Minnesota Department of **Human Services**

SCHOOL-LINKED MENTAL HEALTH SERVICES GRANTS

COMPOSITE REPORT

January 2007 through December 2007

School-Linked Mental Health Services Grants
Composite Report
January 2007 – December 2007

Grant Purpose:

This grant funding supported school-located or school-linked clinical mental health services to children with an Emotional Disturbance. 24 Children's Mental Health Collaboratives and Family Services Collaboratives coordinated these funds and services among their partners, including schools, mental health providers, and counties. These services benefited children and their families in 24 counties and 85 school districts.

The grantees were expected to implement various strategies to work toward the following objectives:

I. Increase accessibility to mental health services for children with a mental health diagnosis
II. Improve the functioning and reduce symptoms of children with a mental health diagnosis
III. Strengthen coordination with student support and other school services
IV. Address stigma associated with seeking or receiving mental health services
V. Develop long-term funding efforts to sustain these services

By integrating clinical standards, diagnostic assessments, and individual outcomes measurements with other promising practices at the local level, this initiative brought together standards of care with systems of care. This effort also strengthened the state's mental health infrastructure for improving the mental health system for children with mental health needs, particularly those who are uninsured or underinsured.

The grantees submitted quarterly progress reports to describe the number of children served, number served with or without Minnesota Health Care Programs (Medical Assistance and Minnesota Care), and the amount of third-party reimbursement received for these services. The progress reported also contained information about efforts to implement work plan strategies to realize the objectives listed above. Furthermore, grantees submitted quarterly outcomes measures data sheets containing CASII (Child and Adolescent Service Intensity Inventory) and SDQ (Strengths and Difficulties Questionnaire) scores.

The intent of this grant was to sustain specific existing collaborative services at risk due to the projected loss of LCTS funding. Although these were continuing programs, many initially needed some time to adapt to the additional requirements associated with this grant for reporting, diagnosing, claiming third party reimbursement, etc.

I. Objective: Increase Accessibility to Mental Health Services for Children with a Mental Health Diagnosis

A. Number of Children Served/Grant Financial Information:

Quarter	Total Served During Quarter [a]	% Annual Total Proposed [b]	Dollars Billed [c]	% Total Annual Budget [d]
Q1 2007	1,498	40.7%	$399,629.00	20.1%
Q2 2007	1,727	47.0%	$527,833.00	26.5%
Q3 2007	1,190	32.4%	$559,892.00	28.1%
Q4 2007	1,441	39.2%	$493,996.00	24.8%

[a] Total number of unduplicated cases is not available. These numbers reflect the number of children served during the representative quarter. This includes all children served through school-linked mental health programs, not just those funded through grant dollars.
[b] Grant proposal indicated that 3,677 children would receive services each year of the two-year grant period.
[c] Dollars billed is the amount billed for services and administrative costs. This does not necessarily reflect the amount of compensation received from the grant for that period.
[d] Total Annual Budget = $1,989,209.00.

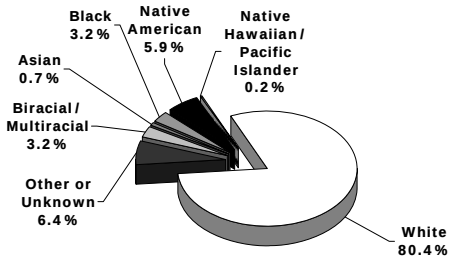
B. Demographics of Children Served:

1. Gender: Of the 1784 children for whom initial data (Time 1) was sent, 58.2% were male and 41.8% were female. Of the 717 children with follow-up data (Time 2), 58.7% were male and 41.3% were female. At time 3 (sample size = 141), 57.4% were male and 42.6% were female. At Time 4, 78.9% of the 19 children were male and 21.1% were female

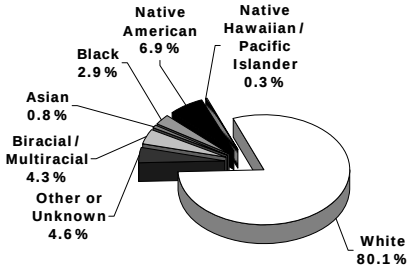
2. Age: The average age of children served at Time 1 was 11.3 (SD = 3.63). The average age at Time 2 was 11.6 (SD = 3.60). The average ages at Times 3 and 4 were 11.8 (SD = 3.14) and 12.4 (SD = 2.24) respectively.

3. Racial Background: The racial backgrounds represented are graphed on page 2:

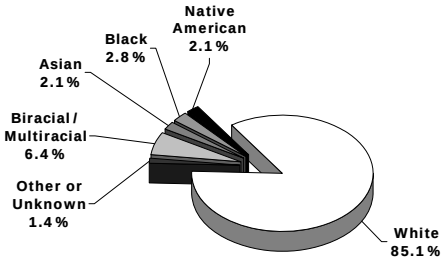
Racial Background - Time 1



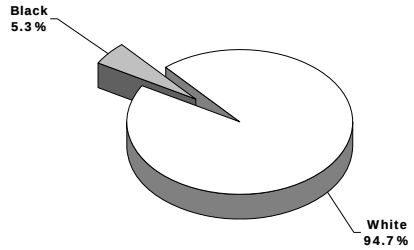
Racial Background - Time 2



Racial Background - Time 3



Racial Background - Time 4



- The percentage of children with Latino/a ethnic background was 3.4% at Time 1 and 2.6% at Time 2. At Time 3, 2.2% were identified as having Latino/a ethnic background. No children were reported to have Latino/a ethnic background at Time 4.
- According to 2006 U.S. Census Bureau estimates, the racial background for Minnesota is 3.5% Asian, 4.5% Black, 89.3% White, 1.2% Native American, 0.1% Native Hawaiian/Pacific Islander, and 1.5% Bi-racial or Multiracial. 3.8% identify themselves as having Latino ethnic background. Collaboratives involved in the School-Linked Mental Health Services Grant appeared to be serving a higher percentage of children with minority backgrounds at Times 1, 2, and 3. (Source: U.S. Census reports from http://quickfacts .census.gov/qfd/states/27000.html, printed 1/09/2008).
- Additional information is available in Appendix A.

C. Collaborative Grantees:

Collaborative	Time 1		Time 2		Time 3		Time 4	
	N	%	N	%	N	%	N	%
Beltrami Area Service Col. (BAC)	118	6.6%	17	2.3%	2	1.4%	0	0.0%
Benton Co. Children's MH Col. (BCC)	110	6.2%	45	6.1%	0	0.0%	0	0.0%
BRIDGES Col. (BRD)	28	1.6%	4	0.5%	0	0.0%	0	0.0%
Clearwater Co. Children's MH Col. (CCC)	13	0.7%	7	1.0%	0	0.0%	0	0.0%
Cass Co./Leech Lake Reservation Children's Initiative (CLL)	39	2.2%	13	1.8%	0	0.0%	0	0.0%
Crow Wing Co. Family Services Col. (CWC)	194	10.9%	27	3.7%	11	7.8%	0	0.0%
Dakota Co. Col. (DCC)	27	1.5%	15	2.0%	0	0.0%	0	0.0%
Hubbard Co. Family Services Col. (HCC)	26	1.5%	9	1.2%	0	0.0%	0	0.0%
Mahnomen Co. Interagency Col. (MCI)	22	1.2%	10	1.4%	0	0.0%	0	0.0%
Northern St. Louis Co. Family Services Col. (NSL)	293	16.4%	208	28.3%	0	0.0%	0	0.0%
Otter Tail Family Services Col. (OTC)	200	11.2%	130	17.7%	67	47.5%	0	0.0%
PACT 4 Families Col. (PFF)	28	1.6%	3	0.4%	0	0.0%	0	0.0%
Pine Co. Family Services Col. (PCF)	38	2.1%	26	3.5%	0	0.0%	0	0.0%
Redwood Co. Col. (RCC)	91	5.1%	14	1.9%	1	0.7%	0	0.0%
Stearns Co. Family Services Col. (SCC)	154	8.6%	62	8.4%	2	1.4%	0	0.0%
Scott Family Net (SFN)	83	4.7%	37	5.0%	6	4.3%	0	0.0%
Suburban Ramsey Family Col. (SRC)	118	6.6%	9	1.2%	0	0.0%	0	0.0%
Three Counties for Kids Children's MH Col. (TCK)	29	1.6%	1	0.1%	0	0.0%	0	0.0%
Washington Co. Child and Family Council (HSI)	97	5.4%	78	10.6%	48	34.0%	19	100.0%
Wright Co. Family Services Col. (WFS)	76	4.3%	19	2.6%	4	2.8%	0	0.0%
Total	**1784**	**100%**	**734**	**100%**	**141**	**100%**	**19**	**100%**

Note: Co. = County; Col. = Collaborative; MH = Mental Health; N = Number of cases; % = Percentage of all cases that administration time.

D. Progress implementing work plan strategies to increase accessibility to mental health services for children with ED or SED:

This project expected that these services would be accessible beyond the academic school year and would be available to children and their families as needed throughout the calendar year. Each grantee also submitted strategies designed to increase the accessibility of services for children with a mental health diagnosis.

The following are some of the promising practices as reported in quarterly progress reports for 2007:

- **Implemented outreach and education efforts to students, staff and families:**
  - Collaborative staff created brochures and a list of referral sources for school personnel, made presentations to school and county boards and school staff meetings, and were present at booths during parent visitation evenings and school conferences.
  - Spent the first two weeks of school checking in with students and school staff, screening students and sharing information.
  - Attended back-to-school conferences and orientations to hand out pamphlets.
  - Provided information at back-to-school open house for parents on how to access services and what to look for if you suspect your child may need these services.
  - Worked with school staff to address accessibility issues.
  - Participated in school conferences, events and consultation with teachers, such as IEP meetings.
  - Worked closely with schools and outside community agencies to ensure they were aware of our services, coordination opportunities.
  - Training to school staff on symptoms of mental health, concerns, and referral process was provided.

- **Developed new procedures for reaching and referring students:**
  - Conducted more screenings and assessments.
  - Staff coordinated with mental health centers to establish regular hours for assessments and supervision on-site at the schools.
  - The Juvenile Diversion Program served as an access point for a number of children seen by this agency. If mental health needs were identified by the screening process, and the child attended school in the district, the child and parent were then given information about school-linked services for follow-up care.
  - Collaborative staff coordinated with school staff (superintendents and teachers) to ensure service time during school day.
  - A direct referral process from school staff to mental health providers was developed via weekly referral and coordination meetings.
  - School staff members were trained on referral process and procedures for accessing insurance reimbursement.
  - Staff consulted with Bi-lingual Liaisons to connect children with culturally appropriate services.
  - Program staff met with school staff when referred children did not meet program criteria to discuss resources, including case management, available within the agency and community.
  - Referred uninsured and underinsured children who might not have easy access to other mental health services.
  - Mental health services were offered to uninsured youth with SED/ED diagnosis through the Connect Program.
  - School social workers referred uninsured and underinsured children who might not have easy access to other mental health services.
  - Collaborative staff met with county family services to discuss services, referrals, and eligibility.
  - Students were seen within one week of referral.
  - Uninsured and underinsured children were given priority on the provider's waiting list.

- **Offered times for services beyond the school building, day and year:**
  - School-Based Mental Health staff worked flexible schedules to accommodate for services outside the school setting.
  - Services were provided in ten school districts and were made available during and after school, as well as during summer months.
  - Treatment was continued over the summer months to ensure continuity of services over the summer for a successful start to the school year in the fall.
  - A plan with school staff for on-site summer services was developed in each district which involved coordinating building access, supervision, transportation, summer school hours, and other issues.
  - Services were continued for students during the summer. These services included home visits, meetings at neutral locations, or transportation assistance.

- The summer program was co-located at various school sites. The schools donated space, equipment and staff for this skills building service.
- Successfully developed strategies to overcome summer issues including referral, limited access to buildings, limited working school staff and strict summer school attendance/credit policies.
- Offered services to students throughout the summer, most often in their homes or at the school office.
- Provided summer services, including social skills with peers and adults.
- Provided additional summer support to those districts who requested the service, including classroom support and participation in summer camp programming.

➢ **Enhanced and expanded resources:**
- Maximized health insurance payments so more youth can be served with grant dollars.
- Procedures for obtaining insurance reimbursement were implemented for insured students.
- School Social Workers have been receiving clinical supervision to assist them in working toward funding for position sustainability.
- Sought additional resources, such as other grants, in order to expand program and increase access.

E. Summary of Increasing Accessibility to Mental Health Services:

➢ Twenty Collaboratives reported serving at least 1784 children in the first year of the grant. This is 48.5% of the proposed amount. It is possible that more children were served than are represented by outcome measures. It is important that outcome measures are submitted for all children served. Some agencies needed additional time at the beginning of the grant to develop services, which might also affect the total number of children served in 2007.

➢ Collaboratives served a higher percentage of children with minority backgrounds than statewide estimates.

➢ The Collaboratives increased accessibility through a variety of activities, such as:
- Implementing outreach and education efforts to students, staff and families
- Developing new procedures for reaching and referring students
- Offering times for services beyond the school building, day, and year
- Enhancing and expanding resources

➢ It would be helpful to have more information regarding efforts to address transportation barriers and decrease the waiting period for services.

➢ Many therapists had waiting lists, suggesting that students were accessing services.

➢ Students are seen within one week of referral suggesting that the waiting lists are not hindering student access, although access time should be monitored and the need for additional staff reviewed.

➢ It might be helpful to implement additional methods of educating parents and school personnel about available mental health services. Possibilities could include creating educational materials for teachers and parents regarding what types of problems or concerns would indicate referral for mental health services, adding a notice or article regarding services to a school newsletter or website, or providing educational materials (with contact information for the collaborative) about common mental health concerns for placement in the teachers' lounge and principal's office.

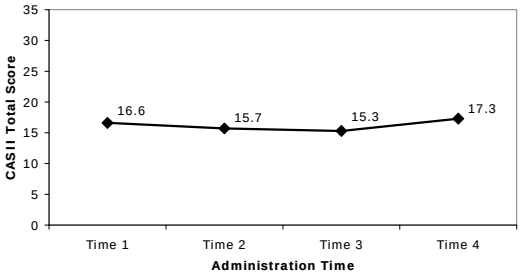
II. Objective: Improve Functioning and Reduce Symptoms of Children with a Mental Health Diagnosis

A. Child and Adolescent Service Intensity Inventory (CASII):

➢ A description of the CASII is available in Appendix B. Additional CASII results are available in Appendix A.

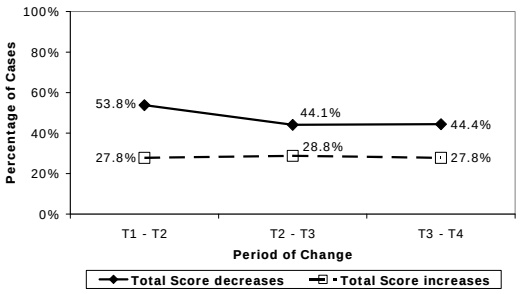
➢ The average CASII scores are listed on page 5:

Average CASII Total Scores across Administration Times



- Changes in CASII Total Scores between administration times. Percentages indicate the percentage of cases in which CASII Total Scores increased or decreased from one administration time to another. Comparisons between other administration times are available in Appendix A.

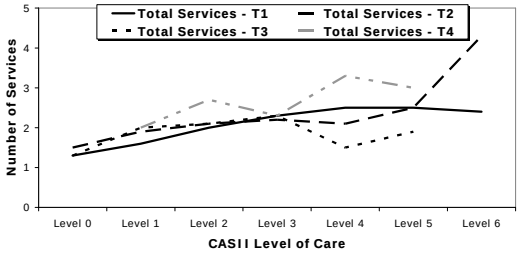
Changes in CASII Scores between Administration Times



- Comparison of CASII Levels of Care and providers' recommended services.

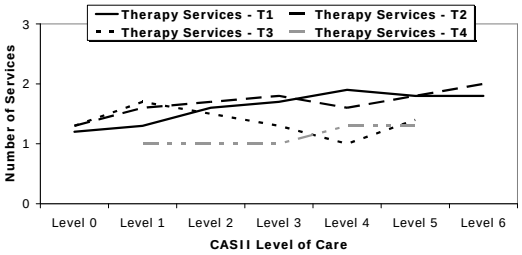
CASII Levels and Number of Services Recommended

Average Number of Services Recommended at each CASII Level: Total Services



Note. Total Services is the sum of all types of services recommended.

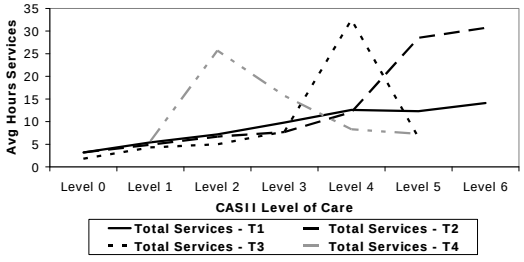
Average Number of Services Recommended at each CASII Level: Therapy Services



Note. Therapy Services include individual, family, and group psychotherapy and skills training.

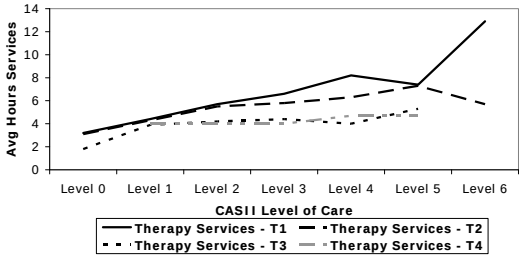
CASII Levels and Frequency of Services Recommended

Average Frequency of Services Recommended at each CASII Level: Total Services



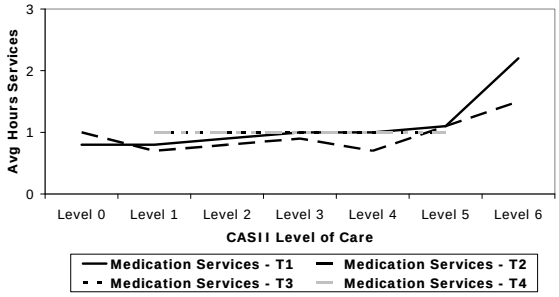
Note. Total Services is the sum of all types of services recommended.

Average Frequency of Services Recommended at each CASII Level: Therapy Services

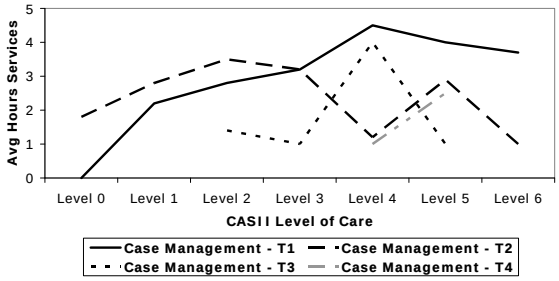


Note. Therapy Services include individual, family, and group psychotherapy and skills training.

Average Freuqency of Services Recommended at each CASII Level: Medication Services



Average Frequency of Services Recommended at each CASII Level: Case Management Services



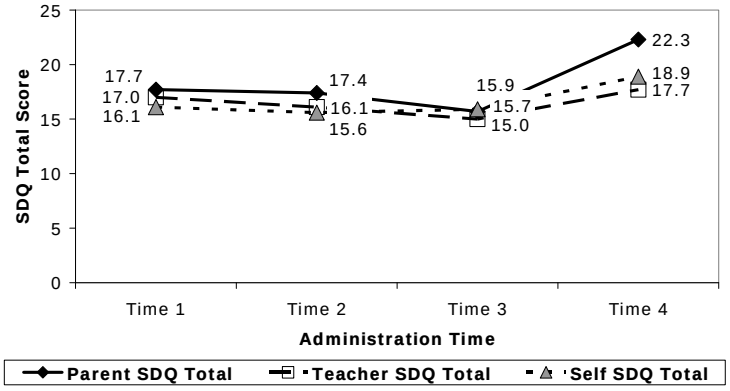
- Scoring errors in calculating Total Score were evident in 15.4% percent of CASII's at Time 1, 10.7% at Time 2, 12.8% at Time 3, and 0% at Time 4. Scoring errors in calculating Level of Care Recommended were observed in 19.6% of CASII's at Time 1, 19.1% at Time 2, 16.3% at Time 3, and 16.7% at Time 4. Providers should review scoring criteria. Common scoring errors are listed in Appendix A. Computer scoring was used for analyses presented in this report.

B. Strengths and Difficulties Questionnaire (SDQ):

- A description of the SDQ is available in Appendix B. The client (child), a parent, and/or a teacher can complete this instrument. Additional SDQ results are available in Appendix A.

- Average SDQ scores at Time 1 and Time 2.

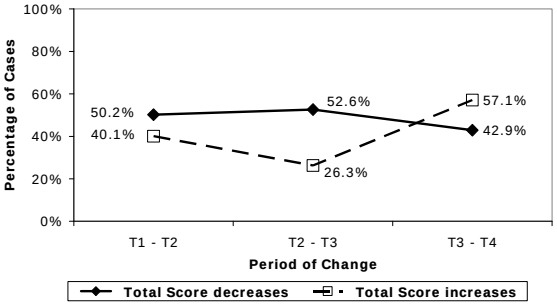
Average SDQ Total Scores at each Administration Time



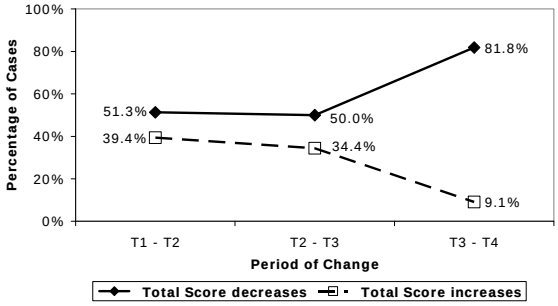
- Average SDQ subscales scores are available in Appendix A.

- Changes in SDQ Total Scores between Administration Times are depicted on page 7. Percentages indicate the percentage of cases in which SDQ Total Scores increased or decreased from one administration time to another. Comparisons between other administration times are available in Appendix A.

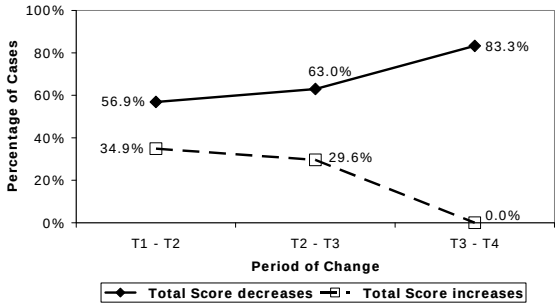
Changes in Parent SDQ Total Score between Administration Times



Changes in Teacher SDQ Total Scores between Administration Times



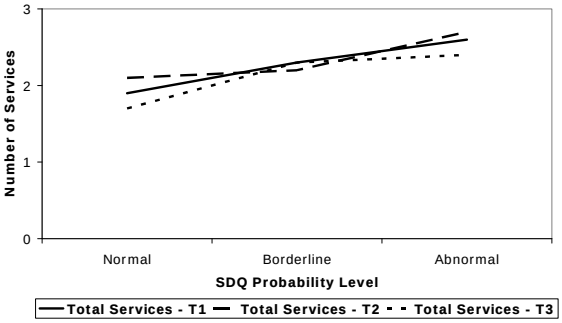
Changes in Self SDQ Total Scores between Administration Times



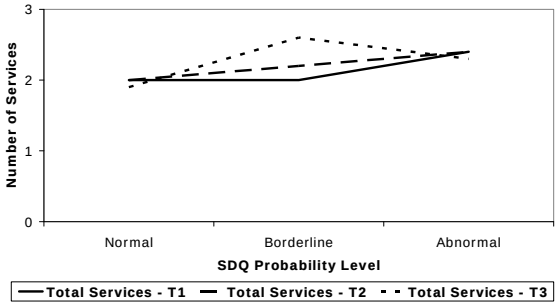
- SDQ Probability Level and Services Recommended: Time 4 not included due to small sample size.

SDQ Probability Levels and Number of Services Recommended

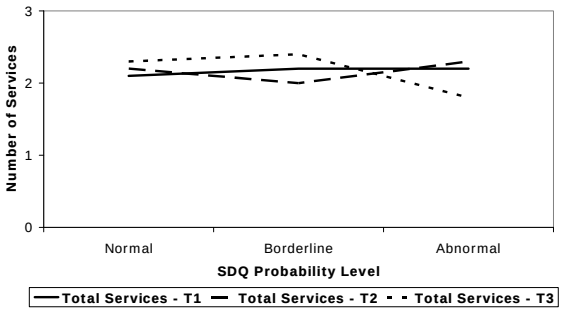
Parent SDQ and Average Number of Services Recommended



Teacher SDQ and Average Number of Services Recommended

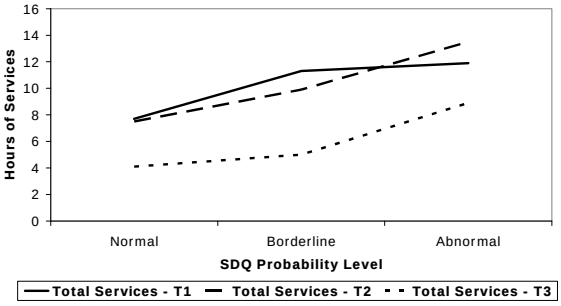


Self SDQ and Average Number of Services Recommended

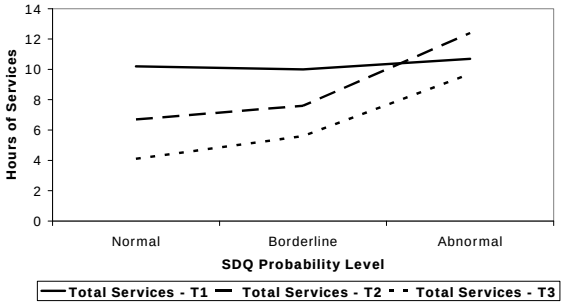


SDQ Probability Levels and Frequency of Services Recommended: All Services

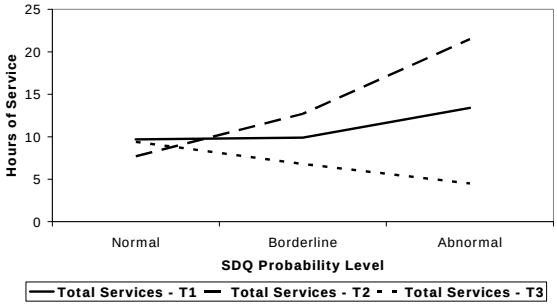
Parent SDQ and Average Frequency of Recommended Services: All Services



Teacher SDQ and Average Frequency of Recommended Services: All Services

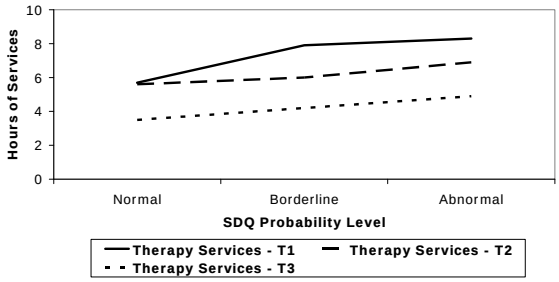


Self SDQ and Average Frequency of Recommended Services: All Services

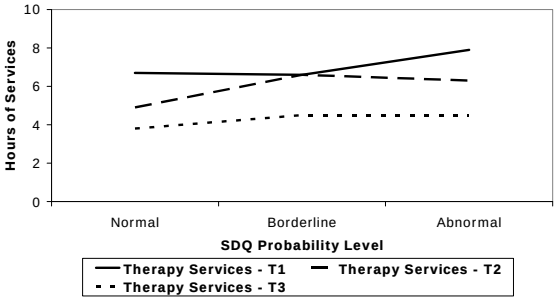


SDQ Probability Levels and Frequency of Services Recommended: Therapy Services

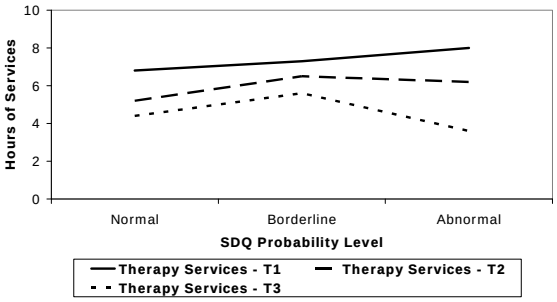
Parent SDQ and Average Frequency of Recommended Services: Therapy Services



Teacher SDQ and Average Frequency of Recommended Services: Therapy Services

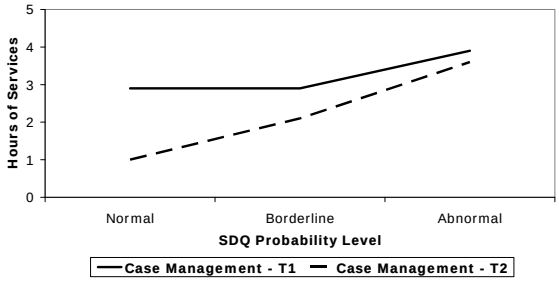


Self SDQ and Average Frequency of Recommended Services: Therapy Services

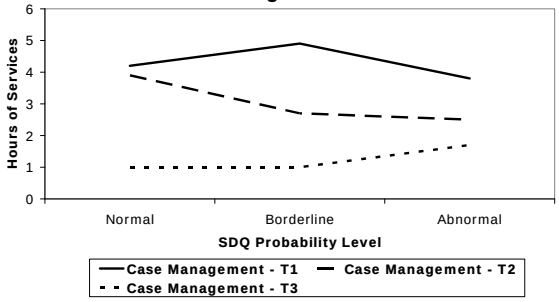


SDQ Probability Levels and Frequency of Services Recommended: Case Management Services

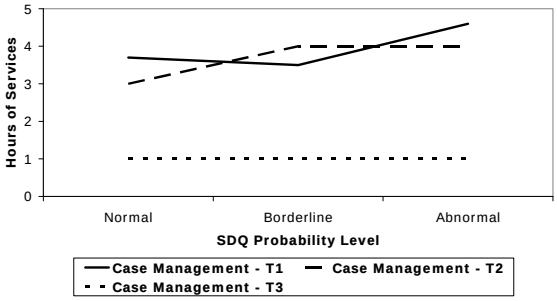
Parent SDQ and Average Frequency of Recommended Services: Case Management



Teacher SDQ and Average Frequency of Recommended Services: Case Management



Self SDQ and Average Frequency of Recommended Services: Case Management



C. Summary of Functioning and Mental Health Symptoms:

The CASII Total Scores initially decreased with an increase at Time 4. The CASII Total Scores decreased from Time 1 to Time 2 for 54% of cases. Approximately 44% of CASIIs decreased between other administration times. Although the number of services recommended by providers generally increased for higher CASII levels, this trend was variable across administration times. The trend was more pronounced at Time 1 and Time 2. The number of therapy services recommended did not increase greatly across CASII Levels. It is important to use caution when interpreting averages of service recommendations at CASII Levels 0 and 6, due to the small number of cases at these levels.

The frequency of services recommended was also variable across CASII Levels. At Time 1 and Time 2 there appeared to be a strong trend toward recommending increased hours of service for higher levels of service needs as rated by providers. Recommendations for hours of therapy did increase at higher CASII Levels. Frequency of medication and case management services were variable across CASII Levels. It is

important to note that medication and case management services were recommended for a smaller subgroup of cases. However, the pattern of increasing services for higher levels of service needs would still be expected. The number of errors in calculating the CASII Total Score and Level of Care suggests that providers should review scoring criteria of the CASII. Common scoring errors are listed in Appendix A. Addressing the common errors in scoring listed in Appendix A would greatly reduce errors in scoring in the future.

As with the CASII, average Parent, Teacher, and Self SDQ scores initially decreased with an increase at Time 4. Children receiving services at Time 4 would have been in treatment for 18 months. It is possible that the children who remain in treatment for this time period are those who have higher symptom severity overall. From 50% to 63% of parents, teachers, and clients endorse lower symptom severity from Time 1 to Time 2 and from Time 2 to Time 3.

The correspondence between SDQ scores and the number and frequency of recommended services is varied. The number of services recommended appears to be more strongly related to parent reports of symptom severity as compared to teacher and self reports. Service frequency also appears to be more closely related to parent reports than to teacher or self reports. Standardized ratings of service needs and symptom severity can be useful tools in making service recommendations.

III. Objective: Strengthen Coordination with Student Support and Other School Services

This project required the Collaborative grantees to implement communication and coordination processes between the mental health providers and the schools. This involved ways for mental health professionals and student support services to work together in the areas of outreach, referrals and service coordination.

The following are some of the promising practices as reported in quarterly progress reports for 2007:

- **Introduced school-linked mental health services to school staff:**
  - Informed superintendents and school personnel about new services and protocols, including how to access services through letters and emails.
  - Collaborative staff met with IEIC Coordinator and Early Childhood Special Education director to clarify referral process and procedural changes.
  - School staff was provided contact information for the collaborative staff over the summer.
  - During orientation, program information was provided to administration and key school personnel.
  - Therapist attended the open house for the school in late August and school conferences to distribute brochures about the services and answer questions.
  - Updated each district on summer services and coordinated ongoing services.
  - Mental health staff met with school staff from each district to plan for new and continued services.
  - Planned provisions for coordinating with school staff and families during the summer months.

- **Coordinated students' services through meetings and teams:**
  - In collaboration with Indian Education, Special Education teachers, counselors and social workers, organized a "Mental Health Team" that planned to coordinate mental health services at the High School.
  - Mental health staff met regularly with administration and school staff to coordinate services and evaluate progress.
  - Co-located therapists met weekly with school counselors (Elementary, Middle, and High School) to provide updates on student status and plans, coordinate treatment efforts, and monitor progress.
  - Co-located therapists met with teachers regularly and used Teacher SDQs to facilitate communication with teachers.
  - Program staff communicated on an ongoing basis with designated school staff regarding individual client referrals, client progress, goals met, family interaction, treatment timelines, etc.
  - Submitted diagnostic assessment summaries to the IEP teams.
  - Met with teachers on an individual basis to provide updates, information on treatment goals, and recommendations for how the teacher could best accommodate the needs of the student.
  - Held weekly meetings with school counselors to share updates, coordinate treatment and monitor progress by phone and face to face.
  - Mental health provider met weekly with the referral team.

- **Established presence and training within the schools:**
  - Practitioners maintained visibility by attending school functions.
  - Mental health practitioners were fully integrated to the school building, being perceived as another member of the school staff. Educators were exposed to issues surrounding children's mental health.

Teachers are actively participating in the scheduling of services and are witness to the outcomes of our interventions.
- Staff was frequently in the school buildings to provide services to the children.
- Participated in workshop sessions regarding mental health needs and awareness of the program.
- Developing student crisis policies and procedures specific to a behavioral crisis in each district.
- Established a training schedule and trained one district on CPI Crisis Prevention Institute non-violent crisis intervention for teachers.
- Planning on training front line staff on managing students with emotion/behavior problems.
- Program staff provided in-service training to school staff regarding mental health topics and the referral process to a variety of services.

- **Coordinated and supported service systems through Collaboratives:**
  - Providers used student study meetings and collaborative meetings to network and discuss the needs of children with emotional disturbances.
  - Work groups and a board were established between the Children's Mental Health Local Advisory Council (LAC) and the Collaborative.
  - Collaborative-wide mental health team meetings were held on a regular basis, enabling staff to learn from each other.
  - Collaborative staff created brochures and a list of referral sources for school personnel, made presentations to school and county boards and school staff meetings, and were present at booths during parent visitation evenings and school conferences.
  - Collaborative staff developed systems to communicate to school staff about the use of new assessment tools.
  - Coordinated with the county on the "Safe Schools" grant.

IV. Objective: Address Stigma Associated with Seeking or Receiving Mental Health Services

This project also asked Collaboratives to adopt at least one approach to address stigma often surrounding children and youth who seek or receive mental health services. Grantees needed to coordinate efforts with their school partners to tackle issues associated with such stigma.

The following are some of the promising practices as reported in quarterly progress reports for 2007:

- **Delivered training about mental health issues and services:**
  - Offered training and/or coordinate training for school personnel and the general public related to mental health.
  - Provided parent education and developmentally appropriate presentations in classrooms or school assemblies.
  - Providers did participate in educational events such as anti-bullying presentations to reduce stigma attached to mental health concerns.
  - Spoke at open houses and conferences.
  - School staff received training regarding mental health issues between April and June 2007 on such topics as stigma, cultural factors and community resources as well as information regarding specific disorders including ADHD, depression, interventions, and collaborative opportunities.
  - Culturally specific mental health trainings were held in conjunction with the Minnesota Department of Education and Department of Human Services on their Refugee School Impact discretionary grant, with the goal of building the capacity of service providers to support the mental health and social-emotional related needs of refugee students and families in our communities, including addressing stigma.
  - Collaborative used each district's mental health training teams to train school staff about mental health issues and stigma and supporting help-seeking behavior by identifying it as a strength and asset of staff, student and families.
  - Program staff developed a PowerPoint presentation to address mental health in the schools and specific interventions which staff can utilize when managing student behavior.
  - Provided teacher and parent education on mental health issues as well as the need for consistency of services, and the need for a multi-modal program that includes cognitive therapy, positive behavior supports and education.
  - Therapists participated in fall workshops in each district to provide education on mental health issues.

- **Created informational materials:**
  - Collaborative staff indicated working on stigma articles for school newspapers.
  - Developed educational materials and brochures to distribute to school and community partners.
  - Worked with Our Children Succeed Initiative on social marketing strategies focused on reducing

stigma.
- We drafted a newsletter about stress after the holidays and tips for coping. The newsletter is available on the website and optional for schools to share with students and families.
- The "Children Who Care" booklet, written by the Shoreview Human Rights Commission, helps parents raise kids who are non-biased. Much of the language in this book talks about stigma and bias and is a very helpful tool for parents in our Suburban Ramsey communities. This book is free and distributed by all the agencies to parents.
- Developed and distributed brochures and literature.
- Worked on special stigma articles for school newspapers.

➢ **Developed sensitive, respectful approaches for connecting with students and families:**
- Worked with providers and schools on strategies for approaching parents to overcome possible misperceptions that may contribute to stigma (e.g., the biological basis of mental illness, parity for mental health, rights to coverage, etc.)
- Sent letters to families that identified positive benefits of additional services.
- Assured families of confidentiality and highlighted convenience of services in the letters.
- Coached case managers and teachers individually regarding thoughtful and careful approaches to introducing services to students and families.
- Normalized mental health therapy in the schools and seen as good self care that is respectful and fun. Kids found ways, on their own, to get to therapy weekly during the summer.
- Developed private and appropriate space for mental health services to aide increasing student willingness to participate and ensure confidentiality.
- Mental health professionals became an integrated, positive, accessible and visible part of the school teams and culture.
- Held regular meetings with parents and staff focused on education and acceptance (of mental health issues). Meetings occurred in the school to assist in normalizing the process.

V. Objective: Develop Long-Term Funding Efforts to Sustain These Services

A. The following strategies for developing funding and sustainability were outlined in the original grant work plan:

1. Allocate grant funds for clinical mental health services only when Medical Assistance and private insurance coverage are unavailable.

2. Ensure responsibility of mental health providers to establish billing systems to maximize third party billing for these services.

3. Encourage mental health providers to enroll in Prepaid Medical Assistance Programs (PMAPs) and private health plans.

4. Demonstrate increasing capacity over the grant period to capture third party revenues for the types of services funded by this grant:

   ➢ Track & report quarterly third party revenues captured for these services.

5. Other long-term funding strategies for sustaining these services.

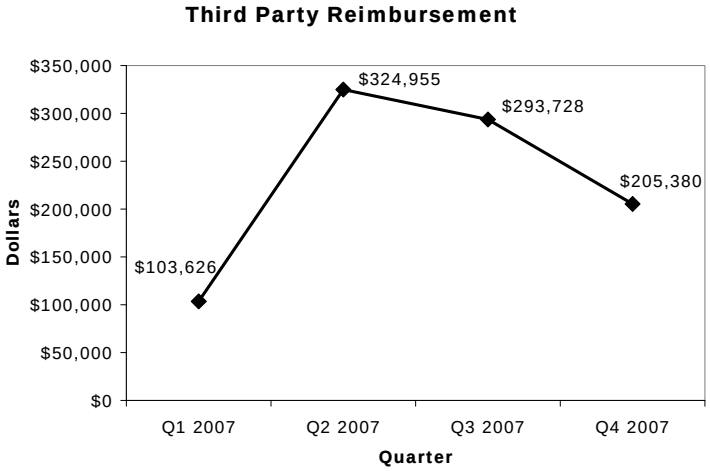
B. Funding from non-grant sources:

➢ **Children Funded by Minnesota Health Care Programs**

Quarter	Children with MHCP		Children Without MHCP	
	# Served	% of Total	# Served	% of Total
Q1 2007	516	34.3%	987	65.7%
Q2 2007	632	39.3%	975	60.7%
Q3 2007	502	41.4%	710	58.6%
Q4 2007	722	49.2%	745	50.8%

Note. Reported # served/quarter: Q1 = 1,498, Q2 = 1,727, Q3 = 1,190, Q4 = 1,441. Due to inconsistencies in reporting, the number served with and without MHCP might not equal the total number reported to be served. Total number represented above: Q1 = 1,503, Q2 = 1,607, Q3 = 1,212, Q4 = 1,467.

- **Reimbursement from Third Party Payers**



C. Summary of Long-Term Funding Efforts:

- The percentage of children enrolled in Minnesota Health Care Programs increased from 34% in the first quarter to 49% in the fourth quarter of 2007. Assisting families in enrolling their children in Minnesota Health Care Programs is beneficial to sustaining collaborative funding.

- Reimbursement from third party payers was also stable throughout 2007, although payments decreased slightly after second quarter.

VI. Report Highlights: Observations and Recommendations

- Improving Accessibility:

  - Twenty Collaboratives reported serving at least 1784 children in the first year of the grant. This is 48.5% of the proposed amount. It is possible that more children were served than are represented by outcome measures. It is important that outcome measures are submitted for all children served.

  - Collaboratives served a higher percentage of children with minority backgrounds than statewide estimates.

  - The Collaboratives increased accessibility through a variety of activities, such as:
    - Implementing outreach and education efforts to students, staff and families
    - Developing new procedures for reaching and referring students
    - Offering times for services beyond the school building, day, and year
    - Enhancing and expanding resources

- Improving Functioning and Reducing Symptoms of Children with a Mental Health Diagnosis:

  - The CASII Total Scores initially decreased with an increase at Time 4. The CASII Total Scores decreased from Time 1 to Time 2 for 54% of cases. Approximately 44% of CASII Total Scores decreased between other administration times.

  - The CASII Total Scores initially decreased with an increase at Time 4. Although the number of services recommended by providers generally increased for higher CASII levels, this trend was variable across administration times.

  - The frequency of services recommended was also variable across CASII Levels. At Time 1 and Time 2 there appeared to be a strong trend toward recommending increased hours of service for higher levels of service needs as rated by providers. Recommendations for hours of therapy increased at higher CASII Levels. Frequency of medication and case management services were variable across CASII Levels.

- The number of errors in calculating the CASII Total Score and Level of Care suggests that providers should review scoring criteria of the CASII. Common scoring errors are listed in Appendix A. Addressing the common errors in scoring listed in Appendix A would greatly reduce errors in scoring in the future.

- As with the CASII, average Parent, Teacher, and Self SDQ scores initially decreased with an increase at Time 4. Children receiving services at Time 4 would have been in treatment for 18 months. It is possible that the children who remain in treatment for this time period are those who have higher symptom severity overall.

- From 50% to 63% of parents, teachers, and clients endorse lower symptom severity from Time 1 to Time 2 and from Time 2 to Time 3.

- The correspondence between SDQ scores and the number and frequency of recommended services is varied. The number of services recommended appears to be more strongly related to parent reports of symptom severity than to teacher or self reports. Service frequency also appears to be more closely related to parent reports than to teacher or self reports.

➢ Strengthening Coordination with Student Support and Other School Services:

- The Collaboratives strengthened communication and coordination between mental health and student support services in the schools through a variety of activities, such as:
  - Introducing school-linked mental health services to school staff
  - Coordinating students' services through meetings and teams
  - Establishing presence and training within the schools
  - Coordinating service systems through the Collaboratives

➢ Addressing Stigma Associated with Seeking or Receiving Mental Health Services:

- The Collaboratives coordinated the following efforts to reduce stigma associated with students seeking or receiving mental health services:
  - Delivering training about mental health issues and services
  - Creating informational materials
  - Developing sensitive, respectful approaches for connecting with students and families

➢ Developing Long-Term Funding Efforts to Sustain These Services:

- The percentage of children enrolled in Minnesota Health Care Programs increased from 34% in the first quarter to 49% in the fourth quarter of 2007. Assisting families in enrolling their children in Minnesota Health Care Programs is beneficial to sustaining collaborative funding.

- Reimbursement from third party payers was stable throughout 2007, although payments decreased slightly after second quarter.

Appendix A: Additional Results

This section contains additional tables and information from the SDQ and CASII data submitted quarterly. SDQ, CASII, and services recommended are organized into three different administration times:

Time 1 = initial information received for a case, regardless of the quarter in which the case was seen
Time 2 = First follow-up information for a case number
Time 3 = Second follow-up information received for a case number
Time 4 = Third follow-up information received for a case number

Results are in four sections: Demographic information, CASII Results, SDQ Results, and Services Recommended

I. Demographic Information: Includes Gender and Racial/Ethnic Background, Age, and Measures Received

A. Gender and Racial/Ethnic Background

	Time 1		Time 2		Time 3		Time 4	
	N	%	N	%	N	%	N	%
Gender								
Male	1036	58.2%	421	58.7%	81	57.4%	15	78.9%
Female	743	41.8%	296	41.3%	60	42.6%	4	21.1%
Total	**1779**	**100.0%**	**717**	**100.0%**	**141**	**100.0%**	**19**	**100.0%**
Race/Ethnicity								
Asian	13	0.7%	6	0.8%	3	2.1%	0	0.0%
Black	56	3.2%	21	2.9%	4	2.8%	1	5.3%
Native American	104	5.9%	49	6.9%	3	2.1%	0	0.0%
Native Hawaiian/Pacific Islander	3	0.2%	2	0.3%	0	0.0%	0	0.0%
White	1418	80.4%	572	80.1%	120	85.1%	18	94.7%
Other or Unknown	113	6.4%	33	4.6%	2	1.4%	0	0.0%
Biracial or Multiracial	56	3.2%	31	4.3%	9	6.4%	0	0.0%
Total	**1763**	**100.0%**	**714**	**100.0%**	**141**	**100.0%**	**19**	**100.0%**
Latino/a (Y,N)								
Latino/a	57	3.4%	18	2.6%	3	2.2%	0	0.0%
Not Latino/a	1533	90.5%	643	93.7%	132	97.1%	19	100.0%
Unknown	104	6.1%	25	3.6%	1	0.7%	0	0.0%
Total	**1694**	**100.0%**	**686**	**100.0%**	**136**	**100.0%**	**19**	**100.0%**

Note. N = Sample size. % = percentage of sample at that administration time. Due to incomplete data, sample sizes vary within administration times. Total number of cases: T1 = 1784, T2 = 717, T3 = 141, T4 = 19.

B. Age

	Mean (Average)	Standard Deviation	Minimum Age	Maximum Age	Sample Size
Time 1	11.3	3.63	2	19	1746
Time 2	11.6	3.60	2	20	727
Time 3	11.8	3.14	5	19	140
Time 4	12.4	2.24	10	17	19

C. Measures Received

Measure	Time 1		Time 2		Time 3		Time 4	
	N	%	N	%	N	%	N	%
SDQ								
Parent	1069	59.9%	408	55.6%	61	43.3%	12	63.2%
Teacher	1146	64.2%	520	70.8%	86	61.0%	15	78.9%
Child [a]	710	72.7%	252	57.9%	41	46.6%	11	73.3%
CASII [b]	1660	99.8%	671	95.7%	125	89.9%	18	94.7%

Note. N = Number of cases providing data, % = percentage of sample (T1, T2, T3, or T4). Only complete data is included. Data was not included if SDQ's did not include respondent information (Parent, Teacher, or Child), if scores were outside the possible range, or if there was a problem with Client ID numbers.

[a] Only children age 11 and older can complete the SDQ. % = the percentage of children age 11 and older who completed the SDQ.
[b] Only Children 6 and older are appropriate for the CASII. % = % of children 6 and older.

II. CASII: Includes Mean (Average) Scores, Level of Care Recommendations, Change in Scores, and CASII Scoring Errors

A. CASII: Mean (Average) Scores

CASII Items and Scales	Time 1		Time 2		Time 3		Time 4		Possible Range
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Item i: harm	2.0	0.85	1.9	0.76	1.8	0.70	2.3	0.90	1 - 5
Item ii: functioning	2.6	0.78	2.4	0.75	2.3	0.69	2.6	0.85	1 - 5
Item iii: comorbidity	1.8	0.91	1.7	0.85	1.7	0.86	1.7	0.96	1 - 5
Item iv-a: stress	2.7	0.94	2.5	0.84	2.3	0.86	2.3	0.75	1 - 5
Item iv-b: support	2.5	0.88	2.3	0.82	2.4	0.73	2.8	0.73	1 - 5
Item v: resilience	2.7	0.80	2.5	0.81	2.4	0.73	3.1	0.64	1 - 5
Item vi-a: child acceptance	2.3	0.77	2.2	0.74	2.1	0.60	2.1	0.73	1 - 5
Item vi-b: parent acceptance	2.3	0.79	2.2	0.78	2.3	0.62	2.4	0.78	1 - 5
CASII Composite Score - Provider	16.8	3.95	15.8	3.69	15.4	3.32	17.3	3.43	7 - 35
CASII Composite Score - Computed	16.6	3.89	15.7	3.67	15.3	3.31	17.3	3.43	7 - 35
Level of Care - Provider	2.6	1.22	2.3	1.26	2.3	1.08	3.1	1.26	0 - 6
Level of Care – computed	2.7	1.39	2.3	1.30	2.2	1.18	3.0	1.33	0 - 6

Note. Mean = Average score. SD = Standard Deviation.

B. CASII: Level of Care Recommendations

	Level 0		Level 1		Level 2		Level 3		Level 4		Level 5		Level 6	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Time 1	34	2.0%	334	20.1%	468	28.2%	427	25.7%	154	9.3%	208	12.5%	35	2.1%
Time 2	30	4.5%	154	23.0%	225	33.5%	152	22.7%	48	7.2%	58	8.6%	4	0.6%
Time 3	5	4.0%	30	24.0%	45	36.0%	32	25.6%	4	3.2%	9	7.2%	0	0.0%
Time 4	0	0.0%	3	16.7%	3	16.7%	6	33.3%	3	16.7%	3	16.7%	0	0.0%

C. Change in CASII Total Score

Administration Times	Total Score Decreases		Total Score Stays Same		Total Score Increases	
	N	%	N	%	N	%
Time 1 to Time 2	348	53.8%	119	18.4%	180	27.8%
Time 1 to Time 3	70	57.4%	19	15.6%	33	27.0%
Time 1 to Time 4	8	44.4%	3	16.7%	7	38.9%
Time 2 to Time 3	49	44.1%	30	27.0%	32	28.8%
Time 2 to Time 4	7	38.9%	6	33.3%	5	27.8%
Time 3 to Time 4	8	44.4%	5	27.8%	5	27.8%

D. CASII Errors

	CASII Total Score			CASII Level of Care		
	# Cases	# Errors	% Errors	# Cases	# Errors	% Errors
Time 1	1658	255	15.4%	1632	320	19.6%
Time 2	671	72	10.7%	658	126	19.1%
Time 3	125	16	12.8%	123	20	16.3%
Time 4	18	0	0.0%	18	3	16.7%

Note. # Cases = Total number of cases for that administration time; # Errors = Total number of cases with errors for that administration time; % Errors = Percentage of cases that have errors.

- Typical errors in computing the Total Score include adding both parent and child acceptance scores into the total, using the lower of the two acceptance scores (parent and child) instead of the higher score, and basic errors in addition or data entry.
- The most common error in determining the Level of Care in the CASII is the failure to use the independent criteria. The independent criteria states that if a provider rates a child at level 4 for Risk of Harm, Functioning, or Comorbidity the level of care recommended is automatically 5 or higher. If the provider rates a child at a level 5 on any of these scales the level of care recommended is automatically 6. These criteria can only be waived for Functioning and Comorbidity if the sum of Stress and Support equals 2.

- Other errors in determining CASII Level of Care include using miscalculated total scores to identify the level and listing the incorrect level for the listed total score.

III. SDQ: Includes Mean (Average) Scores; Change in SDQ Total Scores; Figures for Parent, Teacher, and Self SDQ Subscale Scores; and SDQ Probability Levels

A. SDQ: Mean (Average) Total and Subscale Scores

SDQ Scales	Time 1		Time 2		Time 3		Time 4		Possible Range
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	
Parent Form	(N = 1069)		(N = 408)		(N = 61)		(N = 12)		
Total	17.7	6.71	17.4	7.01	15.7	6.79	22.3	5.21	0-40
Emotional Problems	4.3	2.59	3.9	2.59	3.4	2.44	5.5	2.75	0-10
Conduct Problems	4.0	2.43	3.8	2.43	3.5	2.17	5.2	2.55	0-10
Inattn./Hyp. Problems	6.1	2.75	6.3	2.62	6.0	2.94	7.4	2.61	0-10
Peer Problems	3.4	2.14	3.4	2.19	2.8	1.86	4.2	1.95	0-10
Prosocial Behavior	6.8	2.12	6.8	2.22	6.8	1.73	6.4	2.07	0-10
Impact Score	4.9	3.28	3.5	3.03	4.4	2.81	6.5	3.12	0-10
Teacher Form	(N = 1146)		(N = 520)		(N = 86)		(N = 15)		
Total	17.0	6.93	16.1	6.93	15.0	6.23	17.7	6.17	0-40
Emotional Problems	4.0	2.63	3.6	2.60	3.6	2.22	4.5	2.53	0-10
Conduct Problems	3.4	2.61	3.1	2.50	2.3	2.15	3.3	2.06	0-10
Inattn./Hyp. Problems	6.0	2.87	5.9	2.93	5.3	2.61	5.5	2.39	0-10
Peer Problems	3.6	2.26	3.5	2.28	3.8	2.29	4.4	2.06	0-10
Prosocial Behavior	5.6	2.52	5.8	2.49	6.3	2.40	6.2	2.05	0-10
Impact Score	3.5	1.95	3.5	1.80	3.6	1.88	3.4	1.64	0-6
Self Form	(N = 710)		(N = 252)		(N = 41)		(N = 11)		
Total	16.1	5.90	15.6	6.14	15.9	5.43	18.9	5.92	0-40
Emotional Problems	4.2	2.50	3.9	2.48	3.8	2.31	4.8	2.93	0-10
Conduct Problems	3.6	2.10	3.4	2.12	3.3	1.94	4.2	1.33	0-10
Inattn./Hyp. Problems	5.4	2.31	5.3	2.39	6.0	1.88	6.2	1.83	0-10
Peer Problems	2.9	2.04	2.9	2.09	2.8	1.82	3.7	1.27	0-10
Prosocial Behavior	7.1	2.09	7.3	2.01	7.3	1.89	6.8	1.99	0-10
Impact Score	2.4	2.60	1.5	2.11	2.6	2.68	2.6	1.80	0-10

Note. Mean = Average score. SD = Standard Deviation.

B. Change in SDQ Total Scores

1. Change in Parent SDQ Scores

Administration Times	Total Score Decreases		Total Score Stays Same		Total Score Increases	
	N	%	N	%	N	%
Time 1 to Time 2	165	50.2%	32	9.7%	132	40.1%
Time 1 to Time 3	29	76.3%	1	2.6%	8	21.1%
Time 1 to Time 4	3	42.9%	1	14.3%	3	42.9%
Time 2 to Time 3	20	52.6%	8	21.1%	10	26.3%
Time 2 to Time 4	4	40.0%	1	10.0%	5	50.0%
Time 3 to Time 4	3	42.9%	0	0.0%	4	57.1%

2. Change in Teacher SDQ Scores

Administration Times	Total Score Decreases		Total Score Stays Same		Total Score Increases	
	N	%	N	%	N	%
Time 1 to Time 2	216	51.3%	39	9.3%	166	39.4%
Time 1 to Time 3	39	68.4%	2	3.5%	16	28.1%
Time 1 to Time 4	7	70.0%	0	0.0%	3	30.0%
Time 2 to Time 3	32	50.0%	10	15.6%	22	34.4%
Time 2 to Time 4	6	54.5%	2	18.2%	3	27.3%
Time 3 to Time 4	9	81.8%	1	9.1%	1	9.1%

3. Change in Self SDQ Scores

Administration Times	Total Score Decreases		Total Score Stays Same		Total Score Increases	
	N	%	N	%	N	%
Time 1 to Time 2	111	56.9%	16	8.2%	68	34.9%
Time 1 to Time 3	19	63.3%	3	10.0%	8	26.7%
Time 1 to Time 4	3	50.0%	1	16.7%	2	33.3%
Time 2 to Time 3	17	63.0%	2	7.4%	8	29.6%
Time 2 to Time 4	4	57.1%	0	0.0%	3	42.9%
Time 3 to Time 4	5	83.3%	1	16.7%	0	0.0%

C. SDQ Probability Levels

SDQ Scales	Time 1						Time 2					
	Normal[1]		Borderline[2]		Abnormal[3]		Normal[1]		Borderline[2]		Abnormal[3]	
	N	%	N	%	N	%	N	%	N	%	N	%
Parent Form												
Total Score	286	26.8%	165	15.4%	618	57.8%	132	32.4%	53	13.0%	223	54.7%
Emotional Problems	442	41.2%	146	13.6%	484	45.1%	202	49.5%	45	11.0%	161	39.5%
Conduct Problems	325	30.3%	142	13.2%	605	56.4%	138	33.7%	62	15.1%	210	51.2%
Inattention/Hyperact	439	41.0%	141	13.2%	490	45.8%	169	41.2%	52	12.7%	189	46.1%
Peer Problems	402	37.6%	183	17.1%	485	45.3%	158	38.5%	64	15.6%	188	45.6%
Prosocial Behavior	759	71.2%	162	15.2%	145	13.6%	285	70.0%	60	14.7%	62	15.2%
Impact Score	24	10.4%	24	10.4%	182	79.1%	25	27.2%	8	8.7%	59	64.1%
Teacher Form												
Total Score	376	32.8%	158	13.8%	612	53.4%	193	37.1%	84	16.2%	243	46.7%
Emotional Problems	534	46.6%	148	12.9%	465	40.5%	270	51.9%	70	13.5%	180	34.6%
Conduct Problems	472	41.2%	154	13.4%	520	45.4%	247	47.5%	70	13.5%	203	39.0%
Inattention/Hyperact	505	44.0%	118	10.3%	524	45.7%	244	46.9%	48	9.2%	228	43.8%
Peer Problems	391	34.1%	181	15.8%	574	50.1%	198	38.1%	83	16.0%	239	46.0%
Prosocial Behavior	562	49.1%	222	19.4%	361	31.5%	248	48.2%	121	23.5%	145	28.2%
Impact Score	23	13.4%	9	5.2%	140	81.4%	8	10.0%	3	3.8%	69	86.2%
Self Form												
Total Score	329	46.3%	172	24.2%	209	29.4%	122	48.4%	65	25.8%	65	25.8%
Emotional Problems	486	68.5%	81	11.4%	143	20.1%	187	74.2%	24	9.5%	41	16.3%
Conduct Problems	365	51.4%	110	15.5%	235	33.1%	135	53.6%	41	16.3%	76	30.2%
Inattention/Hyperact	359	50.6%	116	16.3%	235	33.1%	131	52.0%	42	16.7%	79	31.3%
Peer Problems	470	66.2%	154	21.7%	86	12.1%	160	63.5%	65	25.8%	27	10.7%
Prosocial Behavior	549	77.4%	87	12.3%	73	10.3%	199	79.0%	33	13.1%	20	7.9%
Impact Score	22	36.7%	10	16.7%	28	46.7%	18	54.5%	2	6.1%	13	39.4%

Note. Impact scores were not available for cases, thus numbers for this scale are lower than those of other scales.
[1] Normal = Approximately 0-79th percentile; [2] Borderline = Approx. 80-89th percentile; [3] Abnormal = Approx. 90-100th percentile

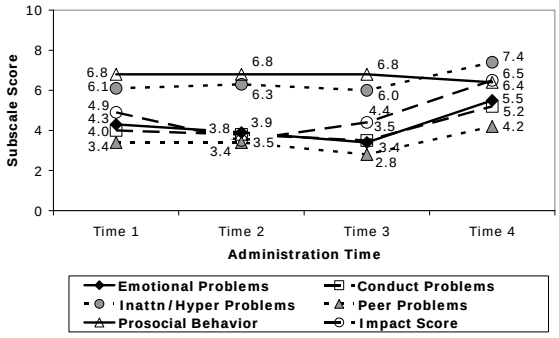
C. SDQ Probability Levels (continued)

SDQ Scales	Time 3						Time 4					
	Normal[1]		Borderline[2]		Abnormal[3]		Normal[1]		Borderline[2]		Abnormal[3]	
	N	%	N	%	N	%	N	%	N	%	N	%
Parent Form												
Total Score	24	39.3%	8	13.1%	29	47.5%	1	8.3%	1	8.3%	10	83.3%
Emotional Problems	33	54.1%	9	14.8%	19	36.2%	3	31.1%	0	0.0%	9	75.0%
Conduct Problems	24	39.3%	7	11.5%	30	49.1%	2	16.7%	1	8.3%	9	75.0%
Inattention/Hyperact	26	42.6%	7	11.5%	28	45.9%	4	33.3%	0	0.0%	8	66.6%
Peer Problems	30	49.2%	11	18.0%	20	32.8%	4	33.3%	1	8.3%	7	58.3%
Prosocial Behavior	47	77.0%	9	14.8%	5	8.2%	9	75.0%	1	8.3%	2	16.7%
Impact Score	3	12.5%	1	4.2%	20	83.3%	1	8.3%	0	0.0%	11	91.7%
Teacher Form												
Total Score	39	45.3%	11	12.8%	36	41.9%	5	33.3%	1	6.7%	9	60.0%
Emotional Problems	40	46.5%	18	20.9%	28	32.6%	6	40.0%	3	20.0%	6	40.0%
Conduct Problems	51	59.3%	16	18.6%	19	22.1%	4	26.7%	4	26.7%	7	46.7%
Inattention/Hyperact	47	54.7%	13	15.1%	26	30.2%	9	60.0%	2	13.3%	4	26.7%
Peer Problems	26	30.2%	14	16.3%	46	53.5%	3	20.0%	1	6.7%	11	73.3%
Prosocial Behavior	50	58.8%	20	23.5%	17	17.6%	7	50.0%	5	35.7%	2	14.3%
Impact Score	3	8.8%	3	8.8%	28	82.4%	0	0.0%	2	13.3%	13	86.7%
Self Form												
Total Score	18	43.9%	12	29.3%	11	26.8%	2	18.2%	5	45.5%	4	36.4%
Emotional Problems	33	80.5%	3	7.3%	5	12.2%	7	63.6%	1	9.1%	3	27.3%
Conduct Problems	22	53.7%	8	19.5%	11	26.8%	2	18.2%	5	45.5%	4	36.4%
Inattention/Hyperact	17	41.5%	7	17.1%	17	41.5%	3	27.3%	4	36.4%	4	36.4%
Peer Problems	25	61.0%	15	36.6%	1	2.4%	5	45.5%	5	45.5%	1	9.1%
Prosocial Behavior	34	82.9%	4	9.8%	3	7.3%	8	72.7%	2	18.2%	1	9.1%
Impact Score	6	24.0%	5	20.0%	14	56.0%	2	18.2%	1	9.1%	8	72.7%

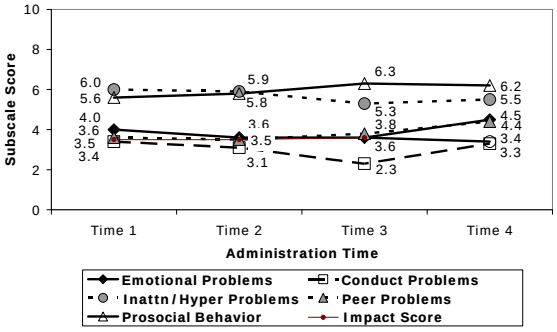
Note. Impact scores were not available for cases, thus numbers for this scale are lower than those of other scales.
[1] Normal = Approximately 0-79th percentile; [2] Borderline = Approx. 80-89th percentile; [3] Abnormal = Approx. 90-100th percentile

D. Figures for Parent, Teacher, and Self SDQ Subscale Scores

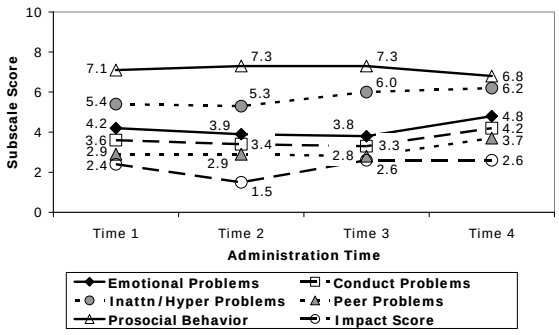
Parent SDQ Subscale Scores



Teacher SDQ Subscale Scores



Self SDQ Subscale Scores



IV. Services Recommended

A. Description: Along with SDQ and CASII data, providers were asked to submit a list of mental health services they would recommend for each case. For each service, providers were asked to list the number of hours of that service they would recommend for the next month. They were also asked to submit this information (i.e., recommended monthly services and service frequencies) at each 6-month review.

B. Services Recommended: List

Service Proposed	Time 1		Time 2		Time 3		Time 4	
	# Clients	% of Cases	# Clients	% of Cases	# Clients	% of Cases	# Clients	% of Cases
Case Management	240	15.0%	55	8.7%	10	8.9%	4	22.2%
Day Treatment	41	2.6%	14	2.2%	2	1.8%	2	11.1%
Family Psychotherapy	304	19.1%	79	12.5%	6	5.4%	0	0.0%
Family Skills	294	18.4%	158	25.0%	35	31.3%	0	0.0%
Group Psychotherapy	88	5.5%	29	4.6%	2	1.8%	0	0.0%
Group Skills	394	24.7%	201	31.8%	20	17.9%	0	0.0%
Individual Psychotherapy	765	47.9%	231	36.6%	27	24.1%	2	11.1%
Individual Skills	692	43.4%	326	51.6%	75	67.0%	18	100%
Med – Primary Physician	128	8.0%	49	7.8%	5	4.5%	0	0.0%
Med – Psychiatrist	242	15.2%	109	17.2%	38	33.9%	15	83.3%
Residential Treatment	6	0.4%	4	0.6%	0	0.0%	0	0.0%

Note. Cases listing recommended services: Time 1 = 1595, Time 2 = 632, Time 3 = 112, Time 4 = 18

C. Services Recommended: Mean Hours/Month Recommended

Service Proposed	Time 1		Time 2		Time 3		Time 4	
	Average Hours	SD	Average Hours	SD	Average Hours	SD	Average Hours	SD
Case Management	3.3	3.40	2.9	2.99	1.2	0.67	1.8	1.50
Day Treatment	64.2	42.6	51.8	17.48	60.0	0.00	60.0	0.00
Family Psychotherapy	2.5	2.90	2.4	2.21	4.0	0.00	--	--
Family Skills	2.7	3.10	3.4	4.44	1.9	0.85	--	--
Group Psychotherapy	6.8	4.39	6.0	5.75	4.0	0.00	--	--
Group Skills	7.0	7.51	4.2	3.18	2.4	1.17	--	--
Individual Psychotherapy	2.8	1.37	2.7	1.60	2.4	0.95	2.0	0.00
Individual Skills	3.9	4.83	3.4	2.42	3.3	1.38	4.0	0.00
Med – Primary Care Physician	0.9	0.81	0.7	0.37	1.2	0.45	--	--
Med– Psychiatrist	1.0	0.69	0.9	0.30	1.0	0.00	1.0	0.00
Residential Treatment	80.5	112.43	300.0	364.97	--	--	--	--
Total # of services	2.1	1.21	2.1	1.23	2.1	1.08	2.6	0.78
Total Hrs of services	8.7	15.44	8.7	32.87	5.9	8.36	13.1	18.99
Total # of therapy services	1.6	0.85	1.7	0.89	1.5	0.76	1.1	0.32
Total Hrs of therapy services	6.3	6.84	5.6	5.34	4.1	2.03	4.2	0.65
Total # of medication services	1.0	0.09	1.0	0.11	1.0	0.00	1.0	0.00
Total Hrs of medication services	1.0	0.74	0.9	0.34	0.8	0.30	1.0	0.00

Note. Cases listing recommended services: Time 1 = 1622, Time 2 = 653, Time 3 = 122, Time 4 = 18

Appendix B: Descriptions of Outcome Measures

I. Child and Adolescent Service Intensity Inventory (CASII):

- The CASII (American Academy of Child and Adolescent Psychiatry, 2005) is an 8-item instrument designed to objectively determine the service needs of children and adolescents.

- Mental health providers rate clients on 8 dimensions: Risk of Harm, Functional Status, Comorbidity, Environmental Stress, Environmental Support, Resiliency, Child/Adolescent's Acceptance and Engagement in Treatment, and Parent's Acceptance and Engagement in Treatment.

- Each dimension has five levels that form scales from 1 (low or minimum problem area) to 5 (extreme problem area). Higher numbers indicate higher levels of problems or lower levels of strengths.

- In addition to ratings on each dimension, the CASII provides a Composite Score and Level of Care recommendation. The CASII's recommendations for level of care range from 0 (Basic Services for prevention and maintenance) to 6 (Secure, 24-hour services with psychiatric management).

II. Strengths and Difficulties Questionnaire (SDQ):

- The SDQ (Goodman, 1997) is a brief behavioral screening questionnaire that is separated into two sections.

- The first section has 25 items listing 25 attributes, some positive and some negative, which are divided into five scales of five items each. The five scales include Emotional Symptoms, Conduct Problems, Inattention-Hyperactivity, Peer Problems, and Prosocial Behavior. A Total Score is comprised of the Emotional Symptoms, Conduct Problems, Inattention-Hyperactivity, and Peer Problems subscales.

- The second section is comprised of 7-9 questions and creates an Impact score that assesses the impact of symptoms on the child and the child's family or school environment. The Impact Score was not included in much of the data.

- The SDQ can be completed by parents, teachers, or the child and there are separate versions for each. There are also different SDQ forms based on the child's age. The same attributes are measured on each form, although the wording and examples of behaviors vary.

- The SDQ has been standardized on several populations, allowing scores to be classified into categories by the probability that a significant problem exists in a specific area. Scores are categorized into three levels of probability: Normal (score falls in the 0-79th percentile), Borderline (score falls in the 80-89th percentile), and Abnormal (score falls in the 90-100th percentile).