

What Does Another Year Tell Us About Services and Outcomes for Youth and Their Families Participating in the **Utah Frontiers Project (UFP)?**

Report for FY2003, November, 2003
(Data to 06/30/03)

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The mission of the Utah Frontiers Project continues to be...

To engage in collaborative relationships with families, communities, public and private agencies to build a comprehensive, fiscally sustainable System of Care that utilizes system of care technology for children and their families struggling with serious emotional disturbances (SED).

To improve the quality of life of these children and families by:

- Keeping children safely in their homes,
- Attending school successfully, and
- Participating appropriately in their communities

1. Information taken from grant proposal, funded October, 1998.

UFP Objectives¹

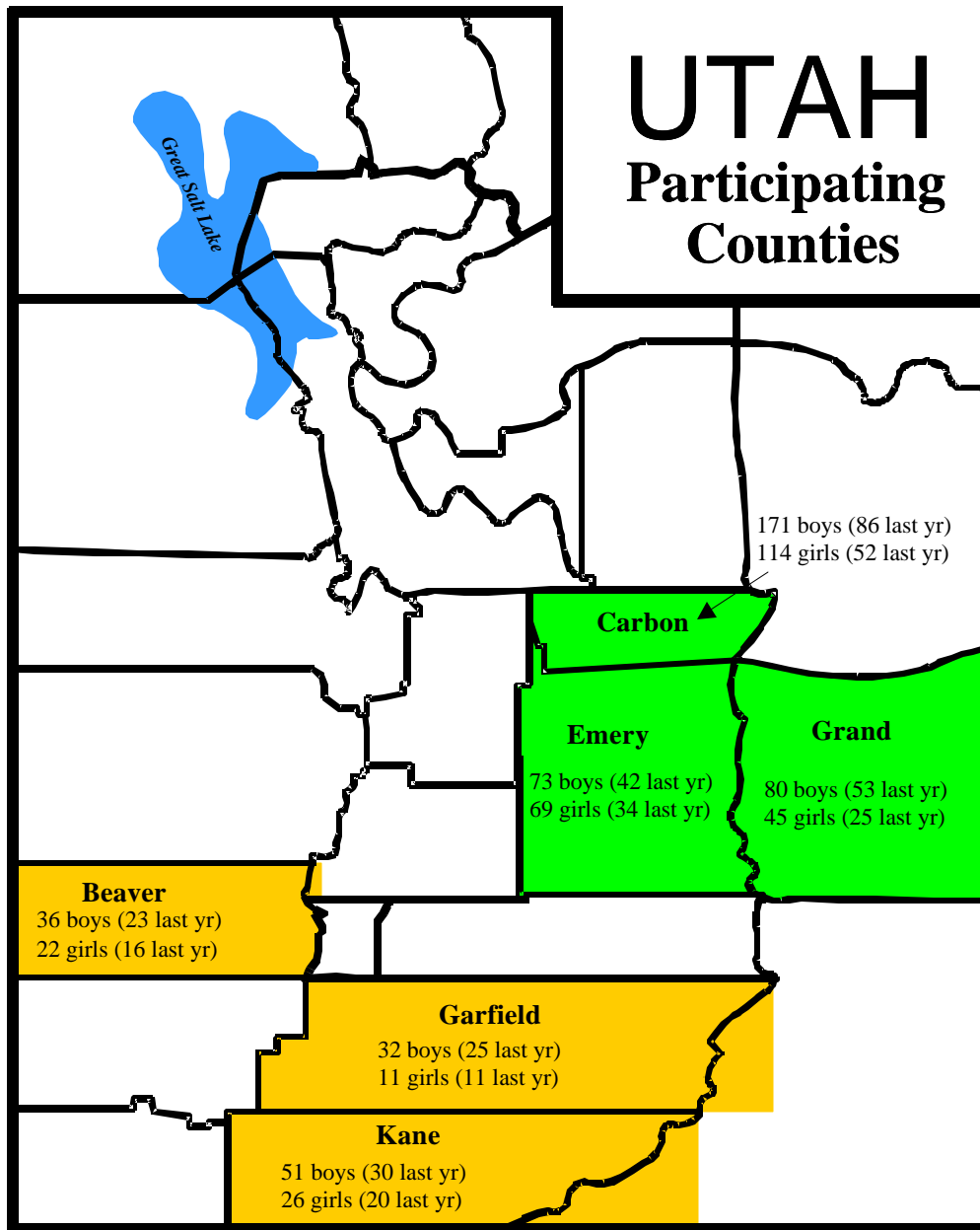
1. Create and expand services for children and youth with SED and their families through interagency activity.
2. Develop *child-centered and family driven, community-based, culturally competent, individualized, and strength-based service planning and delivery*².
3. Build effective, efficient, and fiscally responsible cross-agency services.
4. Improve outcomes for youth and family:
 - Child behavior and functioning
 - Family perceptions of well-being and stress

Using the data currently available, this report provides information about progress on these four objectives, these sections are color-coded with the above objectives.

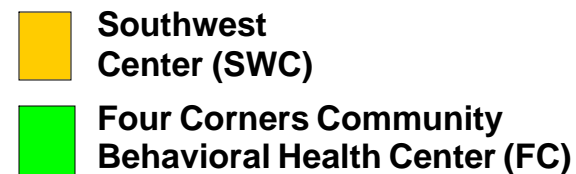
A description of the youth is presented first, to help the reader understand situations and challenges faced by youth with SED and their families.

1. Information taken from grant proposal, funded October, 1998.

2. This objective has been updated to include “child centered and family driven, community-based, culturally competent”.



- Southwest Center (SWC), serving the frontier counties of Beaver, Garfield, and Kane joined project in 1998.
- Four Corners Community Behavioral Health Center (FC), serving Carbon, Emery, and Grand counties, joined project in 2000.
- 730 youth who have SED have been enrolled in services in SWC or FC since the centers joined UFP.
- There has been an increase of 313 youth being served since the last report.
- 196 of the 730 youth (27%) with SED are participating in the Evaluation Study (Southwest = 93, Four Corners = 103).



What Were the Youths' Characteristics at Intake? (Caregiver Report)

Age:	42%	4-11 years	} Average age = 12.3 yrs
	45%	12-15 years	
	14%	16+ years	
Gender:	63%	boys	
	38%	girls	
Race:	88%	Caucasian	
	12%	Other ¹	
Ethnicity:	12%	Hispanic ²	
	88%	Non-Hispanic	
Living Arrangement at Intake	39%	2 caregivers (at least one biological parent)	} 89% of these youth lived with their parent(s) for the entire previous 6 months.
	27%	Biological mother only	
	5%	Biological father only	
	17%	State custody ³	
	12%	Other (e.g., independent, adoptive home, school)	
Income:	65%	below poverty line (n = 164)	
	74%	mother only families below poverty line (n = 74)	

Note: n = 191 to 203

Sums of %'s may not always equal 100%, due to rounding.

1. "Other" includes American Indian, Asian, Pacific Islander, etc.

2. Hispanics may be of any race.

3. State custody includes foster or specialized foster care, residential centers.

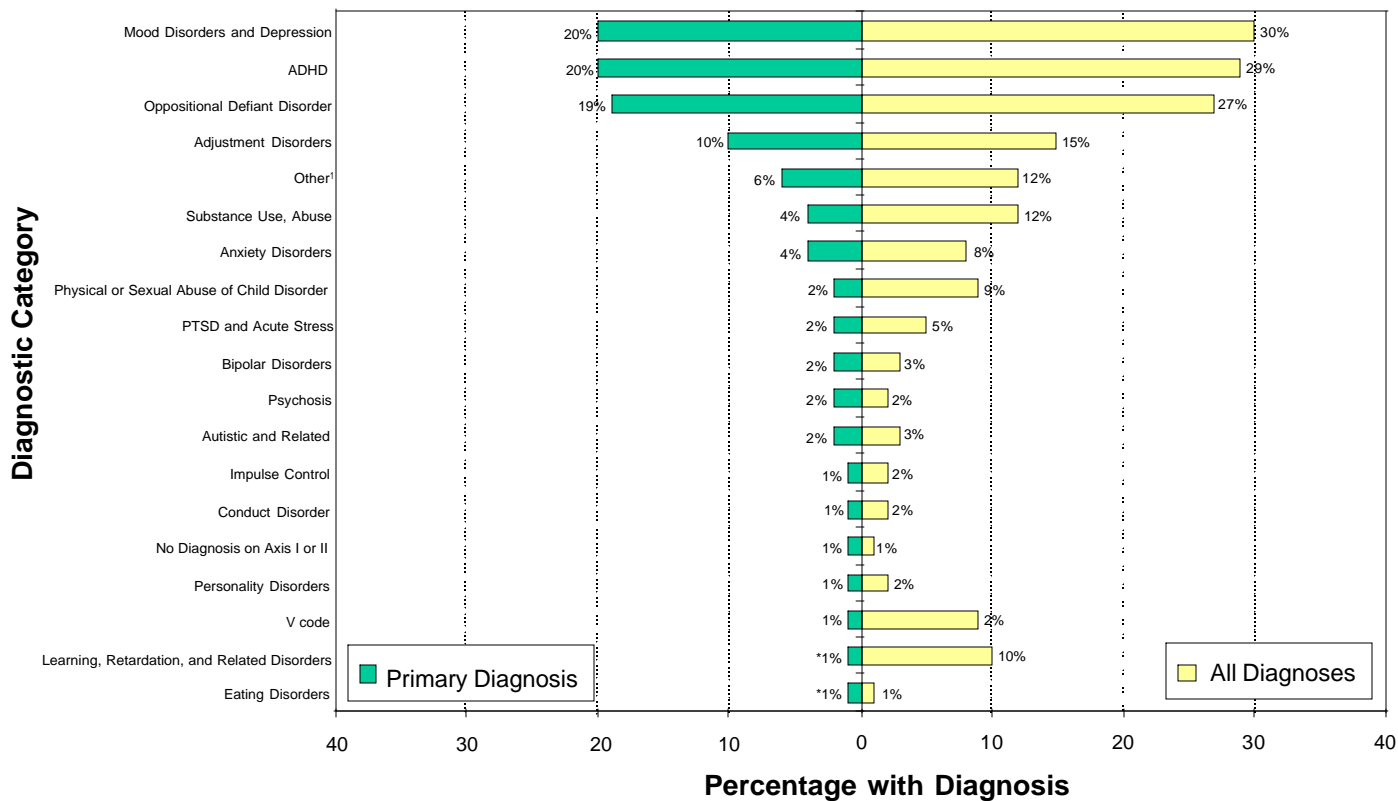
- This sample is not a representative sample of children with SED. Most of this sample are eligible for Medicaid. Consequently, most have limited income. 65% of study youth are at or below the poverty line in the 6 counties, while only 8-19% of all similar-aged youth in the same counties are at or below the poverty line (US Census 2000).
- Almost half of the study youth are 12-15 years of age; boys outnumber girls almost 2 to 1.
- Most of the youth are white; 12% of the youth have a Hispanic heritage, as compared to 7% of the population (US Census 2000) in the six counties.

Action Statement: Find ways to provide and improve services for families who don't meet Medicaid guidelines.

Notes below table present highlights of table, and/or associated information not shown in table.

Description of Sample *** Description of Sample *** Description of Sample

What was the Clinical Diagnosis of Youth on DSM-IV at Intake?



Note: Sample n = 187.

1. Other includes: Mental disorder NOS; Enuresis; Disruptive Behavior Disorder NOS; Reactive attachment disorder of infancy or early childhood.

* One subject with this diagnosis.

** Percentages on left side do not add to 100 due to rounding. Percentages on right side of chart sum to over 100 because a youth may have more than one diagnosis.

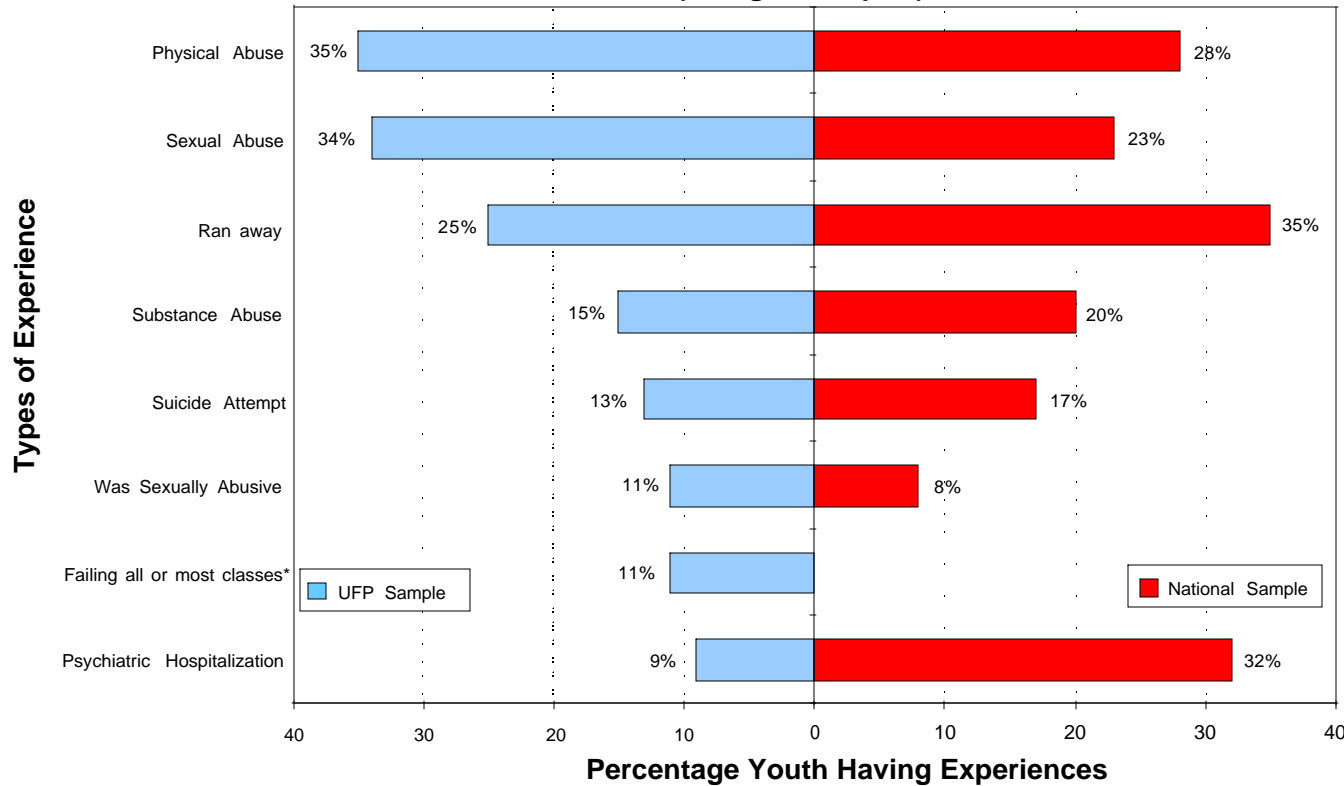
➤ About 86% of all diagnoses are related to **mood disorders, depression, oppositional defiant disorder, and ADHD.**

Action Statement: Focus training for families, mental health professionals, and communities on the most common diagnoses and those conditions (e.g. PTSD) that are under diagnosed. (Training for ADHD has occurred).

Notes below table present highlights of table, and /or associated information not shown in table.

Description of Sample *** Description of Sample *** Description of Sample

What Did the UFP Youth Experience Prior to Intake? (Caregiver Report)



Note: Sample n's varied from UFP 172-182, National CMHS longitudinal sample from 6,174 to 6,497; Aggregate Data Profile, July 2003.
*This statistic was not included in CMHS National Evaluation Aggregate Data Profile, July 2003 report.

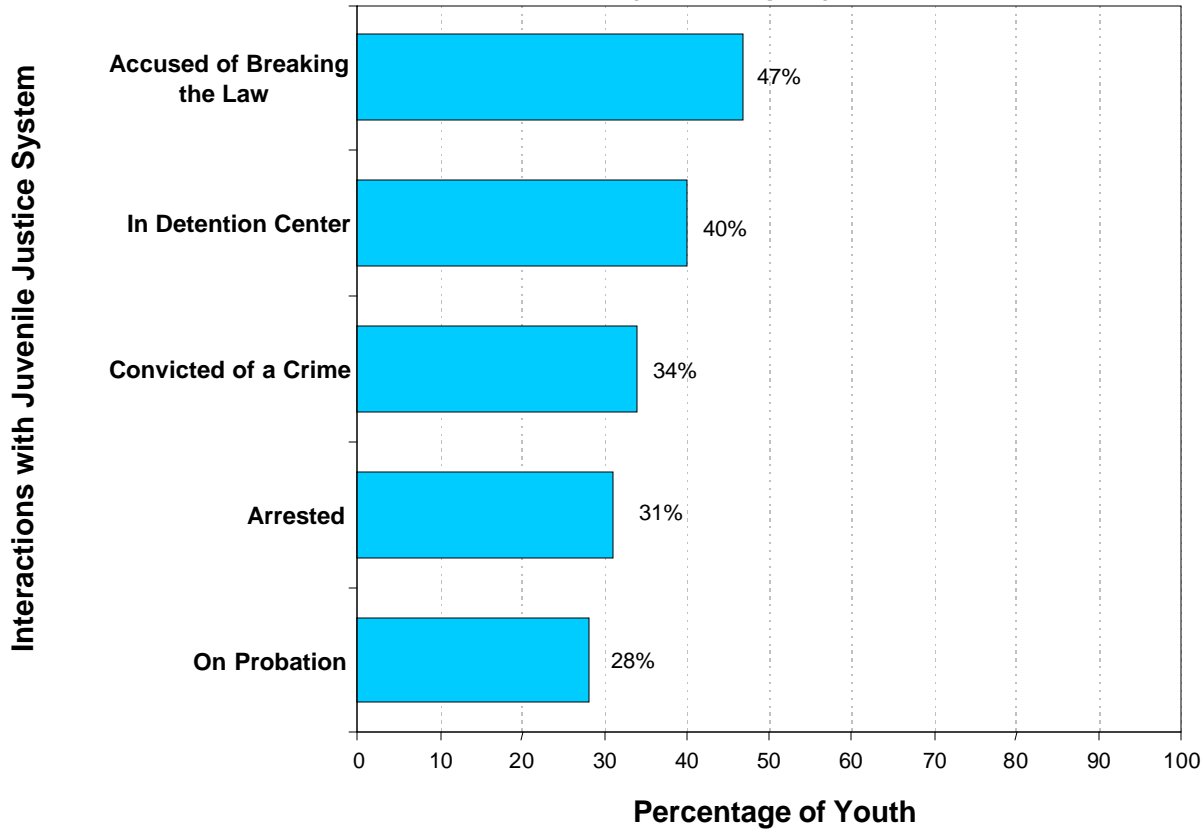
- A significant minority (23%) of UFP youth did not experience any of these “risk-behaviors,” but 38% experienced two or more factors.
- Higher percents of UFP youth had been abused than national sample youth (as per caregiver report).
- Lower percent of UFP youth had received psychiatric hospitalization.
- See page 9 for youth report about experiences with juvenile justice system.

Action Statement: Train community members about post traumatic stress disorder symptoms, diagnosis, and treatment because of the high levels of trauma suffered by the children (physical and sexual abuse).

Notes below table present highlights of table, and /or associated information not shown in table.

Description of Sample *** Description of Sample *** Description of Sample

What Interactions Did the Youth Have with the Juvenile Justice System Prior to Intake? (Youth Report)



Note: Reported on Delinquency Survey Sample n's varied from 119-121.

- Half of the youth with SED reported two or more types of interaction with juvenile justice.
- About 1/3 (35%) of the youth reported none of these experiences.
- The next step is to report data from the juvenile justice agency for evaluation sample.

Action Statement: Screen all youth in the juvenile justice system for psychiatric problems.

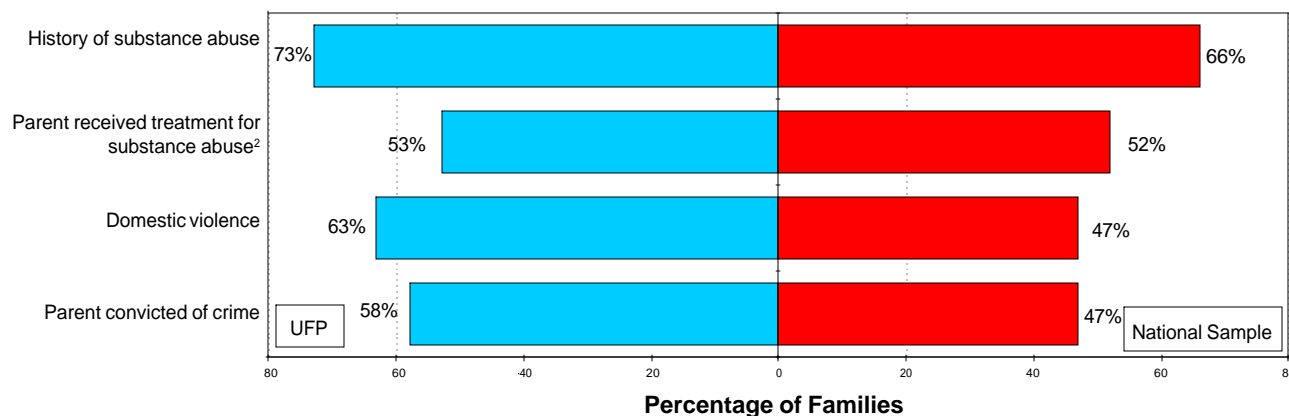
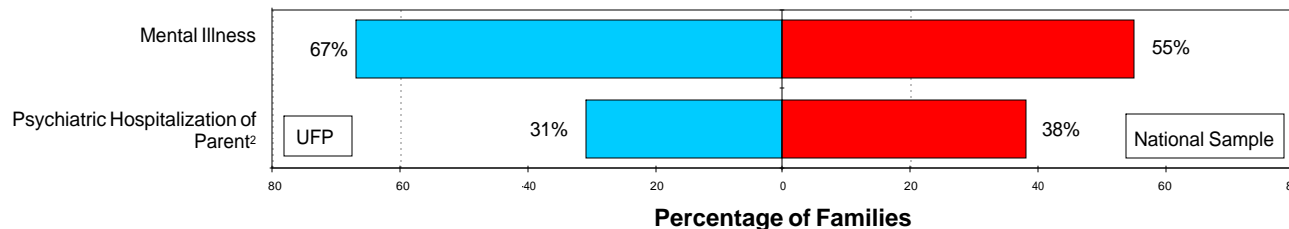
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Description of Sample *** Description of Sample *** Description of Sample

Research has demonstrated that certain “family” experiences are related to the incidence of emotional problems in children. Consequently, caregivers were asked if the following “family” experiences had occurred.....

What Did Youth Experience in Their Families¹ Prior to Intake? (Caregiver Report)

Types of Experience



Note: UFP Sample n's varied from 175-185, National CMHS Longitudinal sample from 3,441-6,285, Aggregate Data Profile, July 2003.

1. "Families" refers to youths' biological family.
2. Caregivers were asked about psychiatric hospitalization only if they reported a history of mental illness in the biological family (n = 99); similarly, caregivers were asked about receiving treatment for substance abuse only if they reported a history of substance abuse (n = 88).

- 90% of UFP youth experienced at least one of these factors.
- 73% of UFP youth experienced two or more.

Action Statement: Continue to improve services for families, especially to lessen domestic and substance abuse.

Notes below table present highlights of table, and /or associated information not shown in table.

Description of Sample *** Description of Sample *** Description of Sample

Annual Report Summary

(See following pages for further evidence)

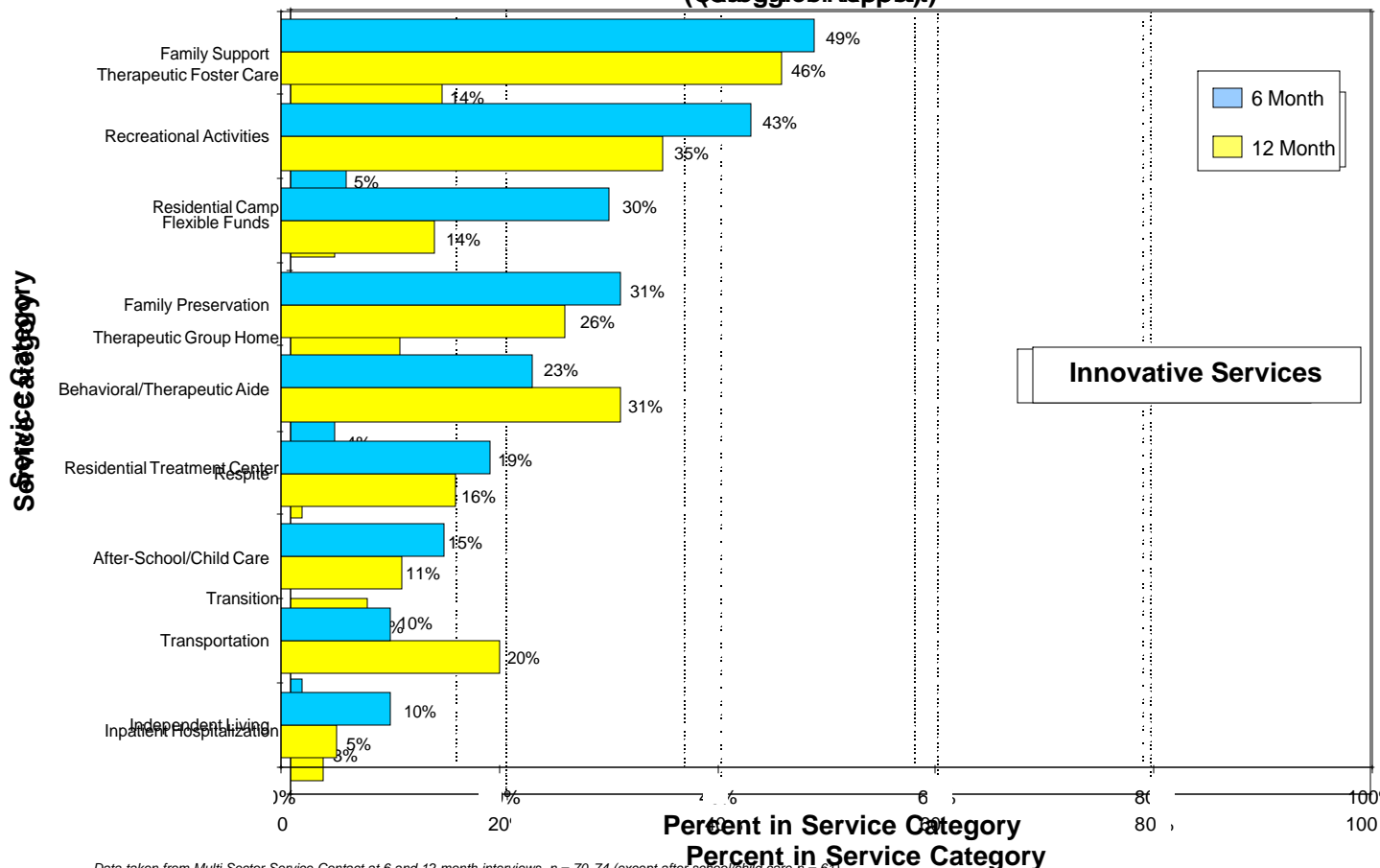
Objective 1. Create and expand services for children and youth with SED and their families through interagency activity.

This expansion of services has involved the creation of the role of **family facilitator** (family advocate) and the use of **family teams**.

Evidence:

- Number of youth served increased in the six counties served by Southwest Center and Four Corners Community Behavioral Health services (see map, page 5).
- Parents reported receiving traditional, innovative, and in a few cases, restrictive services. The array of services received are similar during the first and second 6 month periods.
- The addition of Family Teams and Family Facilitators appears to have increased interagency activity and the involvement of community members, as well as improving the quality of services.

What Services Were Received by Youth and Their Families? A Comparison of the 6 and 12 Month Interviews (Aggregate Report)



Objective I *** Objective I *** Objective I *** Objective I *** Objective I

Innovative Services

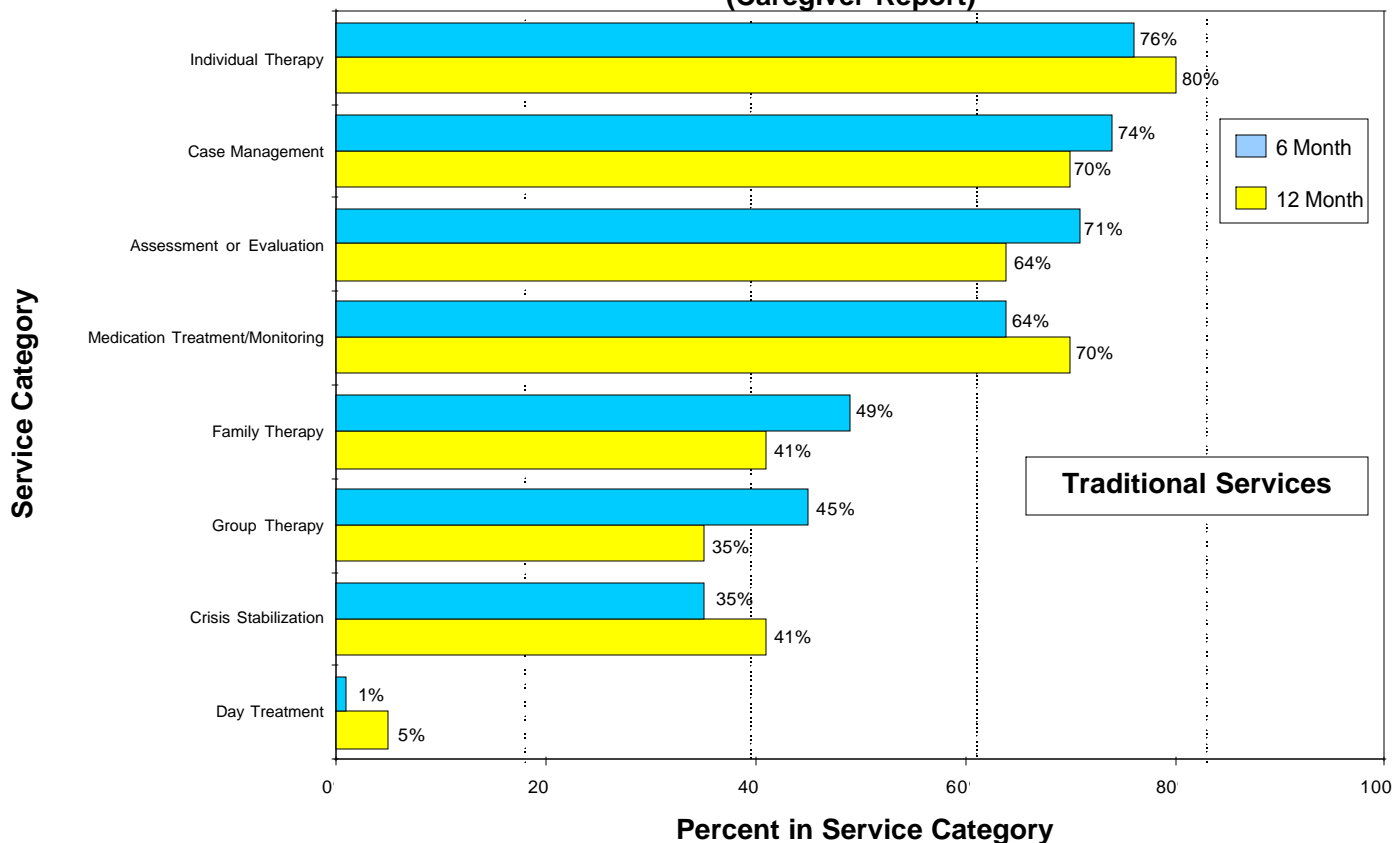
Notes: Data taken from Multi-Sector Service Contact at 6 and 12 month interviews. n = 70-74 (except after-school child care n = 6). The bar graph displays a list of all reported service categories during the first 12 months of services. It does not describe when the types of services were used or around methods which involve innovative services.

- Relatively few youth experienced restrictive services (n = 0 to 13)
- Increase in the use of expensive and disruptive services are seen at 12 months.

Action Statement: Examine clinical records and service plans for those specific youth to see how restrictive services could have been avoided in the previous ways of providing mental health services.

N Notes below table present highlights of table, and /or associated information not shown in table.

What Services Were Received by Youth and Their Families? A Comparison of the 6 and 12 Months Interviews (Caregiver Report)



Data taken from Multi-Sector Service Contact at 6 and 12 month interviews n = 70-74 (except after-school/child care n = 61).

The bar graph provides a "snapshot" of caregiver reported services received during the first 12 months of services. It does not demonstrate whether the types of services varied as sites began to use wraparound methods which involve innovative services.

- Notable changes include a decrease in the number of youth and families receiving family therapy and group therapy services.
- An increase is seen in the provision of crisis stabilization and medication treatment/monitoring.

Action Statement: 1) Given that families report that their needs are better met by innovative services (see page 28), Family Team Members should examine the service plans to see if the balance between types of services is appropriate for individual children and families, and 2) Examine records to determine if any of the individual therapy services are actually case management services.

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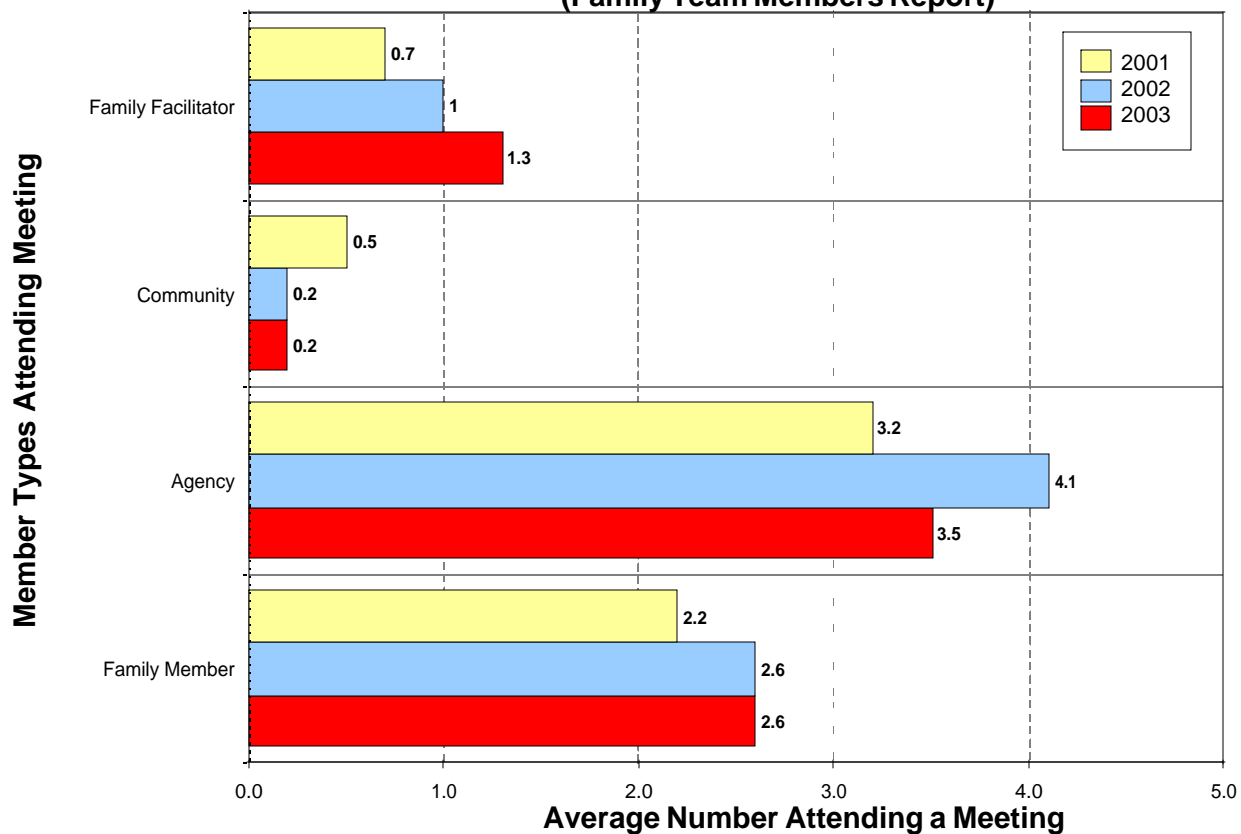
Objective 1 *** Objective 1 *** Objective 1

What is a Family Team?

A Family Team is composed of individuals chosen by the family; it could include the youth/child, a caregiver, a Family Facilitator, agency staff, and community members who provide informal or natural supports.

- Team meets regularly, as needed by family.
- Team jointly plans and implements services for youth and family, including crisis and safety plans.
- The goals are to:
 - Help the family understand the supports available, including agency and community resources.
 - Empower families to better negotiate the system of care to meet their child's needs.

**What Has Been the Participation by Families, Community Members, Agency Staff, and Family Facilitators in Family Team Meetings Over Time?
(Family Team Members Report)**



Notes: Number of meetings varied by year: n = 55 in 2001; 252 in 2002; 358 in 2003; Respondent n = 380 in 2001; 1997 in 2002; 2579 in 2003. Note that 2001 and 2003 are partial years. Information derived from SW Center and FCCBHC data. Detailed display of agency representatives is on page 23.

- Family facilitators participate in most meetings.
- Agency members, mostly mental health staff, typically have the highest attendance.
- The proportion of agency attendance to the attendance by other community members and family facilitators appears well balanced
- On average, 2 family members attend each meeting, and 1 family facilitator, and 3 agency members sit down with family.

Action Statement: Increase the participation of community members and community support.

*Objective 1. *** Objective 1. *** Objective 1.*

What is a Family Facilitator?

A Family Facilitator is a community member who has had experience in her/his own family with serious emotional disturbance and has been trained to support caregivers and youth who have serious emotional disturbance (SED). She/he:

- Ensures that the family voice is heard at Family Team meetings and agency meetings.
- Assists parents and family members to partner with agencies.
- Upon request, attends agency meetings with family.
- Facilitates wrap-a-around services for youth and family.
- Coordinates Family Team meetings.

What Do Mental Health Staff Say About Family Facilitation?

(continued)

PHHS Study (n = 6,000 mental health staff SWC)

Do services have a more strength-based approach when FF is involved?

What are the most important aspects of FF role?

- Yes 85%
- Sometimes 17%

Three selected most frequently:

- Providing Emotional support to family, especially primary caregiver.

Examples informal community supports.

- FF provides services & support in back to back to families.
- FF knows family and is able to present strengths others may not know.

When an FF is present at a Family Team meeting, is the meeting more positive, neutral, or more negative for families?

Does the participation of FF decrease, not change, or increase the effectiveness of services?

100% said more positive

- Decrease 0%
- Unchanged 17%
- Increase 83%

Examples More emphasis on strengths.

Examples Families more comfortable and more willing to share.

- FF is easier [for the families] to contact than MH workers.
- We have less resistance from families and with that we have better outcomes.

- USU staff conducted phone interviews with SWC mental health staff using an interview questionnaire format.
- These interviews indicate that Family Facilitators add an essential component to the provision of services.

Action Statement: Continue to emphasize and increase the involvement of Family Facilitators

Action Statement: Repe Family Team meetings. Corners site.

Objective I. *** Objective I. *** Objective I. *** Objective I. ***

Annual Report Summary

(See following pages for further evidence)

Objective 2. Develop child-centered and family driven, community-based, culturally competent, individualized, and strength-based service planning and delivery.

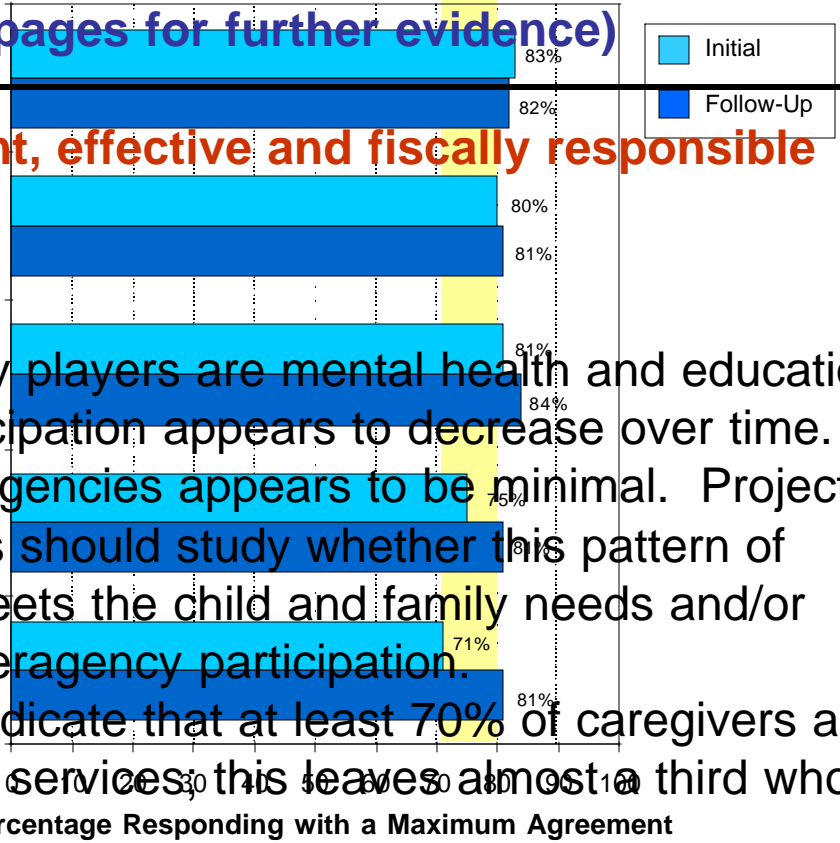
Evidence:

- Participants of the Family Team Meetings report that system of care principles (e.g. strengths-based, culturally competent) were being followed.
- Increased attention to developing long range goals and specific action steps appears to have occurred over time.

Were the Principles of System of Care Followed in Team Meetings?
(Family Team Member Report)

(See following pages for further evidence)

Was the meeting conducted in a strength-based (no shame, no blame) manner?



Objective 3. Build efficient, effective and fiscally responsible cross-agency services.

Evidence:

Were the customs and beliefs of the family considered as plans were developed?

➤ The major team agency players are mental health and education.

➤ DCFS and health participation appears to decrease over time.

Did the team develop/review long range goals for the child based on the strengths and preferences of the child and family?

➤ Participation by other agencies appears to be minimal. Project

staff and Family Teams should study whether this pattern of agency participation meets the child and family needs and/or

Were action steps developed to meet the long range goals?

➤ The satisfaction data indicate that at least 70% of caregivers and youth are satisfied with services; this leaves almost a third who are not satisfied.

Objective 2. *** Objective 2. *** Objective 2.

Respondents that marked a 1 (maximum agreement) on a 1-4 scale, with "Yes" and "No" as anchors.

➤ Participants generally agreed that system of care principles were being followed.

➤ Generally, there was improvement over time in respecting customs and beliefs of family, in basing goals on child strengths and developing associated action steps.

in addition to traditional services.

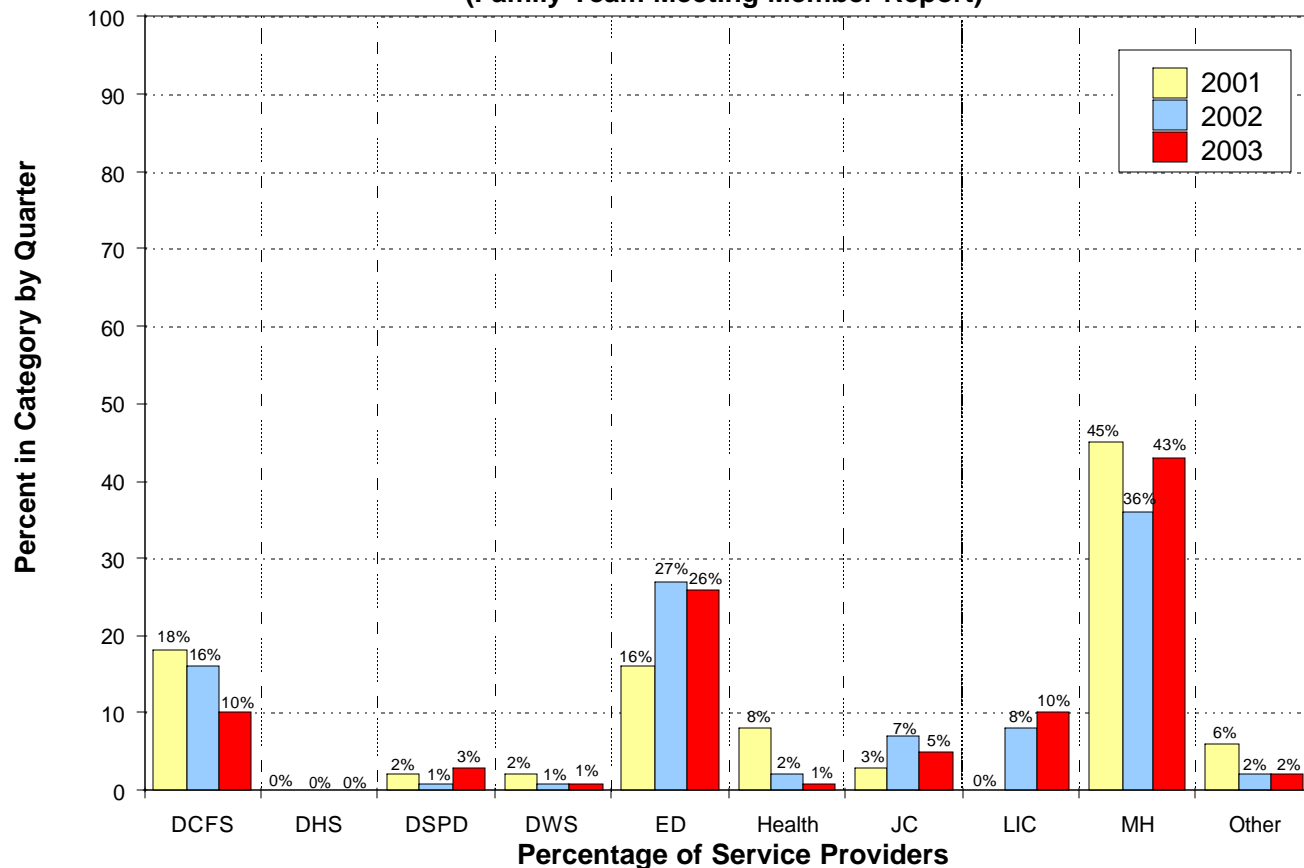
Action Statement: 1) Clearly address long range goals earlier in the service plan, and 2) Continue to provide

services ➤ Over a third of families discontinue services, without completing

services.

Notes below table present highlights of table, and /or associated information not shown in table.

What Has Been the Participation by Agencies in Family Team Meetings Over Time? (Family Team Meeting Member Report)



Objective 3 *** Objective 3 *** Objective 3

Note:
 DCFS = Division of Child and Family Services; DHS = Department of Human Services; DSPD = Division of Services for Persons with Disabilities; DWS = Division of Work Force Services; ED = Education; Health Department of Health; JC = Juvenile Court; LIC = Local Interagency Council; MH = Mental Health; Other includes: Disability Law Center, Project Turn, Project Excel, and Police Department and Local Interagency Council.
 Percentages across providers sum to 100% within years (bars of like color).
 SWC initiated Family Team meetings in 2001, FCCBHC initiated Family Team meetings in 2002.
 Total meetings = 55 in 2001, 252 in 2002, and 358 in 2003. (Note: 2001 and 2003 were partial years).
 Number of meetings: n = 55 in 2001; 252 in 2002; 358 in 2003; Respondent n = 190 in 2001; 1032 in 2002; 1149 in 2003.

- Mental Health and education continue to participate more than other agencies.
- The participation of DCFS appears to have decreased over time.
- LIC participation in Family Team meetings.

Action Statement: Increase agency collaboration at administrative level to facilitate collaboration at the Team Meeting level.

Two surveys asked about the benefits or satisfaction with services.

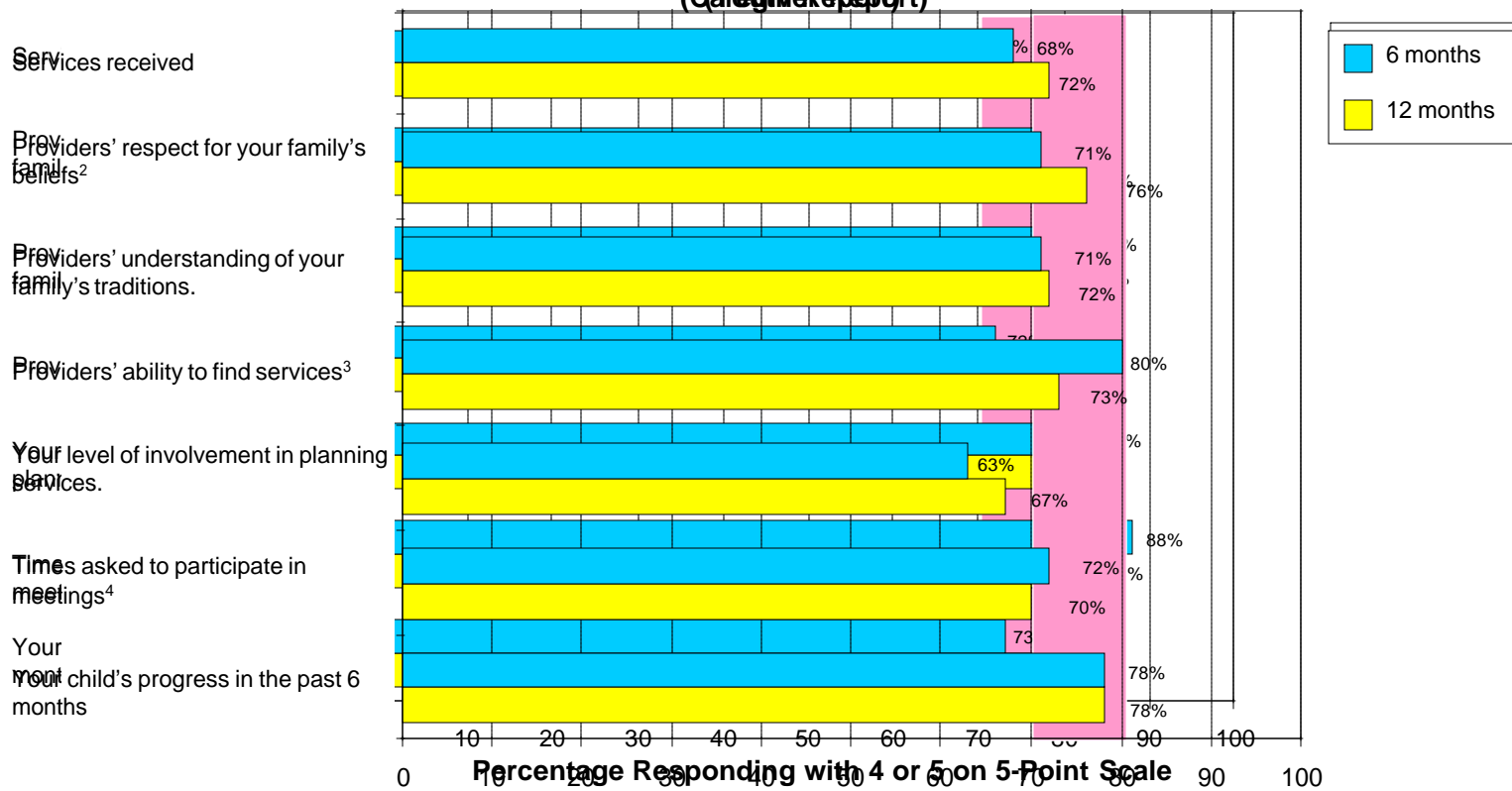
Family Satisfaction Questionnaire (completed by caregiver and youth).

7 statements about services, approach of system of care to client and family, involvement of family, and progress of youth were rated.

Multi-Sector Service Questionnaire.

This survey asks caregiver about 23 types of services. If the family received that service, the caregiver is asked to rate *“How well the service met their need.”*

**What Percentage of Caregivers Reported Being Satisfied with Services at a 6 or 12 Month Interview?
(Caregiver Report)**



Objective 3 *** Objective 3 *** Objective 3 *** Objective 3 ***

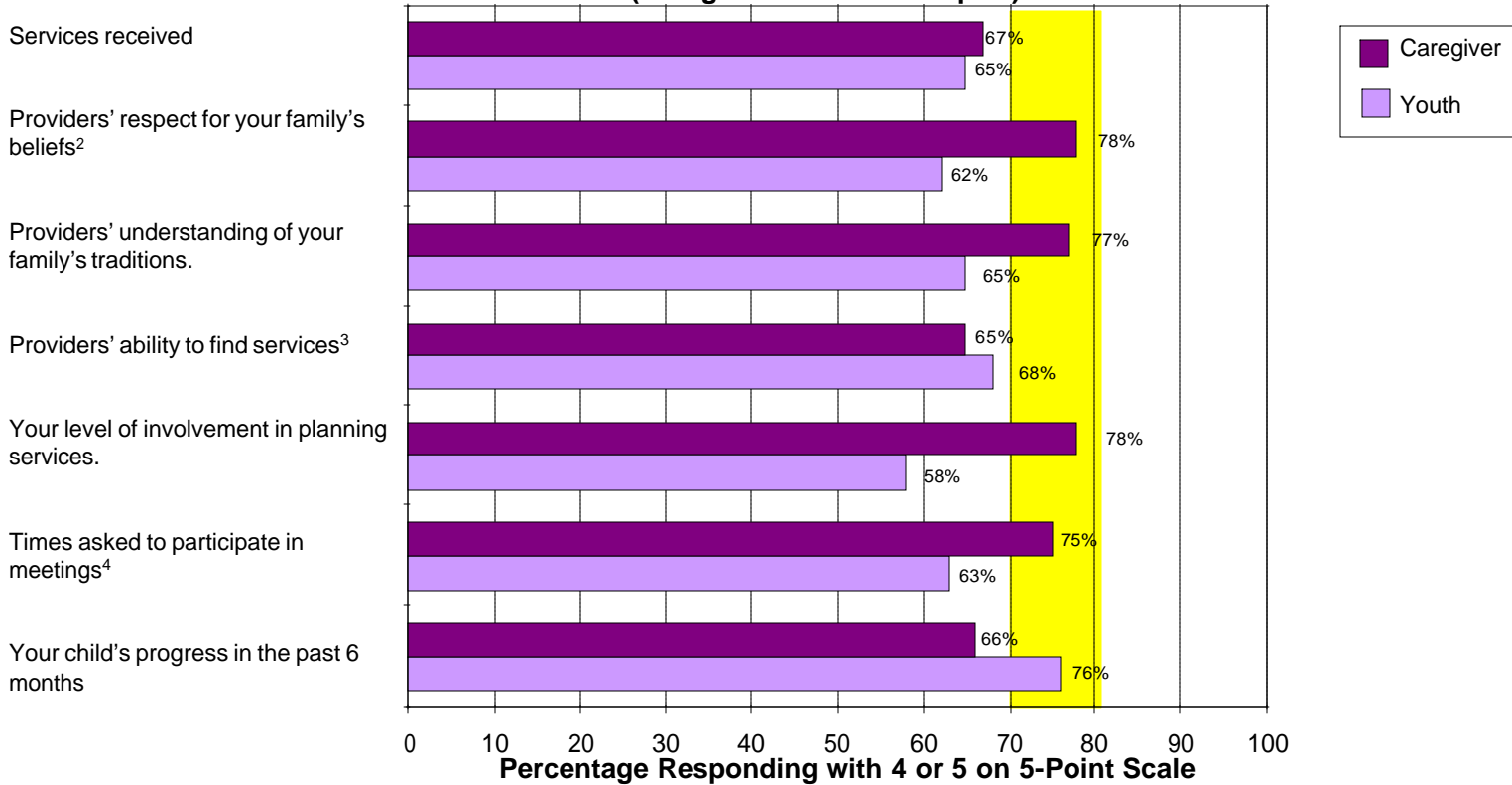
Notes: Sample n's varied from 63-70. Caregiver satisfaction was measured with the Youth Satisfaction Questionnaire, Abbreviated Version (YSQ-A).
 1. Percentages (e.g. 70% on first bar) are not averages; instead, they are the percentage of respondents who responded "satisfied" or "very satisfied" on a five point scale ranging from very dissatisfied to very satisfied.
 2. Satisfaction was measured with the Youth Satisfaction Questionnaire, Abbreviated Version (YSQ-A).
 3. Specifically, these services first had to be provided in the past 6 months of the caregiver's child's care and then the caregiver responded "satisfied" or "very satisfied" on a five point scale ranging from very dissatisfied to very satisfied.
 4. These are meetings where services for youth or family were discussed.

- Overall, caregivers are satisfied with services.
- Overall, there are few differences in satisfaction ratings given after 6 and 12 months of services.
- Youth were least satisfied with their involvement in planning services at the 12 month interview
- Overall, there are few differences in average satisfaction ratings given after 6 and 12 months of services.

Action Statement: 1) Continue present efforts to increase youth participation in services which make adjustments as needed to parent's involvement when planning future services.

Notes below table present highlights of table, and /or associated information not shown in table.

**Across All Interviews, How Do the Caregiver and Youth Service Satisfaction¹ Ratings Compare?
(Caregiver and Youth Report)**



Objective 3 *** Objective 3 *** Objective 3

Notes: Sample n's varied from 136-138. Caregiver satisfaction which was measured with the Family Satisfaction Questionnaire, Abbreviated Version (FSQ-A). Sample n's varied from 103-107 for youth satisfaction which was measured with the Youth Satisfaction Questionnaire, Abbreviated Version (YSQ-A).

1. Percentages (e.g. 67% on first bar) are not averages. Average satisfaction scores on each item was computed for each family and youth across time points. The percentages refer to respondents whose average response was "satisfied" to "very satisfied" on a five-point scale ranging from very dissatisfied to very satisfied.

2. Specifically, beliefs about mental health.

3. Specifically those services that acknowledge the positive aspects or strengths of your family's culture and traditions.

4. These are meetings where services for child (or caregiver) were discussed.

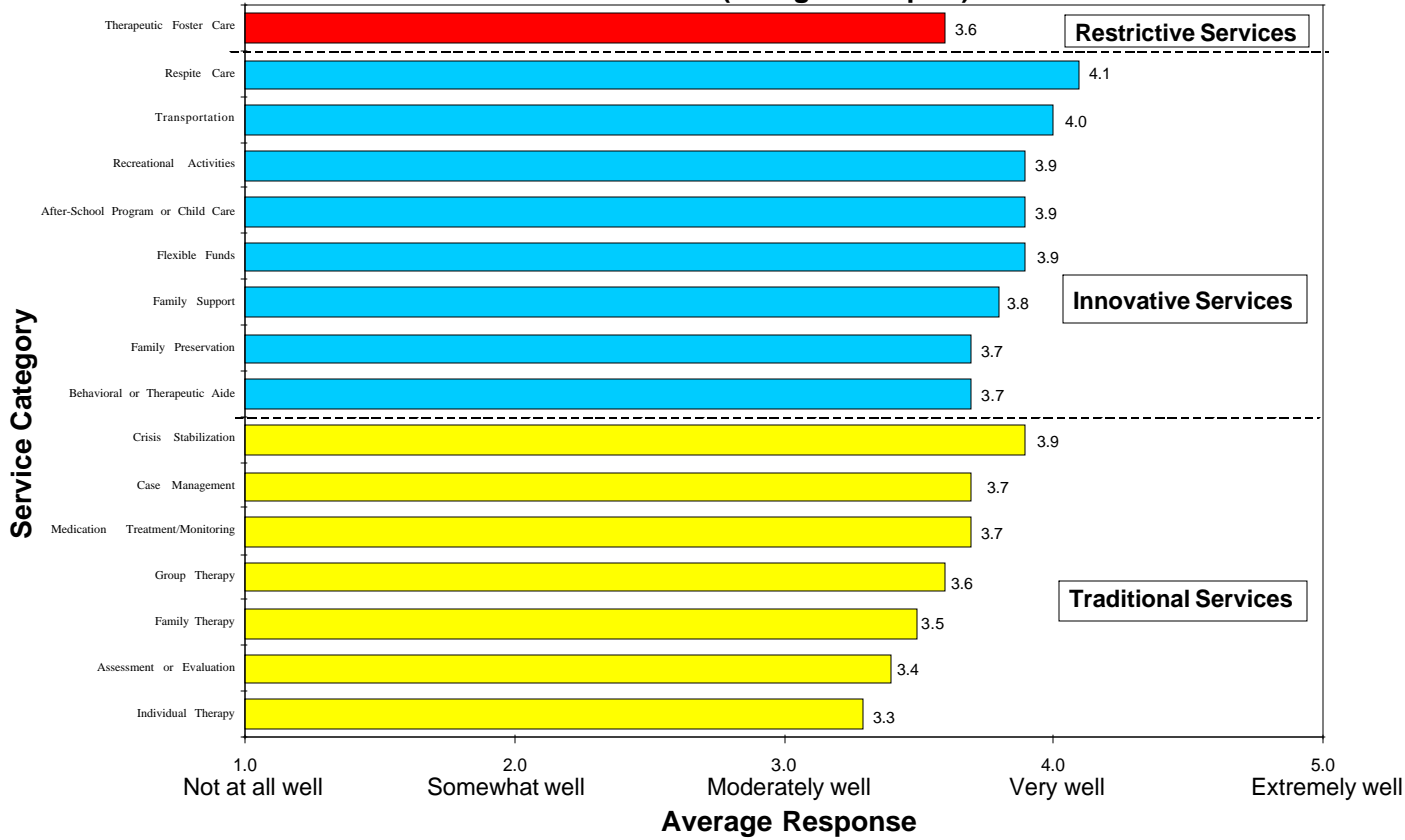
NOTE: The bar between 70-80% indicates an estimate of general satisfaction.

- Caregivers' report of satisfaction ranges from 63 – 78%.
- Youth report of satisfaction ranges from 58 – 76%.
- Across all interviews caregivers and youth are generally less satisfied than the 6 and 12 month reports indicate (see previous 2 tables).

Action Statement: Make efforts to understand why youth's satisfaction is generally less than caregivers. Make changes in policy as needed to better meet youth needs – as they perceive them.

Notes below table present highlights of table, and /or associated information not shown in table.

Over All Times, How Well Did Each Service Meet Families' Needs?*
(Caregiver Report)



Objective 3 *** Objective 3 *** Objective 3

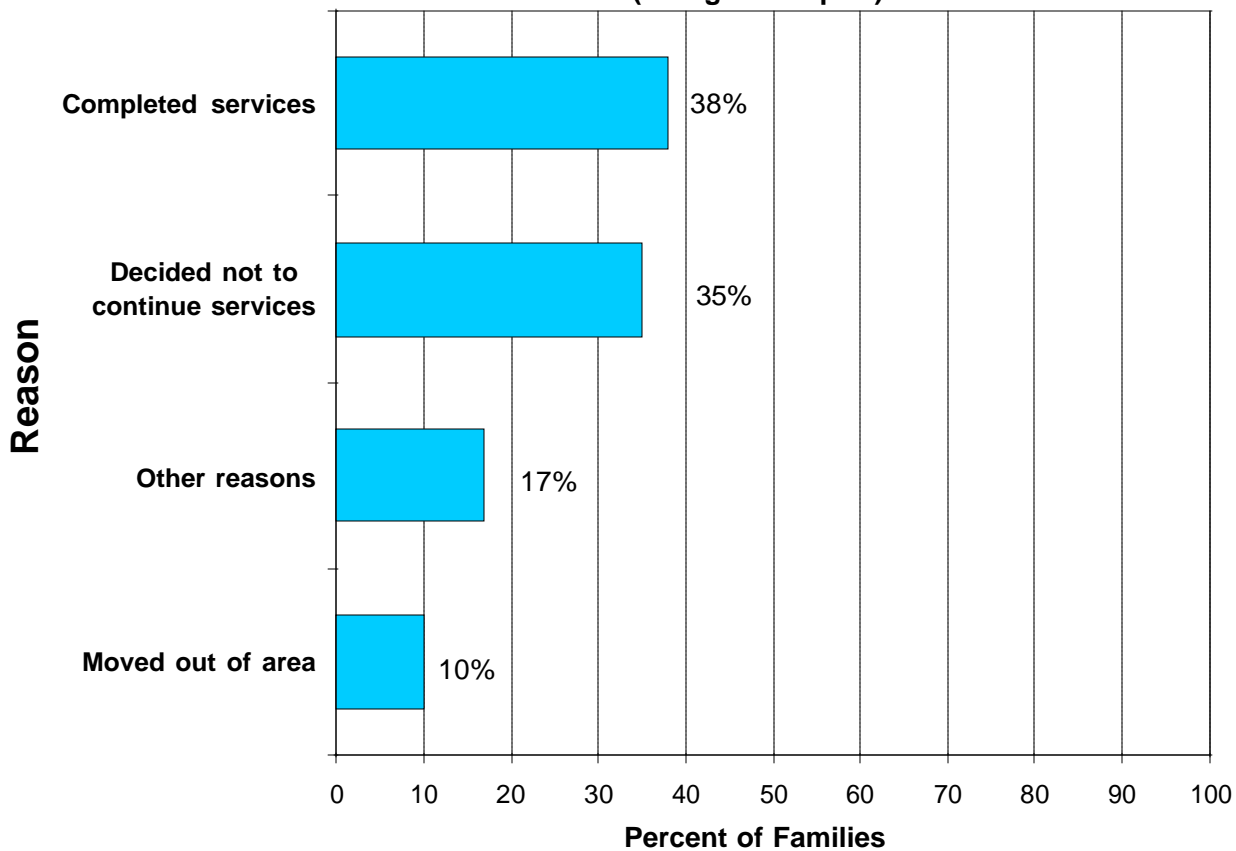
* Data taken from Multi-Sector Service Contacts measure. For each family who received a type of service, an average was computed across all interviews. Averages of those mean scores are shown here. Therefore, a family who rated a service type at 5 assessments is weighed equally with a family who rated a service type once. Only service types received by more than 20 families are reported.

- On average, families reported that their needs were well met.
- Generally, families reported that their needs were better met via innovative services than via traditional or restrictive services.
- This does not negate the importance of traditional and restrictive services, but indicates the importance of Innovative Services.
- A comparison of this table with the tables on pp. 12-14 is instructive. For example, more children receive individual therapy (p. 14) than any other service. Yet, caregivers report on average that individual therapy meets their needs only moderately well.

Action Statement: Use these data to inform policy decisions about services, staff training, funding, etc.

Notes below table present highlights of table, and /or associated information not shown in table.

**Why Did Youth and Family Discontinue Services?
(Caregiver Report)**



*Data taken from Multi-Sector Service Contacts measure at the first interview in which a family reported receiving zero services during the previous 6 months. (n = 48).

- Approximately, a similar percent of youth completed services as discontinued services. Does the percent completing services reflect sufficient success?

Action Statement: 1) Compare parent report of this question with agency report to better understand the reasons for the discontinuance of services; 2) Complete follow-up interviews with families who left services to identify factors that would encourage families to continue.

Notes below table present highlights of table, and /or associated information not shown in table.

Objective 3 *** Objective 3 *** Objective 3

Annual Report Summary

(See following pages for further evidence)

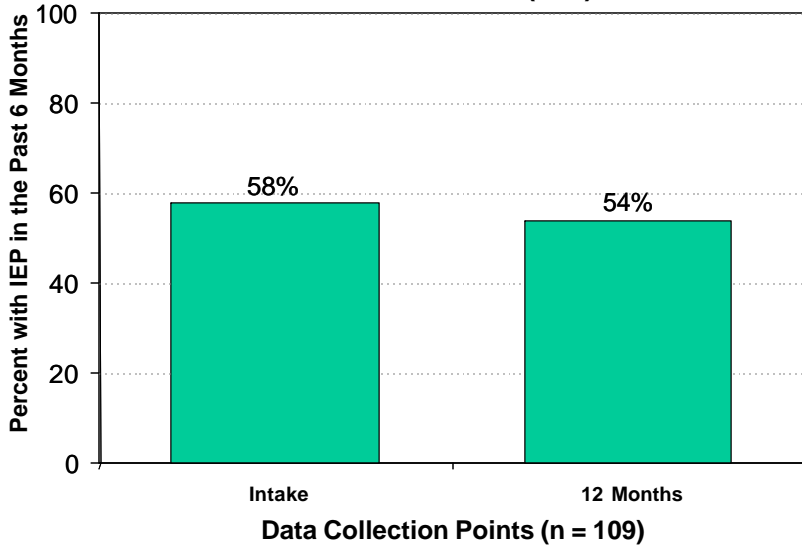
Objective 4. Improve outcomes for youth and family.

- Child behavior and functioning.
- Family perceptions of well-being and stress.

Evidence:

- There was a reduction in detentions and suspensions in school.
- Child behaviors improved over time.
- Caregiver perceptions of stress decreased over time.
- Caregiver perceptions of family resources improved over time.

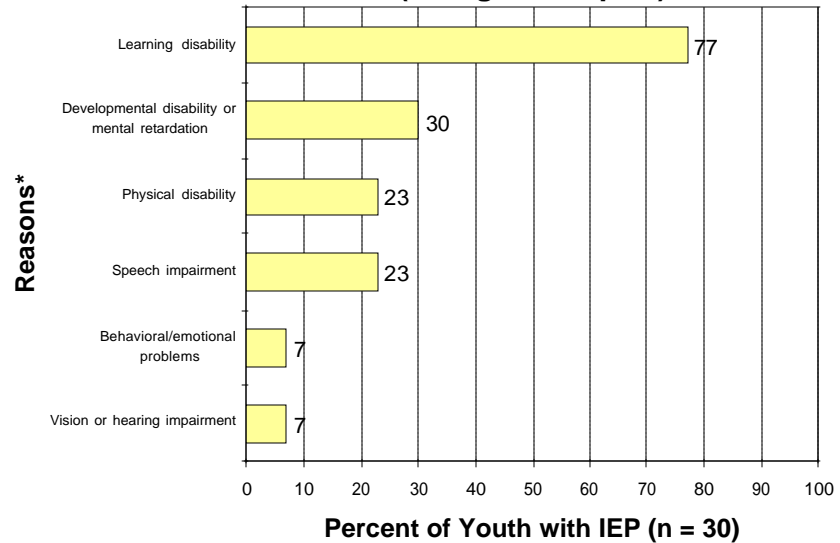
What Percent of the Youth Had Individualized Education Plans (IEP)?



Data taken from the Educational Questionnaire (EQ).

* Because individuals may have more than one reason for IEP, the reasons for IEP variable may add to more than 100%.

What Were the Reasons for the IEP's (Based on 12 Month Interviews) (Caregiver Report)

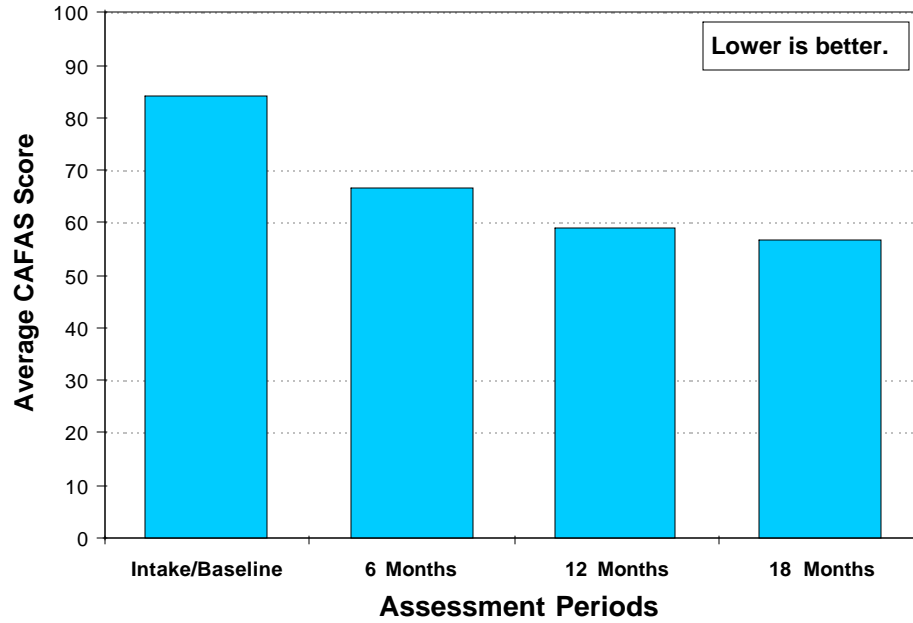


Objective 4. *** Objective 4. *** Objective 4.

- Given that all the children in the sample had SED, the limited percent listing behavioral/emotional problems on the IEP is surprising.

Action Statement: 1) This finding needs to be further examined by the Family Teams for youth who have IEPs, and 2) Review cases with no IEP's to determine whether the child qualifies for an IEP and request an IEP from the school.

Did Child Functioning (CAFAS¹) Improve Over Time? (Clinician Report)



Notes: n = 48 across all timeframes. -For this and following analyses, the sample was limited to the first four time periods to maximize meaningful statistical tests.
 -Statistical tests using Hierarchical Linear Modeling (HLM) were also performed so we could use all available data for those with at least two assessments (n=162 of 202 families). HLM results also showed a statistically significant improvement in functioning.

1. Youth functioning was measured with the Child Adolescent Functional Assessment Scale (CAFAS).

- Youth functioned better over time (changes were statistically significant).
- Changes were statistically significant for the total score and for 4 of the 8 subscales.
- CAFAS information states that individuals with scores of 50 or greater may need additional services beyond outpatient care. Thus, even with the improvement, many youth still need substantial services.

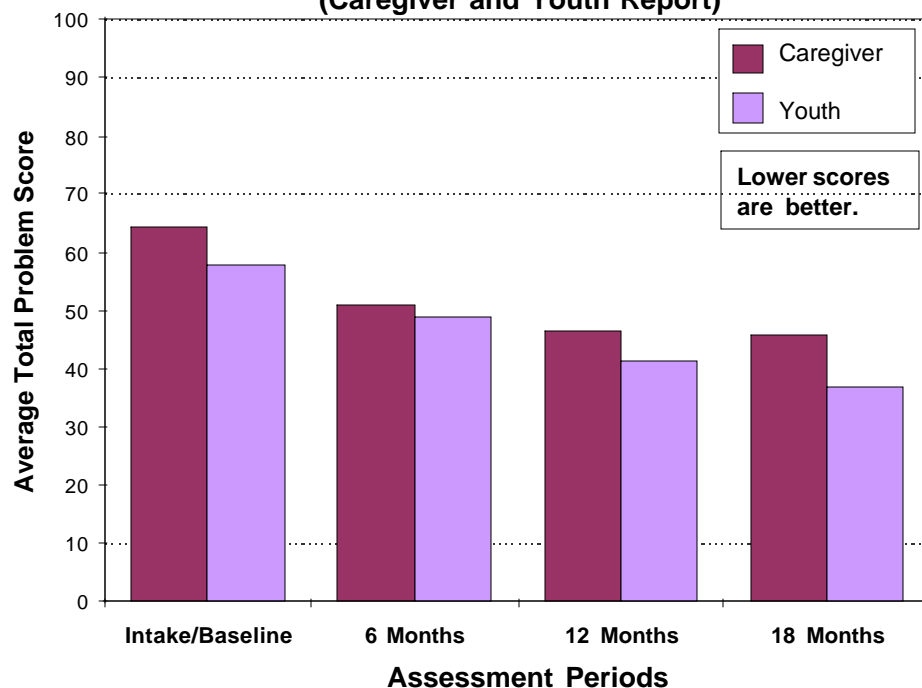
Objective 4. *** Objective 4. *** Objective 4.

Subscales with statistically significant improvements in scores:	School/Work Role scale Home Role scale Behavior toward others scale Mood scale	Subscales without statistically significant improvements, although scores generally improved:	Community Role scale Thinking scale Self-harm Behavior scale Substance Use Behavior scale
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Action Statement: Use to inform policy decision about the effectiveness of wrap-around service and celebrate the success of our families.

Notes below table present highlights of table, and/or associated information not shown in table.

Did Youth Behavior Problems¹ Decrease Over Time? (Caregiver and Youth Report)



Note: n = 98 across all timeframes (Caregiver = 60 plus Youth = 38). Youth do not participate in assessments unless they are 11 years of age or older. Analysis was limited to the same subjects over 4 time periods for statistical tests. Changes were statistically significant.

Statistical tests using Hierarchical Linear Modeling (HLM) were also performed so we could use all available data for those with at least two assessments (CG: n=158; Youth: n=120).

1. The Child Behavior Checklist (CBCL) and the Youth Self Report (YSR) measure youth behavior problems.

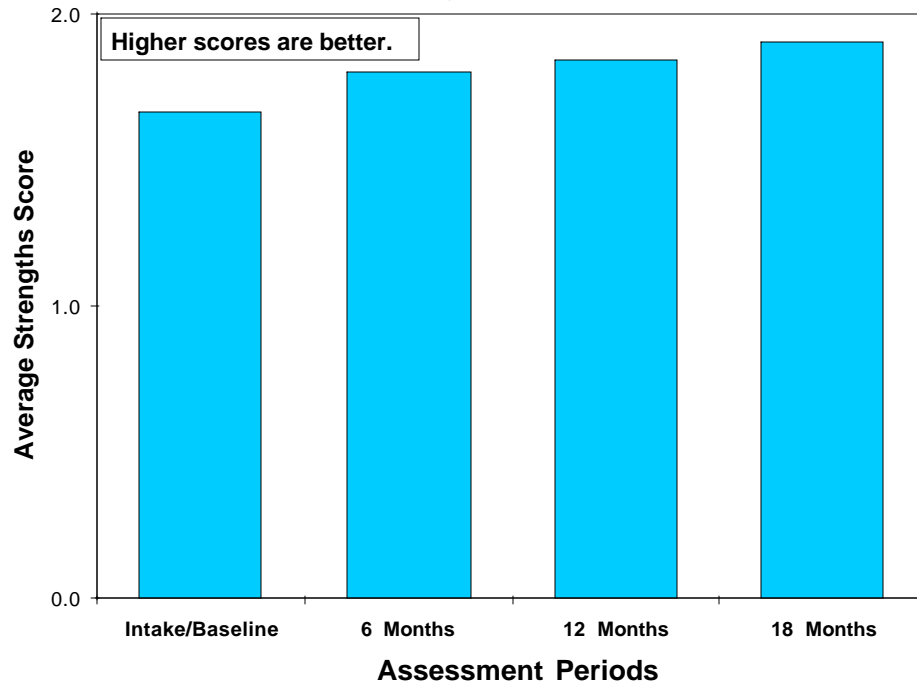
- Decreases in problem behaviors and negative emotions were reported by both the youth and caregivers (changes were statistically significant).
- Given that parents and youth see many other things differently, the agreement between parent and youth report is noteworthy.
- Scores below 60 indicate an individual is in the normal range for symptoms.

Action Statement: Use to inform policy decision about the effectiveness of wrap-around service and celebrate the success of our families.

Notes below table present highlights of table, and /or associated information not shown in table.

Objective 4. *** Objective 4. *** Objective 4.

**Did Youth Behavioral and Emotional Strengths (BERS¹) Improve Over Time?
(Caregiver Report)**



Note: n = 60 across all timeframes. Improvements were statistically significant. Statistical tests using Hierarchical Linear Modeling (HLM) were also performed so we could use all available data for those with at least two assessments (n=161). HLM results also showed a statistically significant increase.

1. Behavioral and Emotional Rating Scale (BERS) measured the strength of youth behaviors and emotional strengths using a 4-point scale (from 0 = "not at all like my child" to 3 = "very much like my child").

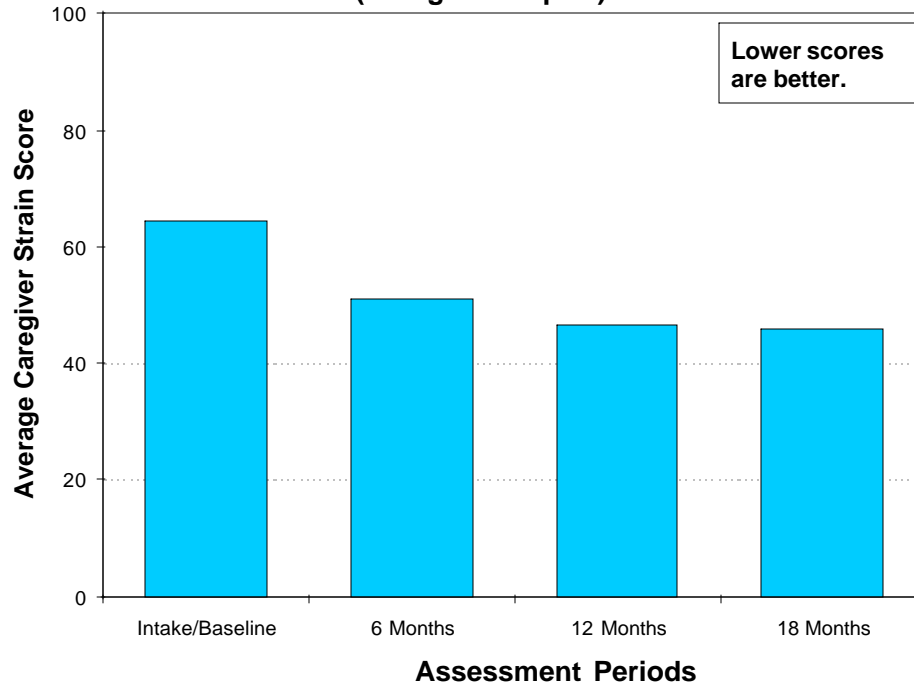
- Caregivers reported increased positive behaviors and emotions of their children (changes were statistically significant) over time.
- Four of five subscales of the BERS had statistically significant increases in scores over time:
 - Interpersonal Strength
 - Family Involvement
 - Intrapersonal Strength
 - School Functioning
- Affective Strength also increased but increases were not statistically significant.

Objective 4. *** Objective 4. *** Objective 4.

Action Statement: Use to inform policy decision about the effectiveness of wrap-around service and celebrate the success of our families.

Notes below table present highlights of table, and /or associated information not shown in table.

**Did Caregiver Strain (CGSQ¹) Lessen Over Time?
(Caregiver Report)**



Note: n = 50 across all timeframes. Changes were statistically significant. Statistical tests using Hierarchical Linear Modeling (HLM) were also performed so we could use all available data for those with at least two assessments (n=150 of 194 families). HLM results also showed a statistically significant decrease.

1. The Caregiver Strain Questionnaire (CGSQ) measured the level of caregiver stress using a 5-point scale with 1 = "not at all a problem" to 5 = "very much a problem".

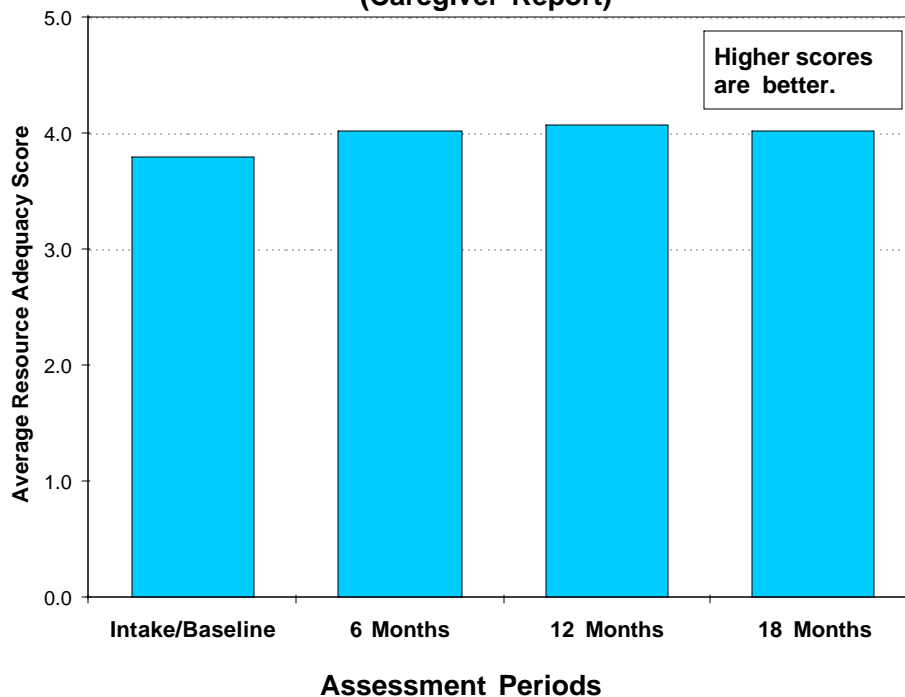
- Caregivers of youth with SED often report increased or high stress in relation to caring for the youth.
- The overall stress/strain reported by caregivers decreased over time.
- All three subscales of the CGSQ had statistically significant decreases in scores over time:
 - Objective Strain
 - Subjective-externalized Strain
 - Subjective-internalized Strain

Action Statement: Use to inform policy decision about the effectiveness of wrap-around service and celebrate the success of our families.

Notes below table present highlights of table, and /or associated information not shown in table.

Objective 4. *** Objective 4. *** Objective 4.

**Did the Adequacy of the Family’s Material and Social Support Resources (FRS¹) Increase Over Time?
(Caregiver Report)**



Note: n = 53 across all timeframes. Statistical tests using Hierarchical Linear Modeling (HLM) were also performed so we could use all available data for those with at least two assessments (n=151 of 195 families). Results showed a statistically significant increase

1. The Family Resource Scale (FRS) measured the adequacy of the family’s resources using a 5-point scale. Five subscales were averaged for the results shown above.

- Family resources reported by caregivers increased over time (changes were statistically significant).
- Two of five subscales of the FRS also had statistically significant increases in scores over time:
 - Time and Social Support
 - Basic Needs
- The following subscale scores also generally increased but were not statistically significant:
 - Cash and Recreation
 - Secondary Needs
 - Health Care/Social Services
 - Child Care

Action Statement: Use to inform policy decision about the effectiveness of wrap-around service and celebrate the success of our families.

Notes below table present highlights of table, and /or associated information not shown in table.

Objective 4. *** Objective 4. *** Objective 4.

Triangulation of Results Increases Confidence in Positive Findings

