivers. The three subscales are mutually exclusive, i.e., one item contributes to one and only one subscale. Each scale score is the mean of the valid responses across items that make up that scale. Higher scores on any of the scales indicate greater strain.

Educational Questionnaire (EQ)

The EQ is administered to caregivers or staff-as-caregivers in interview format to collect information on children’s educational status and their experiences in school during the past 6 months. It contains 21 questions, including items about school (first grade through twelfth grade) attendance; grade level; school achievement; type of school setting (e.g., special or alternative school); reasons for placements; special education; overall academic performance; and whether the child has been suspended, detained, or expelled from school. The final items on the questionnaire assess availability and effectiveness of help (from the school) to meet educational, behavioral, and/or emotional needs of the child. Response questions include yes/no, multiple choice, and fill-in-the-blank.

Family Assessment Device (FAD)

The FAD is the only family measure administered to both caregivers and youth to measure how families interact, communicate and work together. The modified version used in the National Evaluation for Phase III sites has 12 statements about general family functioning in the last 6 months. Items on the FAD are rated on a 4-point scale with the following response options: 1=Strongly disagree; 2=Disagree; 3=Agree; and 4=Strongly agree. A single general functioning scale score is the mean of the valid responses across the 12 items. Higher scores on the scale indicate higher levels of family functioning.

Family Resource Scale (FRS)

The FRS is a caregiver report to measure the adequacy of a variety of resources needed by households with young children. It has 30 questions about the extent to which resources are adequate for families in the last 6 months. For example, Question 1 asks about “food for 2 meals a day.” Items on the FRS are rated on a 5-point scale with the following response options: 1=Not at all adequate; 2=Seldom adequate; 3=Sometimes adequate; 4=Usually adequate; and 5=Almost always adequate. The FRS is comprised of 6 domains of family resources. The 6 subscales are mutually exclusive, i.e., one item contributes to one and only one subscale. Each scale score is the mean of the valid responses across items that make up that scale. Higher scores on any of the scales indicate more family resources.

Family Satisfaction Questionnaire, Abbreviated Version (FSQ-A)

The FSQ-A is a caregiver report to assess the caregiver’s satisfaction in the past 6 months with services received as a whole, the child’s progress, the cultural competence and family-focused nature of services, and the effects (if any) of the system of care on the ability of the caregiver (or other family member) to be productive in his/her work. The FSQ-A contains one screening question followed by 14 questions. The initial screening question asks whether the caregiver, youth, and/or his/her family have received any services in the past 6 months. If not, the remainder of the questionnaire is skipped. The first data collection point for the FSQ-A is at 6 months after children and families enroll in system-of-care programs.

The first part of the FSQ-A contains seven questions that assess the caregiver’s satisfaction in the past 6 months with services as a whole, the child’s progress, and the cultural competence and family-focused nature of services. For example, question 7 asks, “How satisfied have you

been with *child's name* progress in the past 6 months.” These seven questions are rated on a 5-point scale with the following response options: 1=Very dissatisfied; 2=Dissatisfied; 3=Neutral; 4=Satisfied; 5=Very satisfied.

The second part of the FSQ–A contains seven questions that assess whether the services the family received improved the caregiver’s (or other family member’s) ability to work for pay, and quantifies the impact in terms of days worked. For example, question 13 asks, “Have the services *child's name* or your family received helped *you/other person* miss fewer days or fewer hours of work?”

Multi Sector Service Contact (MSSC)

The MSSC is a caregiver report to assess the types and frequencies of services children and families receive across different service settings and child-serving sectors, as well as whether services meet the child and family’s needs. The MSSC contains 23 multi-part questions to assess 23 different services received in the last 6 months, in addition to the first two questions which determine whether families receive services in the last 6 months and, if so, for how long and from which major child-serving agencies. If no services were received, two brief follow-up questions are asked to determine the reason(s) no services were received and to obtain the date of the last service. Once these follow-up questions are asked to determine why no services were received, the remainder of the questionnaire is skipped. The first data collection point for the MSSC is at 6 months after children and families enroll in system-of-care programs.

The remaining questions are specific to services received in the last 6 months. For example, the first part of question 4 asks, “Did (*child's name*) receive crisis stabilization services?” The second part asks “Where was the service provided, “ the third part asks “How many times did (*child's name*) receive this service in the past 6 months,” the fourth part asks “Did you receive this service during the first part, the middle part, the end of the last 6 months, or throughout the entire 6 months,” and the fifth and last part of the question asks “How well did this service meet (*child's name*) needs and/or the needs of your family.” The last question of the MSSC asks whether the family receive any other services not listed in the questionnaire and, if so, descriptions of these other services.

Restrictiveness of Living Environment Scale, Revised (ROLES-R)

The ROLES-R incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) with a Placement Stability Scale. This adapted scale provides valuable information about children’s living environments, which helps determine how the type and number of living arrangements may affect children’s lives. For instance, children with fewer changes in living environments within a 6-month period may experience more stability. Information collected with this tool also makes possible further insight into the way in which shifts in types of settings affect children’s lives. Data should also indicate frequency of use of more restrictive service settings such as residential treatment centers. The ROLES-R is administered to caregivers or staff-as-caregivers in interview format.

The ROLES-R documents the settings in which children have lived during the past 6 months. There are 27 placement categories, such as independent, living by self; living independently in community with minimal supervision; two parents/caregivers, at least one biological; biological mother only, without partner; camp; supervised independent living; and foster care.

Youth Self Report (YSR)

The YSR is the adolescent self-report version of the Child Behavior Checklist (CBCL). Youth aged 11 through 18 years assess their own competencies and behavioral and emotional problems. It has 18 competence items and 112 problem behavior items for youth to assess their

own competencies and symptoms in the last 6 months. Response options for the 18 competence items vary based on the types of questions asked. For example, the item on time spent in each sport is rated on a 4-point scale: don't know, less than average, average, and more than average. The 112 problem behavior items are rated on a 3-point scale with the following response options: 0=Not true; 1=Somewhat or sometimes true; 2=Very true or often true.

The YSR is comprised of 2 competency subscales*, as well as a total competency scale; 8 narrowband syndrome scales, 2 broadband syndrome scales, and a total problem scale. The scales are not mutually exclusive, i.e., one item may contribute to more than one scale. Higher scores on the competency scales indicate greater competence, while higher scores on the problem behavior scales indicate higher level of problems. Calculating each YSR scale score involves taking the sum of valid responses across items that make up that scale; then the raw scores are converted into standardized T-scores using a look-up table. For more information on the scoring and interpretation of the CBCL scales, please refer to the YSR Manual (Achenbach, 1991).

The two competence subscales have a T-score range from 20 to 55, with scores under 30 in the clinical range (i.e. less competence), scores between 30 and 33 in the borderline clinical range, and scores over 33 below the clinical range (i.e. greater competence). The total competence has a T-score range from 10 to 80, with scores under 37 in the clinical range (i.e. less competence), scores between 37 and 40 in the borderline clinical range, and scores over 40 below the clinical range (i.e. greater competence). The 8 narrowband syndrome scales have a T-score range from 50 to 100, with scores under 67 below the clinical range (i.e. fewer problems), scores between 67 and 70 in the borderline clinical range, and scores over 70 in the clinical range (i.e. more problems). The Internalizing scale has a T-score range from 31 to 100, the Externalizing scale has a T-score range from 30 to 100, and the Total Problem scale has a T-score range from 23 to 100. All three scales have scores under 60 below the clinical range (i.e. fewer problems), scores between 60 and 63 in the borderline clinical range, and scores over 63 in the clinical range (i.e. more problems).