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Identifying and Building on Strengths of Children With Serious Emotional Disturbances

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IDENTIFYING AND BUILDING ON STRENGTHS OF CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES

by

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DISSERTATION APPROVAL

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ABSTRACT

An abstract of the dissertation of Michael Orval Taylor for the Doctor of Philosophy in Social Work and Social Research presented November 7, 2002.

Title: Identifying and Building on Strengths of Children with Serious Emotional Disturbances

The aim of this study is to explore strengths assessments and the participation of parents in assessment of strengths and functioning of their children challenged by serious emotional disorders. The children in this study have a high level of exposure to mental illness, domestic violence and substance abuse in their biological families. These children are living with family members or foster families in the community, with the majority at continuing risk of placement outside of their homes and communities due to serious emotional and behavioral problems.

The research questions investigated are the concordance of families and professionals in assessment of strengths, differences in assessment of strengths, problems in specific domains of functioning, and relationships of characteristics of the child with recognition of strengths by the parent and professional.

This study uses data collected from families of children with serious emotional disorders receiving services through community-based wraparound services supported by the mental health services program for children #5 HSS SM52297 funded by the Center for Mental Health Services, Substance Abuse and Mental Health Administration. The dissertation research presents a secondary analysis of a portion of the evaluation data collected for that demonstration.

Eighty-five children were assessed by the parent and professional using the Behavioral and Emotional Rating Scale (BERS), the Achenbach Child Behavior Checklist (CBCL), and the Child and Adolescent Functioning Scale (CAFAS). It was found that families provided significant and unique information regarding their children. A repeated measures analysis of the strengths scores revealed significant differences in the assessment of strengths by the parent and professional raters in domains of intrapersonal strengths, affective strengths and family involvement. The findings support the use of the strengths measure by multiple informants to provide unique information regarding the child's strengths and functioning.

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This dissertation is dedicated to my son Daniel, who has demonstrated great strengths and to my life partner, Linda Marshall, who lives and works from the strengths perspective daily.

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CHAPTER I

SYSTEMIC AND INDIVIDUAL INTERVENTIONS FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL DISORDERS

Introduction

Mental and emotional disorders in children and adolescents touch at least one in ten children – and just one in five of those children receives treatment, as documented in the recent report on Mental Health by the United States Surgeon General (U.S. Department of Health and Human Services, 1999). Mental health care available to families challenged with children suffering from serious emotional disturbances has been historically fragmented, restrictive, and categorical. Many families lack access to the right level of treatment for their children in the community. This lack of sufficient services can exacerbate the development of more severe disorders. Mental health treatment and services provided to these children and their families must be better coordinated and integrated with other elements of the health care, education, and social service system.

Social workers and other helping professionals have relied too long on a deficit-based approach in practice emphasizing pathology over strengths. This approach serves to stigmatize families and their children. This study explores

practice methods that instill hope for these children and families through involvement of families and professionals in assessing strengths of the child.

Jane Knitzer's (1982) groundbreaking work, *Unclaimed Children*, gave heed to the harm done to children and families poorly served due to service disorganization. Knitzer's study highlighted a systemically ineffectual delivery of services that contributed to isolation, harbored unmet needs, and favored institutional care. Her work asserted that mental health treatment services did not minimize or eliminate existing problems, but exacerbated them. Her published investigation became a rallying point for reform efforts.

This need for increased collaboration at the systems level has been well established, supported by Knitzer's (1982) work and others advocating for systems reforms (Stroul & Friedman, 1986). To address this need, federal funding has supported initiatives to develop and enhance child centered, family-focused *systems of care* in local communities. According to Stroul and Friedman (1986), a system of care is based on multi-agency collaboration that is responsive to the individual child and the unique cultural needs of the family. Essential elements of a system of care include: strength-based service planning; coordinated agency efforts; and family voice, access, and ownership streams. These features serve to build systems that are responsible and accountable to children and families challenged by complex and enduring social, behavioral and emotional problems. Under this collaborative system of care, Knitzer's "unclaimed children" are embraced as the entire community's children.

While current research provides support for the successful implementation of systems changes and practice improvements (Friedman & Burns, 1996; Rosenblatt, 1998; Whitbeck, Kimball, Olsen, Lonner, & McKenna, 1993), the relationship between systems level changes and practice methods for children and families remains unclear. Additional research is needed to refine the interventions and assess fidelity of practice to selected values and principles (Epstein, 1999b; Lourie, Stroul, & Friedman, 1998).

This study identifies some key practice constructs of the system of care philosophy and explores these through the use of standardized instruments. In the study, the *Behavioral and Emotional Rating Scale* (BERS; Epstein & Sharma, 1998) is used to identify strengths and to explore agreement between professionals and family members on assessment of strengths. Traditional child assessment instruments appraising behavior problems and functional deficits are also utilized to explore the extent of agreement and differences regarding both strengths and functioning of the child. Practice constructs being explored are the identification of strengths and participation of family members in assessing the child's strengths and needs. These constructs are posited as key practice elements associated with improved services for children with serious emotional disorders (Cowger, 1994; McCammon, Spencer, & Friesen, 2001).

Social work researchers have raised practice challenges inherent in implementing a strengths perspective and increasing collaboration between families and professionals to increase productive partnerships and mutuality (Collins &

Collins, 1990; Saleeby, 1996; Weick, Rapp, Sullivan, & Kisthardt, 1989). The process of assessing strengths including the perspectives of both the family and professional are investigated through this study. Saleeby (1996) provides a context for the importance of focusing on strengths:

> The impetus for the evolution of a more strengths-based view of social work practice comes from the awareness that U.S. culture and helping professions are saturated with psychosocial approaches based on individual, family and community pathology, deficits, problems, abnormality, victimization and disorder. (p. 226)

A strengths perspective challenges the dominant deficit-oriented approach to assessment, evidences a belief in the dignity, worth, and capabilities of the individual, and challenges the reliance of professional authority as the dominant voice in assessment and diagnosis (Weick, Rapp, Sullivan, & Kisthardt, 1989).

The following review of literature and research addresses the prevalence of mental health disorders in children and practice improvements in systems of care; including strengths-based assessment and family participation in assessment and care planning. The aim of this study is to explore recognition of strengths by families and professionals and explore participation of families with practitioners regarding those strengths. The assessment of strengths and functioning from the perspectives of both the family and professional are examined to determine relationships can be predicted between a child's behavior problems, functional level, age and gender and the recognition of strengths. The purpose of this study is to increase our understanding of methods to assess and build upon strengths of children living with behavioral and emotional challenges.

Mental Disorders in Children

Mental disorders appear in families of all social classes and backgrounds, although children with physical problems, family history of mental and addictive disorders, poverty and caregiver neglect are at higher risk. The manifestation of mental disorders in children derives from a complex mix of individual development and constitutional factors. This complexity requires clinicians and researchers to attend to multi-determinant etiology encompassing biological, social, and psychological factors in assessment and treatment planning.

The 1999 U.S. Department of Health and Human Services report of the Surgeon General on children and mental health, citing results of the MECA Study (Methodology for Epidemiology of Mental Disorders in Children and Adolescents), reports a prevalence estimate of 21% of U.S. children ages 9-17 with a diagnosable mental or emotional disorder. These findings reveal a serious statistic: one in five children and adolescents experience symptoms of a mental or emotional disorder, with 5% suffering from an extreme functional impairment. The incidence of specific disorders, by diagnostic categories resulting in at least a mild level of impairment includes anxiety disorders (13%); mood disorders (6.2%); disruptive disorders (10.3%); and substance abuse disorders (2%) (Shaffer et al., 1996; U.S. Department of Health and Human Services, 1999).

A range of treatments exists for many mental disorders in children and emerging research explores effectiveness of these treatments. Though traditional

practice models have relied on the etiology of these disorders being negative environmental influences, there is an increasing consensus that constitutional factors have pronounced influences on many disorders. Disorders such as autism, childhood schizophrenia, attention-deficit disorders, and mood disorders have only recently been accepted as predominantly biologic in origin (Jensen, 1999; U.S. Department of Health and Human Services, 1999; Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997). Research on neurobiology challenges a provincial overemphasis on family dynamics as the source of serious emotional disorders. However, these traditional models of practice based on pathology and blaming the family are rooted deeply in our professional cultures and practices (Ryan, 1976, Saleeby, 1996).

Clinical Practice Research

Research verifies the importance of a multi-determinant model in assessment and treatment that includes *biologic* (genetic and environmental), *social* (familial and societal), and *psychological* (developmental and interpersonal) influences. Controlled studies of treatment interventions, primarily limited to outpatient treatments in research settings, demonstrate that improvements in functioning are consistently greater in groups receiving treatment and that multi-modal treatment leads to better outcomes (U.S. Department of Health and Human Services, 1999). Research on children's mental disorders and treatment are summarized in the Surgeon General's report which emphasizes the need for more

extensive study of optimal treatment practices, especially for children with the most severe disorders.

Current research does not adequately address a range of interventions for the most seriously disordered children. Clinical practices studied in much of the current research is most often designed around a particular service modality, outpatient therapy, and are usually tested in controlled research settings (Rosenblatt, 1998). Rosenblatt suggested that the study of interventions focus at the services level, examining specifics of therapist or caseworker interactions with children, their families, and community support systems. As multi-level services include a number of interventions across community and clinic settings, this requires a capacity to describe and measure the interventions beyond those conducted via clinical trials research in outpatient settings. This inquiry requires methods relevant to emerging practices, methods derived from the experience of program evaluation and formative research methods (Patton, 1994; Tyson, 1992). Studies on outcomes of intensive community-based treatments, though limited in number, have supported positive benefits of these comprehensive interventions (Heflinger, Northrup, Sonnichsen, & Brannan, 1998; Kutash & Rivera, 1996; Rosenblatt, 1998).

Research focusing on benefits of residential treatment for children and adolescents has been sparse, though these settings account for up to one-half of the dollars spent on treatment for children (Burns, 1991). Burns and others (Weller, Cook, Hendren, & Woolston, 1995) have expressed concern regarding the lack of

data on outcomes for hospital and residential treatment settings, as these are the most expensive and intrusive treatment options for children. Rising admissions to inpatient psychiatric settings during the 1980s and 1990s were not supported by evidence of increased clinical need or social benefit. Concerns have been raised about this lack of data for residential and hospital treatments including admission criteria; cost-benefit ratio; risks inherent in removal from the home and community; difficulty of reintegration into the family; and potential for victimization by residential treatment center staff (Friedman & Street, 1985; Greenbaum et al., 1998). Knitzer (1982) initially raised these concerns in the early 1980s, focusing on the excessive and inappropriate use of psychiatric hospitals and reliance on residential treatment for children and adolescents. These concerns support the need for investigation of emerging practices in community-based systems of care for children as alternatives to institutional treatment.

The need for more empirical data regarding community-based treatment supports this investigation of key practice constructs of these evolving systems of care. This study focuses on two practice constructs: using a strengths-based assessment and exploring family participation in assessment of both strengths and functioning of their child. Strengths identification and participation of families in assessment are posited as essential components of community-based treatment for children and adolescents living in their own families and communities. These constructs are components of a practice model described as *wraparound* services

provided to children with serious emotional disorders through coordinated *systems of care*.

Systems of Care for Children with Serious Emotional Disorders

Evaluations of services provided to targeted children with severe mental/ emotional disorders have produced a body of research on implementation of *systems of care* endeavoring to link outcomes with practice improvements. These studies have documented changes in service delivery as well as improved child outcomes in functioning and behavior (Center for Mental Health Services, 1999). This literature has increased understanding of some key elements of community-based and integrated services for children, implementing the principles first articulated in Child and Adolescent Services Systems Principles (CASSP) and later referred to as *systems of care* (Stroul & Friedman, 1986). Much of this literature has focused on implementation and measurement of systems-level and practice changes (Center for Mental Health Services, 1997, 1999). Research provides evidence of successful implementation of the system of care approach through practice improvements including: (a) increased access, voice, and ownership by families and consumers (Whitbeck et al., 1993); (b) involvement of key individuals in developing community wraparound plans (VanDenBerg, 1990); and (c) engagement of the family as a collaborator in the use of a strengths-based approach (Malysiak, 1998).

Findings of positive outcomes for children served by systems of care comes from a number of sources related to these efforts and has been increasing (Center for Mental Health Services, 1999; Stroul, 1993). Functional improvements for children in family life, school success, and reduction of juvenile arrests has been reported in several studies. Data from California's experience in pioneering system reform efforts identified a specific target population and a mission to keep children "in school, at home and out of trouble" (Rosenblatt, 1993, p. 275). Interagency coordination and collaboration along with requirements that services be community based and culturally competent are key elements in this system. In assessing the system's success in achieving its goals, Rosenblatt and his colleagues found a reduction in out-of-home placement, cost savings through placement avoidance, improved school performance, increased school attendance, and a reduction in juvenile justice recidivism (Jordan & Hernandez, 1990; Rosenblatt, 1993). The cost containment data for California is compelling and has been substantiated by data from Vermont (Bruns, Burchard, & Yoe, 1995) as well as Wisconsin and Hawaii (Foster, Kelsch, Kamradt, Sosna, & Young, 2001).

Data from the SAMHSA Child Mental Health Initiative programs have been positive, especially regarding the impact on quality of life for families. Significant improvements in child and family functioning have been associated with practice changes and systems' interventions (Farmer 1996). The Milwaukee "25 Kids Project" focuses on a group of children who have experienced multiple challenges in their lives, including residential treatment, and whose care has been particularly

costly. As a result of the Milwaukee project, the majority of these adolescents have returned to their communities, many to live with their families. Many returned to school and have avoided contact with the juvenile justice system (Center for Mental Health Services, 1999; Kamradt, 1996).

Systems of care initiatives have not received universally positive evaluations. Research conducted on the Fort Bragg demonstration project and in Stark County, Ohio found no differences in children's outcomes for those enrolled in systems of care versus those receiving usual services (Bickman, 1996b; Bickman, Summerfelt, Firth, & Douglas, 1997). These findings have been challenged on the basis that the Fort Bragg project did not establish fidelity to the theory and practices of systems of care (Friedman & Burns, 1996). The Bickman studies underscore the need for increased empirical evidence about both the practices that constitute system of care interventions and the connection between practice changes and child and family outcomes.

Supporting and Sustaining Systems of Care

Intensive services for children with serious emotional disturbances remains primarily managed and funded by the public sector, which has been dependent on the identification of a categorical need under educational or mental health criteria and funding. The continued prevalence of categorical services is rooted in the financing mechanisms codified in special education law and Medicaid regulations. These categorical restrictions can limit access to flexible funding needed to support

community-based practices. Barriers to flexible funding and individualized service delivery continue to impede the full implementation of system of care values (Malekoff, 2000). Expenditures for residential and hospital care still exceed those for community and family-based treatments. There is a lack of evidence of effectiveness of these more restrictive traditional interventions (Burns, Hoagwood, & Maultsby, 1998).

Implementation of mental health managed care in the public sector provides new opportunities to focus on improved access, practice innovations, and flexible services. The success of mental health managed care for children is closely related to the level of community and family involvement in implementation, quality assurance and public oversight of contract performance (Pires, Stroul, & Armstrong, 2000).

The impact of managed care initiatives differs greatly by state and community, most often related to the parameters of the managed care contracts. Managed care entities are widely varied in their goals depending on whether they are profit or service driven. The managed care business model can result in either an emphasis on limiting care to increase profit or improving flexibility to achieve positive outcomes. Incentives often do not align at the systems and services levels, resulting in categorical services such as residential care receiving higher levels of reimbursement than intensive community-based care (Foster et al., 2001).

Creating service delivery systems capable of meeting the needs of these children and families requires a sustainable infrastructure to deliver and support

these services (Stroul & Friedman, 1996). This drives the call for systematic research addressing demonstrations of services integration in mental health, education, and human services that goes beyond descriptions of systems reforms to evaluation of practice changes raised repeatedly in the literature on developing systems of care. Research on practice changes resulting from expanded and alternative structure of service delivery technologies at the systems, program, and services level is needed to link essential practice elements to long-term successes for these children and their families (Friedman, 1997; Knapp, 1995; Rosenblatt, 1998).

The focus of this dissertation research is to study some key practice constructs of a practice model advocated in the literature on system of care: identification of strengths and exploring participation of families in assessment. The implementation of these practice constructs are posited to optimize the match between the needs of the child and family and services through identification of strengths of the child and involvement of the family in conducting the assessment and implementing a plan of care.

Wraparound Practice Model

Wraparound is a collaborative practice model, derived from ecological systems theory, which defines a process of implementing individualized, comprehensive services for youth with complicated serious emotional disturbances. The wraparound approach emphasizes meeting the individualized needs of the child

in the least restrictive setting (Malysiak, 1997). Wraparound practices were advanced by John VanDenBerg (1990), initially through the Alaska Youth Initiative, and by other innovators in North Carolina, Florida, Illinois, and Vermont (Behar, 1985; Burchard & Clarke, 1990; Dennis, 1992; VanDenBerg & Grealish, 1996). Wraparound practice principles are being actively adopted across the country as a model for meeting the needs of children requiring an array of community services and natural supports to achieve positive outcomes. To increase healthy functioning, the natural ecology of the child including the family, community, and service systems, is engaged to support the strengths and individualized needs of the child and family. Principles of wraparound practice include voice and choice for the child and family, compassion, and flexibility (Franz, 2000). The wraparound process focuses on engaging families and community supports in a process of developing an individualized plan based on individual and family strengths and needs in multiple life domains (McGinty, McCammon, & Koeppen, 2001).

Essential practice elements of wraparound include: (a) individualized services, (b) strengths-based perspective and use of natural supports, (c) development of a support team for the child and family, (d) services that are community-based, (e) a collaborative stance between families and professionals, (f) flexible funding and services, (g) outcome-based services, and (h) family voice and choice of services (Burchard, 1998). Wraparound emphasizes a collaborative approach between service providers and families that provides families with

supports and services in the community to maintain their children at home and in school. The wraparound practice model is designed to support families in providing care and treatment at home in lieu of institutional treatment (Burns, Hoagwood, & Maultsby; 1998). VanDenBerg and Grealish (1996) emphasized wraparound must include collaborative child and family teams that create and implement individualized support and plans of care and availability of sufficient funding to meet the needs identified in the plan of care. This approach relies upon the child and family as members of a team coming together to listen and to agree on a plan of action. Successful implementation of wraparound requires a funding infrastructure that includes shared and flexible funding and services necessary to support this practice. Malysiak (1998) reported that a key to positive outcomes is the active engagement of the family as collaborators in the process and the use of a strength-based ecologically oriented approach. Traditional methods of providing services have been described as fragmented, costly, overly restrictive and often disruptive in requiring placement that is outside the child's home and community (Hernandez & Hodges, 1996; Sosna, 1999).

This dissertation research explores key constructs of the wraparound practice model - the recognition of strengths and involvement of the family in assessment of the child's strengths and needs.

Identifying Strengths

The process of mental health assessment, with its embedded bias toward illness and dysfunction and pressure to collect data on pathology, can have a profound negative effect on the client (Graybeal, 2001). Key to a change in perspective is engaging clients and families in a way that builds on their strengths, recognizing that the most challenged children and stressed families have competencies, strengths, and resources (Epstein, 1999b). Saleeby (1996) articulated how an emphasis on pathology has permeated our field of practice and may be antithetical to social work values; reliance on categorical funding and service delivery "silos" perpetuate this deficit-oriented service delivery system.

Embracing a strengths-based perspective has been posited to: (a) lead to more positive engagement of children and families; (b) identify for the child, family, and professionals what is going well in the child's life; (c) remind professionals of the competencies that can become the basis for future growth; and, (d) establish positive expectations for the child (Epstein, 1999b). Strengths-based intervention and case management approaches have been evaluated as useful for adults with serious mental disorders (Modrcin, 1988) and have been postulated as an essential component in promoting positive outcomes for children (Epstein & Sharma, 1998).

Traditional practice approaches have emphasized problem-focused care planning that is driven by services reimbursement, emphasis on medical diagnosis, and professional and facility licensing. Unlike a deficit approach, with well-

entrenched assumptions about human functioning, a strengths-based approach to service provision for high-needs children and adolescents has gained recognition and support (Brun & Rapp, 2001; Graybeal, 2001). A focus on assessment of strengths has commanded increasing attention in the literature on education (Nelson & Pearson, 1991), mental health (Stroul & Friedman, 1996), child welfare (Saleeby, 1992), and family services (Dunst, Trivette, & Deal, 1994).

Fostering strengths in children with serious emotional disturbances builds upon research identifying critical factors present in resilient children. These factors are caring relationships, consistent expectations from a caring adult with capacity to build on strengths, and opportunities for child and family participation (Benard, 1996). Important sources of strength are cultural and personal stories, narratives and lore (Saleeby, 1996), as well as the "survivor's pride" of surviving abuse and trauma (Wolin & Wolin, 1993). These strengths are often evident in youth and their families who are coping with and surviving mental illness. Resiliency research challenges traditional concepts about child development; positing that childhood trauma most inevitably leads to adult psychopathology (Bernard, 1993; Garmezy, 1994) and that social conditions viewed as toxic usually lead to problems in everyday functioning of children, families, and communities (Rutter, 1979; Rutter & Sandberg, 1992).

Strengths-based assessment can facilitate the engagement of the family in services, particularly when a child has a history of unsuccessful placements or services (Courneyer & Johnson, 1991). Strengths-based assessment from multiple

perspectives supports discourse regarding strengths of the child and is theorized in this study to promote family-professional collaboration in recognizing and building upon strengths.

A primary aim of this study is exploring use of a strengths assessment. Adoption of a strengths perspective is examined through use of the *Behavioral and Emotional Rating Scale* (BERS) completed by the family and professional.

Family Participation

In comparison with families of children with physical disabilities and developmental disorders, families of children with serious emotional disabilities (SED) have reported a higher level of personal and family stress (Friesen, 1989). Stigma and blame continue to center on families of these children, based on theoretical approaches dominated by pathology and attribution of problems to individual deficits or family dysfunction (DeChillo, Koren, & Mezera, 1996). The complexity and intensity of challenges facing children with SED and their families have become increasingly well documented. These include a fragmented service delivery system, inadequate insurance coverage for home and community-based care, and difficulty with access to flexible and individualized services. The lag between the recognition of this need and the provision of a systemic response to that need has had a negative impact on these children and their families, resulting in greater stress for and isolation of the family and negative outcomes for the child (Stroul, 1996).

Family involvement is an increasingly recognized value, and family members have assumed administrative and advocacy positions within government and treatment agencies (Koroloff, Friesen, Reilly, & Rinkin, 1996). Family-centered service delivery is accepted as a value, but has not been fully realized or adequately measured at the services level. Changed attitudes toward families and clinical practices that are inclusive of family voice require professionals to hear and heed family input (Allen & Petr, 1995; Tannen, 1991). Involvement of families as full partners in creating a plan for their children is critical to success of that plan. A partnership between parents and professionals is one in which both parties join to determine and meet information and service needs (Heflinger & Bickman, 1996). Essential components of this partnership are: (a) shared power and decision-making, (b) open communication regarding the child's needs in conjunction with shared information about the services systems' strengths and limitations, (c) practical assistance and improved access to services, and (d) readiness of the provider or system to alter services based on feedback from families (Simpson, Koroloff, Friesen, & Gac, 1999). Factors supporting increased involvement of families in assessment and care planning include growth of consumer awareness, research evidence discrediting family dynamics as the primary etiology of mental illness in children, and evidence that social support and family empowerment can lead to improved outcomes (DeChillo, Koren, & Mezera, 1996; Koroloff, Friesen, Reilly, & Rinkin, 1996).

Increased family support has been associated with a higher level of initiation of mental health services (Elliott, Koroloff, Koren, & Friesen, 1998), membership and involvement in parent support groups (Singh, Curtis, Wechsler, Ellis, & Cohen, 1997), participation in systems reform efforts (Koroloff, Friesen, Reilly, & Rinkin, 1996), and increased satisfaction and empowerment (Singh, Wechsler, & Curtis, 2000).

Participation in assessment and care planning endorses families of children with serious emotional disorders as experts regarding their children. Family participation also supports a principle of democratic participation and exercise of client and family rights (Heflinger & Bickman, 1996). Social work has codified self-determination in its practice values. Nevertheless, mental health professionals from social work and other disciplines have contradicted these values in striving for professional role identity, increased reimbursement, and personal status. These factors serve to distance professional helpers from families of children with serious emotional disorders (Johnson, Cournoyer, & Fisher, 1994). Examples of exclusion of families are still evident in practice: requiring families to stay in the waiting room while their children receive treatment; isolation of children receiving residential treatment from their families; and pejorative use of diagnostic labels for parents.

Increasing family participation requires rapport between families and professionals in planning, providing, and delivering services and demands changing the balance of power and control between professionals and families (Collins &

Collins, 1990). Implicit in increasing participation is the expectation that no one person is the expert with the answers to all the issues or problems being presented. Relationships between mental health professionals and families should include conveying a caring and non-blaming attitude, sharing of information, recognizing the family as a key resource, and acknowledging limits to professional authority through sharing responsibility and power (Franz, 1999).

Significance of the Study

Essential to evaluating family participation is the collection and analysis of data indicating the degree to which key participants were adequately involved in the process and agreed upon an assessment and care plan. Previous studies have raised questions regarding whether or not families were truly engaged as collaborators in the assessment and service planning and as contributors to the wraparound process itself (Friedman & Burns, 1996). The youth served by this project have many challenges based on their individual histories and biologic vulnerability. This study adds to the body of research through analysis of assessments of strengths by families and service providers, and by exploring agreement and difference between families and professionals on standardized measures.

It is a significant finding that families do endorse higher ratings of strengths of their children, given the context of their own challenges. The findings support the use of diverse perceptions of strengths and functioning, proposed in the

conceptual model, to enhance communication and engagement. Shared assessment provides significant information and the findings indicate that families possess unique information about their children not otherwise available to the therapist. The data provided through use of strengths assessment makes a unique contribution to the assessment.

Aims of the Study

The first aim is to evaluate the adoption of a strengths perspective through use of strengths-based assessment by the family and professional. Exploring the involvement of the family in assessment of the strengths of their child during the initiation of services is a practice construct under investigation.

The second aim is to explore participation of the family in assessments of the child's strength and needs. Areas of concordance and difference between families and professionals will be explored through analysis of scores on instruments assessing both strengths and needs of the child from the family and professional perspectives.

The final aim is to study the recognition of strengths by both family and provider in relationship to characteristics of the child including behavior problems, functional level, age, and gender. This aim explores the associations of strengths-based assessment with a child's characteristics to determine the effect of these characteristics on perceptions of strengths.

These research aims focus on the recognition of strengths across multiple domains and extent of agreement between family members and helping professionals extending previous research studying the implementation of wraparound services (Clark, Lee, Prange, & McDonald, 1996; Sosna, 1999; VanDenBerg, 1992). Prior studies provide support for increased access, voice, and ownership by families as associated with improved outcomes. Whitbeck verified the importance of families having the right to inclusion in decision-making processes, children and families feeling heard and listened to at all points in the process, and child and family having input to agree to any plan involving them (Whitbeck, Kimball, Olson, Lonner, & McKenna, 1993).

The focus of this investigation is exploring components of a conceptual model through the use of valid and reliable assessments of strengths and needs by both the family and professional. The data analyzed in this study have been obtained from consenting family members and professionals at the time of enrollment in intensive community-based services. The data used in this study include: (a) the child and family history collected by the care coordinator by interview via the Description Information Questionnaire (DIQ), (b) behavior and functional problems as assessed by the care coordinator through the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges & Wong, 1996), (c) the parent's view of behavior problems as reported on the Child Behavior Checklist (CBCL; Achenbach, 1991); and the assessment of strengths through the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998). The methods of data collection and instruments used are fully described in Chapter III.

This exploration of these practice constructs investigates the values and principles of system of care reforms in practice. This study focuses on the use of a strengths-based assessment and the involvement of the family in that assessment:

Strengths Assessment

- Family and professional both identify strengths,
- Recognition of a child's strengths,
- Formal assessment of strengths by family and professional.

Family involvement in assessment of both strengths and functioning is being explored to study the level of agreement and difference between assessments and providers by parents and professionals. While this study does not directly measure the quantity or quality of family participation, the aim of the research is to explore the family's participation in assessment through completing assessments of strengths and behavior problems.

Family Participation in Assessment

- Family and professionals assess strengths and functioning during initiation of services,
- Concordance between family and provider on assessment of strengths,
- Agreement between family and professional on severity of problems and functional challenges of the child.

Child characteristics, including age, gender, behavior problems and functioning will be explored to determine if these characteristics might predict a higher or lower strengths score by the family or professional.

CHAPTER II

CONCEPTUAL FRAMEWORK AND RESEARCH QUESTIONS

Conceptual Framework

The research aims and conceptual practice model under investigation evolved from review of research on systems of care and the wraparound practice model. The questions are investigated in the context of a community-based demonstration project for high-needs children and their families. This project embraces a strengths perspective and supports family participation through a wraparound process. This research can lead to more advanced study investigating if the system of care philosophy is associated with improved clinical practices and ultimately to better outcomes for children and families.

Practice constructs described in this chapter reflect some key elements of the wraparound practice model, principally strengths assessment and family participation. These practice constructs are explored to investigate application of strengths assessment from the perspectives of the professional and family. This dissertation provides empirical analysis of assessment data as a method of investigating a strengths perspective for children with serious emotional and behavioral disorders and examining the participation of the family in the assessment process.

This study of the recognition of strengths by the family and professional extends the work of Friedman, Friedman, and Leone who compared strengths assessments from the perspectives of parents and teachers and investigated differences in strengths ratings based on grade level (Friedman, Friedman, & Leone, 2002; Friedman, Leone, & Friedman, 1999). The relationship of gender, age, behavior problems, history, and functional level to the identification of strengths are also explored. The conceptual model being investigated also extends previous research on systems of care values and wraparound practice principles. Practice constructs under investigation in this study extend previous research supporting family inclusion in assessment and identification of strengths by both the family and professional, with the goal of increasing conversation about strengths to decrease a sole focus on problems and deficits (Cowger, 1994; Rapp & Wintersteen, 1989; Saleeby, 1992).

From this systemic view, an important principle is that a strengths perspective is included in the assessment, not which participant brings the information. Parent-professional partnership is complex and multidimensional and includes the parent perspective, professional perspective, the parent-professional interaction, and the systemic/societal context. Components of these multidimensional transactions are being explored in this dissertation through exploration of assessment data from both parent and professional.

As illustrated in the conceptual practice model in Figure 1, optimal long-term outcomes for these children include: (a) improved clinical status; (b)

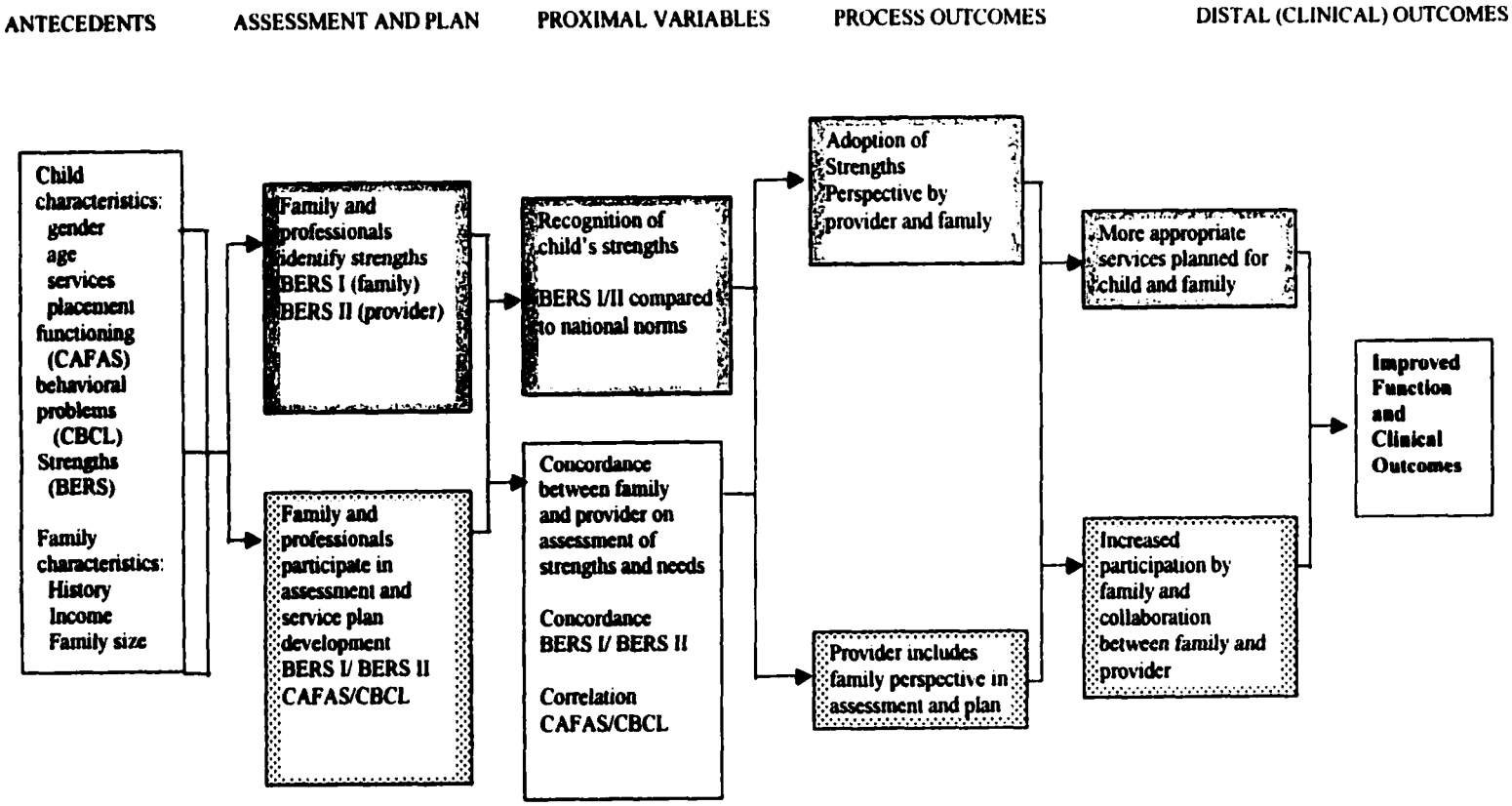

Figure 1. Conceptual practice model and practice constructs.

functional improvements; (c) increased life satisfaction, safety and welfare of the child; and (d) attachment to a caring adult (Bickman, 1987; Friedman & Burns, 1996; Rosenblatt, 1998; Whitbeck et al., 1993). Practice changes posited as linked with these outcomes are being explored through measurement of strengths-identification and participation of both family members and professionals in the assessment. This dissertation explores the practice constructs of this conceptual model that have been associated with positive long-term outcomes in longitudinal studies (Center for Mental Health Services, 1999).

Practice Constructs

The aim of this study is to explore practice constructs through an analysis of measurements of functioning, behavior, and strengths of the child from two perspectives. The study explores the identification of strengths by the parent and professional, and family participation in assessment. Concordance between family and professional assessments and relationships between recognition of strengths and behavioral and functional problems from the perspective of the parent and the professional are analyzed to investigate the constructs. The associations between strengths identification, functional and behavioral assessments of the child by families and professionals, and child characteristics will be studied to determine the effects of these factors on perceptions of strengths.

This study follows others (Burchard & Clarke, 1990; Courneyer & Johnson, 1991; Foster et al., 2001) evaluating the impact of systemic changes in the

interaction between parents and professionals on the manner in which individual children and families are served. This study uses valid and reliable measurements of strengths, problems, and functional level based on scores provided by parents and professionals on standardized instruments. Data collected may be useful to refine the conceptual practice model through precise measurement of the practice constructs as recommended by Patton (1997). Utilizing the BERS instrument to independently measure assessments by the family and professional extends previous research that compared strengths scores from parents and teachers (Friedman, Leone, & Friedman, 1999) and builds on studies comparing BERS scores with established measures of behavioral and functional problems (Nordness & Epstein, 2000). It is proposed that using the BERS instrument with the focus on strengths will support family participation in assessment through the data collection process and sharing this data with the family.

The instruments used in this study are briefly introduced below and referenced in Figure 1. The instruments and their administration are fully described in Chapter III.

The Descriptive Information Questionnaire (DIQ) is a 37-item inventory that gathers child and family demographic information, risk factors, family composition, referral source, and previous service history. Responses collected with the DIQ are used to provide descriptive data and evaluate predictor variables. The DIQ has no subscales or scoring conventions (Center for Mental Health Services, 1998b).

The Behavioral and Emotional Rating Scale (BERS) completed by the parent or legal guardian provides strengths assessment from the family and is used to examine both the level of strengths identification and agreement with professionals' assessment. The BERS is an empirically derived scale assessed to be valid and reliable to report strengths across the domains of Interpersonal Strength (IS), Family Involvement (FI), Intrapersonal Strength (IaS), School Functioning (SF) and Affective Strength (AS) (Epstein & Sharma, 1998). The BERS strengths assessment is also completed by the therapist during the assessment period allowing a study of differences in strengths identification from the perspectives of the therapist and the family (Epstein & Sharma, 1998).

The Achenbach (1991) Child Behavior Checklist (CBCL) is an extensively used parent completed assessment of behavioral and emotional problems used in this study to explore parents' identification of behavioral problems and to study the parents' assessment of both strengths and behavioral problems.

The Child and Adolescent Functional Assessment Scale (CAFAS) completed by the therapist/care coordinator is a widely used instrument to assess functional problems on eight scales assessing: role performance at school, home and community; interpersonal behavior, mood and emotions; thinking problems; and substance abuse issues (Hodges & Wong, 1996). A therapist or care coordinator familiar with the functioning of the child completes this assessment or responses to items may be collected from the parent in a structured interview. In this study, the therapists' assessment of functional level of child is the score used to explore

agreement between families and professionals in identification of functional problems and needs of the child.

Research Questions

This dissertation explores two practice constructs of the wraparound practice model being implemented in an intensive community services demonstration for children with serious emotional disturbances (SED) in Clackamas County, Oregon. The research questions explore constructs of this practice model: (a) identifying strengths and (b) involvement of both families and professionals in assessments of strengths and functioning of the child. The following questions explore the relationships of these practice constructs through an analysis of empirical data gathered with norm-referenced instruments from professionals' and caregivers' assessments.

The first aim of this dissertation is to measure the adoption of a strengths perspective by a professional working with the child and the family. Professionals have been increasingly exposed to training on adopting a strengths perspective. Previous research suggests that families may more readily identify strengths of their child than professionals (Collins & Collins, 1990). Outcomes expected for participants in this sample are that both parents and professionals will identify strengths, but in different domains, based on previous research by Friedman, Leone, and Friedman (1999). An a priori prediction is that therapists may identify more strengths in specific domains emphasized in professional training, such as the

affective domains. It is predicted that professionals may notice and report strengths in these domains at a higher level than parents, predicated on results of a study in which teachers reported higher levels of strengths in school functioning and interpersonal strengths compared to parents (Friedman, Leone, & Friedman, 1999).

Research Question 1

Are there differences between families' and professionals' assessment of strengths and the national norms for children with serious emotional disturbances?

This question compares the mean BERS scores in each domain to the normative data published by Epstein and Sharma (1998). It was anticipated that the sample of children with SED in this study would score at or below the national means for a clinical population of children with emotional and behavioral disturbances.

The second aim for this research is to explore family participation through the analysis of assessment data provided by parents and professionals at the initiation of wraparound services. The ratings on the domains of strengths measured by BERS subscales are addressed by the following two questions.

Research Question 2

Is there agreement in BERS subscale ratings by families and professionals regarding strengths of the child across multiple domains?

This question examines concordance between ratings on the five subscales of the BERS measuring strengths in behavioral and affective domains. The relationships compare the Parent rating in each domain (subscale) and the Therapist rating on each subscale. Exploration of this question addresses both aims of this dissertation - the adoption of a strengths perspective and exploring family participation in assessment. Therapist ratings may be a product of communication between families and professionals during the assessment period, as the therapist/care coordinator gains information from listening to the parent during this assessment period, as well as from direct interaction with the child. Areas of lower correlation or substantial differences on subscale scores may represent areas in which one rater may have different information based on more extended observation or rater bias. In a previous study teachers had higher strengths scores than parents in school functioning and interpersonal domains perhaps due to more extensive exposure or more informed observations (Friedman, Leone, & Friedman, 1999). Family-professional transactions, represented by concordance or differences in the strengths domains scores, is investigated through this analysis as a foundation for increasing family participation through discussion of assessment data. This study of aggregated data as well as review of individual scores in interaction between families and professionals present opportunities for increasing family participation through comparing ratings.

Strengths assessment scores may be used to assess changes in the individual child's functioning, and provide opportunities for discourse between the family and

professional on agreement or difference on observed strengths. A periodic review of strengths scores can also be used to increase participation of youth by reviewing with them the strengths scores from individuals who have observed their progress. A youth self-report scale is under development that may provide opportunities for comparisons between the youth's self perception and those of adult caretakers and professionals (Epstein, 2002).

Research Question 3

What are the differences between families' and professionals' ratings of strengths across the domains measured by the BERS?

This question examines differences in mean standard strength scores reported by the family and professional in the five separate domains. The Behavioral and Emotional Rating Scale is a strengths-based instrument that provides an opportunity to obtain information from multiple sources, particularly adults closest to the child. In the case of children with SED, identifying and discussing strengths is a component of the wraparound model and including data representing diverse perceptions, especially that of the family, increases family participation in assessment of strengths. Professionals or parents may see competencies in areas not recognized by the other and exploring the consistencies and differences in the BERS scores provides more data for discussion on the individual level. Analysis of aggregated scores, the focus of this study, provides the opportunity for patterns of difference to emerge from the data.

The following two questions further explore the first aim, adoption of a strengths perspective, through exploration of the relationship of identification of strengths and assessments of behavioral problems and functional impairments by parents and professionals.

Research Question 4

What is the relationship between behavioral and emotional strengths and functional impairments as reported by the therapist?

A negative correlation between the BERS and CAFAS scores might be expected as a higher CAFAS score represents more severe functional problems. Conversely, therapists may show systematic bias toward lower functioning youth and observe and report a higher level of strengths reflecting the youth's ability to cope with behavioral and emotional challenges.

Research Question 5

What is the relationship between behavioral and emotional strengths and behavior problems as reported by the parent?

An inverse relationship is expected in the parents scores on the BERS and CBCL given the construction of the scales, the BERS assessing strengths and the CBCL behavioral problems. However, the effect of the child dealing with a serious disability may support a systematic bias in which parents perceive higher strengths in their children who are suffering from more serious emotional disorders as reported by Wolin and Wolin (1993) in their studies of resilience.

The following question continues the investigation of the second aim of this dissertation - exploring the participation of the family in assessment of both strengths and needs of the child.

Research Question 6

What is the relationship between behavioral problems as reported by the parent and the functional problems as reported by the therapist?

This question builds on the use of two raters and two scales to support multiaxial assessment utilizing two measurements of functional problems as recommended by Achenbach (1993). Through examination of the level of functioning assessed by the therapist on the CAFAS and behavior problems as assessed by the parents on the CBCL a more complete picture of areas of agreement on the needs of the child can be determined. This extends previous research by Phillips (1999) in which he used these two instruments to explore differences and concordance of assessments between foster parents and caseworkers.

The analysis of the areas of agreement and of lack of concordance offer the opportunity for increased discourse and participation by the family in determining areas for focus of care. Analysis of correlation across this sample provides data to explore patterns of perceptions from parents and professionals. The use of this data in this manner is proposed in the conceptual model to be associated with improved outcomes through increased participation of the family in assessment.

Gathering and reporting these scores can be used to evaluate implementation of the model. Repeated measures of these assessments on an individual basis would provide ongoing opportunity for dialogue between families' and professionals' regarding progress of individual children through examination of changes in functional deficit and behavior problem scores but is beyond the scope of this study.

The third aim is to examine the recognition of strengths in relationship to other characteristics of the child.

Research Question 7

What are the relationships between recognition of strengths and child characteristics from the perspective of the family and professional?

Parents of SED children stressed by their behavioral problems may identify strengths in different domains than professionals or may identify fewer strengths related to their level of stress in managing the child's behavior problems. Conversely, though the severity of the child's behavior is associated with higher stress, other variables in the family environment may moderate the impact and may in fact contribute to enrichment of the parenting experience (Yatchmenoff et al., 1998). The effect of independent characteristics of the child such as age, gender, behavior problems and functioning is explored through this analysis, understanding that parent characteristics described in previous research may moderate the parent's perception of strengths of their child.

Exploration of the recognition of strengths by professionals and families in relationship to gender, age or functional level will probe for any systematic bias in identifying strengths based on group membership. This extends research that explored the differences between counselors and teachers when using the BERS at different grade levels (Friedman, Friedman, & Leone, 2002), with an expectation that families or professionals may have patterns of strengths identification predicted by age, gender or functional impairment. Exploration of the relationships of subscale scores on these instruments explores predictive values in support of the research aim of understanding the differences of perceptions of strengths and problems from the perspectives of family members and professionals.

CHAPTER III

METHODS

This dissertation uses data collected from families of children with serious emotional disorders (SED) receiving services through the Clackamas Partnership located in Clackamas County, Oregon, supported by the mental health services program for children #5 HS5 SM52297 funded by the Center for Mental Health Services, Substance Abuse and Mental Health Administration. This dissertation research presents a secondary analysis of a portion of the evaluation data collected for that demonstration.

The primary goals for Center for Mental Health Services (CMHS) funded Comprehensive Mental Health Services Programs consist of: (a) integrated funding streams; (b) a unified governance structure; (c) family partnerships in all aspects of the system and in care of their children; (d) a single, financially sustainable system; (e) interagency involvement; (f) a state/local relationship, outcome based evaluation; and (g) the creation of a genuine managed care model (Center for Mental Health Services, 1998c).

Context of the Study

The Clackamas Partnership, a collaborative entity of families, child welfare, education, health, mental health, juvenile justice, and private providers, provides community-based care for children and their families who are faced with complex and enduring mental health challenges. Based on the values and principles initially articulated by the Child and Adolescent Service System Program (CASSP) and in response to the Guidance for Applicants (GFA) for the Child Mental Health Initiative, the Clackamas Partnership and Clackamas County Mental Health Center implemented the following programs and services:

- Integrated services around the strengths and needs of families through the creation of Child and Family Teams. Care coordinators authorize and provide flexible services to identified children and their families through an enhanced service array of community-based mental health and non-mental health services to a clearly defined target population - those most at risk for out-of-home placement.
- Improved access to intensive services through outreach, opening a number of pathways to services, and empowering local families to recruit other families into services.
- Blended funds across agencies to provide the necessary resources for community-based services. Contributing to this effort are private and

public intensive service providers and schools who have redirected resources from intensive and residential services to community services.

- Coordination with the Oregon Health Plan, the state-managed care plan, to provide community services for the children and families who need the most intensive services.
- Providing training and technical assistance and on-going supervision for care coordinators and staff of partner agencies to increase skills in collaboration and clinically appropriate, family-centered services.
- Staffing an evaluation team in collaboration with Portland State University's Regional Research Institute and Research and Training Center to implement national and local evaluation, to ensure that data are used to inform all decision-making processes concerning children and families, interventions, and governance (McCormack & Taylor, 1998).

The Clackamas Partnership has built upon efforts in mental health, child welfare, juvenile justice, and special education to provide a model to bring together uncoordinated efforts at the level of system, program and practice and to move those efforts to a sustainable level. Clackamas Partnership combined elements of the current reforms in mental health, child welfare, and juvenile justice and education, offering a demonstration for state and local agencies of the compatibility and portability of these efforts.

Key to the sustainability of these changes has been the development of a collaborative governance structure supported by leadership theory and research and

ongoing local consultation and training. Children's mental health research has stressed the importance of local governance for achieving change that is owned by a community and is implemented in a democratic fashion (Hodges, Nesman, & Hernandez, 1999). Within the leadership literature, collaborative governance is tied to emerging ideas about authority, such as creativity, systems thinking, risk, and vision (Senge, 1994). The principles of collaborative leadership have been endorsed by a local Partnership Council of agencies and community members.

Family involvement is one of the central tenets of the system of care and has been a focus of the Partnership. Systems of care have moved from family-focused to family-centered entities in response to advocacy from parents. Through measuring the significance of family access, voice, and ownership, researchers have discovered family involvement yields positive functional outcomes for children and increases in satisfaction and empowerment in families (Whitbeck et al., 1993). The Partnership contracted with the Oregon Family Support Network to lead these efforts.

The Clackamas Partnership is supported by a foundation of shared decision-making and collaboration among the key child-serving agencies in the county. The Partnership has matured through the introduction of blended funding and collaborative services. Clackamas County Mental Health Center (CCMHC), through its Mental Health Organization (MHO), brought new and flexible resources from the Oregon Health Plan to the county for eligible residents along with managed care business practices, including shared responsibility and risk.

Without interagency collaboration, it is impossible to have a system of care. In the case of children with serious emotional disturbances and their families, the "silo" approach to funding and organizing children's mental health services is a disaster because children have multiple needs and challenges and if they are treated in a compartmentalized way that negates their complexity (Franz & Miles, 1994).

The Clackamas Partnership has established Interagency Treatment Planning for high needs families that supports the family as central in the process of planning for their child. The interagency case review structure focuses on children and adolescents for whom regular agency-based services are not sufficient to support their placement at home and for whom there is often a need for residential or hospital treatment. The interagency case review team includes discussion of intensified local efforts in lieu of residential placement.

Clackamas County, the State Department of Human Services (DHS) and Local Collaborating Agencies through the Partnership Council endorsed core values in building a collaborative approach to mental health services for children and families. The first is that a system of care must be child and family centered with the individual needs of the child and family dictating the provision of services. Second, the service delivery system and infrastructure must be community-based and culturally competent, and the delivery of services, along with management and decision-making authority, must rest at the local level.

The creation of a responsive managed care model for children with SED has been a priority for the State of Oregon. Historically, the steep rise in the costs

of health care and the increased utilization of inpatient treatment for children, particularly adolescents, created the context for the introduction of managed behavioral health care in the 1980s. The introduction of managed mental health care in the private sector has led to even greater reliance on the public safety net for children, adolescents, and adults with serious emotional disturbances (Mechanic, 1993). The implementation of managed care contracting for Medicaid-funded programs has raised concerns regarding the effects on systems of care for children who have been served by a continuum of outpatient and intensive services primarily funded and delivered in the public sector (Pires, Stroul, & Armstrong, 2000). Clackamas County is a local Mental Health Organization for mental health services under the Oregon Health Plan. As a locally operated and state-contracted entity, Clackamas County is integrating systems of care values within the context of managed care. The infrastructure of public mental health services available to children and families in the target community has benefitted from the risk-based, capitated funding methodology of the Oregon Health plan. Clackamas County Mental Health and the Partnership have integrated efficiency in delivery of core "medically necessary" services and supported "reinvestment" of savings from acute hospital care into more flexible intervention efforts with children and families. These reinvested resources have allowed the Partnership to develop creative community-based alternatives to hospitalization and to expand crisis intervention services (Taylor, 2002).

The goal is for the Clackamas Partnership to sustain a "system of care," with a fully developed infrastructure, and a matching service delivery model. Since this system is built on the existing Oregon Health Plan demonstration, Clackamas County Mental Health and the Partnership are uniquely situated to serve as a model for managed care entities providing services to children with serious emotional disturbances, and their families.

Implementation of a Wraparound Approach

In order to create an integrated service system with individualized service planning at its core, the Clackamas Partnership embraced a wraparound approach. Essential to this approach is recognition of family access, voice, and ownership as keys to making the system thrive and produce positive outcomes. Drawing on recent wraparound training methods, direct services staff of the Partnership engaged in an intensive process of learning with families how best to create a plan. The training stressed the imperative of strength-based, culturally-competent approaches to all facets of care. Each child and family were asked to form, and were aided in the process of creating, a team. This team provided the family and child with the kinds of supports and services necessary to help them meet their needs. The wraparound plan is documented in the child's record, matched to strengths, and enacted.

Participants and Procedures

This dissertation utilizes secondary data from the evaluation of the Clackamas County Partnership entitled "An evaluation of the Clackamas County Partnership's System of Care" approved by the Human Subjects Committee of Portland State University (see Appendix A). Michael Taylor, the investigator for this dissertation study, served as Project Director for the Partnership Project from its inception in September 1998 through June 2002. This study examines baseline data of children and families referred for Partnership intensive care coordination services from mental health, child welfare, juvenile justice, and education.

The data were collected as part of a national and local evaluation study for the demonstration site. The Regional Research Institute at Portland State University was retained through a contract with Clackamas County to conduct an evaluation of the Clackamas Partnership. MACRO International, a consulting company located in Atlanta, Georgia, holds the federal contract for implementation of the national evaluator of all 63 communities funded by CMHS (see Appendix A). These data were aggregated and client confidentiality was protected. Families were asked to participate in the local and national evaluation study through a signed consent approved by the Portland State University Human Subjects Committee, and in no case were children denied services if the parent did not consent to participate in the evaluation.

This secondary analysis integrates a descriptive study of the population, including empirical measures of strengths and problems, with an exploratory design investigating the practice constructs. This study was developed to describe relationships between variables measured at baseline and designed to integrate with the continuing local evaluation of this demonstration.

Cross-sectional data were collected at the time of enrollment and were used to examine the defined practice constructs and their relationships to assess characteristics of the practice model under investigation. With complex multi-modal interventions, competing explanations cannot be accounted for and it was not possible to establish causality. An analysis of the logic underlying this practice model requires that constructs are specified, measured, and validated. This research is intended to inform the development of intensive community-based programs through exploring two of the program's practice constructs.

The data for this study were collected from responses by care coordinators and families on instruments that measure: (a) referral patterns and demographics, the Descriptive Information Questionnaire (DIQ); (b) perception of strengths, the Behavioral and Emotional Rating Scale (BERS); (c) functional status, the Child and Adolescent Function Assessment Scale (CAFAS); and (d) symptoms and problems, the Child Behavior Checklist (CBCL).

National Evaluation

The Clackamas Partnership participates in the national evaluation required by the Center for Mental Health Service. MACRO International conducts the national evaluation. Local participation includes: staffing the evaluation team; training data collectors, including consent processes; data collection; data cleaning; data storage; data transmission; local data analysis; and data reports. Data analysis and management is contracted with the Regional Research Institute at Portland State University, Portland, Oregon (see Appendix A).

Local Evaluation

The local evaluation plan for the Clackamas Partnership was derived from questions posed by families and collaborating agencies. Data for the National and Local evaluation provided the source of data for secondary analysis for this dissertation. Local evaluation questions were brought forward throughout the conceptualization of the project. This study of implementation of strengths assessment and wraparound practice constructs will be made available to the evaluation team to further refine the implementation of the project goals and refine the local evaluation.

Target Population/Sample for the Study

Consisting of the children and families with the most complex and enduring needs, the target population represents the most severely needy 5% of the 8,000 children in Clackamas County with emotional disorders who may require mental

health treatment and special education services. Based on national studies of the incidence of serious disorders, the annual target population for intensive services provided by the Partnership is estimated to be 400 children per year (U.S. Department of Health and Human Services, 1999). The children in the sample represents about one-quarter of the population estimated in need of this level of care. Children and families seeking assistance from Clackamas County public agencies, through the Interagency Service Planning Committee, are the targeted population for this initiative. This target population includes children and adolescents with serious mental health concerns who need intensive treatment services and are at risk of residential or hospital treatment, or who are returning to the community from residential or hospital care. When a child is in substitute care, every effort is made to include the biological parents in the service plan (McCormack & Taylor, 1998).

Recruitment and Selection

Priority for inclusion in the program focused on the children with the most serious mental health challenges and requiring intensive treatment services based on criteria developed by the Partnership. Children with serious mental and emotional disorders constitute a vulnerable population protected through integration of clinical supervision throughout the service system, full inclusion of families, and careful evaluation of outcomes. Children and families are referred from various community agencies including Services to Children and Families (SCF), Juvenile

Department, Oregon Youth Authority (OYA), schools, residential treatment centers, hospitals and other community partners. The Interagency Treatment Planning Committee (ITPC) serves as the initial access point for services. Child and family teams are created and entry into the Partnership is initiated through the ITPC meetings. Participation in the program is voluntary and only through the consent of the parent or legal guardian. Recruitment occurs through program announcements sent to all child serving agencies, school districts, and support and advocacy groups, such as the Oregon Family Support Network.

Data Collection Procedures

The data were gathered via standardized interview protocols. Training was provided for purposes of standardization, the local site evaluator and contracted evaluation consultants from Portland State University assured consistency of data collection methods through supervision of staff and evaluation associates, family members hired to interview families. Training included explanations of standardized instruments and their consistent use to collect data in an interview format. For instance, the Behavioral and Emotional Rating Scale (BERS) was discussed to describe its characteristics, why it was used, and how it would be helpful in the provision of services. With this knowledge, data collectors could, in turn, discuss pertinent issues with families and include families in the evaluation. Families often feel no connection to data collection and are often not given a clear

sense of why they are providing information. This data collection method was designed to reduce the problems related by families participating in the evaluation.

In the case of the Child and Adolescent Functional Assessment Scale (CAFAS), care coordinators were trained and certified to test for their reliability as raters by the federal evaluation contractor, MACRO International. In addition to specific training on the instruments and procedures for completing them, data collectors were also trained to establish a safe and comfortable setting for collecting information. Children and families were assured of confidentiality, and were also assured that they could stop participating in the evaluation at any time and continue to receive services (see Appendix A).

Instrumentation

Instruments used for the Local and National evaluation were prescribed by MACRO and approved by the federal Center for Mental Health Services for all sites funded in the 1997 and 1998 grant cycles. MACRO is the federal contractor for the national evaluation and the instruments used to collect standardized information across all participating sites have been approved by the federal Office of Management and Budget and IRB approval of the Center for Mental Health Services. The instruments used in this study were selected for secondary analysis to address the aims of this dissertation focusing on the assessment of strengths.

For the purpose of exploring strengths assessment from the perspective of both the family and care coordinator, a dual administration of the BERS instrument

was included in the local evaluation protocol. The BERS is completed by the primary care coordinator within the first 30 days of enrollment in the program. The family ratings were collected independently by the evaluation associate, also in the first 30 days of enrollment. The raw data entry and scoring of the BERS was completed by the evaluation team and the dual raters did not have access or knowledge of the scores at the time of completing their rating.

Descriptive Information Questionnaire (DIQ)

The DIQ contains 37 items that describe the child and family and includes demographic information, risk factors, family composition, physical custody of the child, referral source, child's mental health service use history, and child's presenting problem. Data collected with the DIQ were utilized to provide descriptive data and predictor variables. The DIQ contains no subscales, and no tabulation or scoring conventions apply to the DIQ (Center for Mental Health Services, 1999).

The DIQ data provides comparison data for children and families being served in the project site with other projects funded by the Center for Mental Health Services. MACRO has reported baseline DIQ data on 5,262 children (Center for Mental Health Services, 2002).

Child Behavior Checklist (CBCL)

The CBCL is collected by the family evaluation associate within the first 30 days of enrollment through an interview process. The CBCL gathers information

from the parent or caregiver about the child's symptoms and problems and the interviewer is trained to collect all data in a supportive manner, as families can be stressed with the volume of data requested. For this reason the evaluation data were collected at a place and time most convenient to the family member, at their home or at the Partnership office.

The CBCL was designed to provide a standardized measure of behavior problems of children ages 4 through 18. The CBCL has been widely used in mental health services research, as well as for clinical purposes. The checklist is a caregiver report of social competence and behavior and emotional problems. It consists of 17 social competence items and 113 behavior problem items. The social competence section collects information related to involvement in organizations, sports, peer relations, and school performance. The behavior problem section documents the presence of symptoms. The CBCL provides scale scores on a number of empirically derived factors (Achenbach, 1991). The CBCL assesses children's symptoms on a continuum and provides two broad band (i.e., internalizing and externalizing) syndrome scores and 12 narrow band syndrome scores (e.g., attention problems, depressive mood, conduct problems). A Total Problem score is also generated.

Reliability and validity. Achenbach (1991) has reported information regarding internal consistency, test-retest reliability, construct validity, and criterion-related validity. Good internal consistency was found for the Internalizing, Externalizing, and Total Problems scales (alpha $\geq$ .82). The CBCL

demonstrated good test-retest reliability after seven days (Pearson r at or above .87 for all scales). The instrument has been normed on a proportionally representative sample of children across income and racial/ethnic groups. Racial/ethnic differences in total and subscale scores of the CBCL disappeared when controlling for socioeconomic status (SES), suggesting a lack of instrument bias related to racial/ethnic differences.

Child and Adolescent Functional Assessment Scale (CAFAS)

The approved evaluation protocol for this project specified the CAFAS was to be completed by the primary therapist/care coordinator within the first 30 days of enrollment based on the data provided by referral sources and the care coordinators enrollment interview with the child and family. The CAFAS is a functional assessment tool anchored by behavioral descriptions completed by a trained rater. The CAFAS is a required assessment tool for all children served in intensive programs in the State of Oregon, including residential and day treatment settings. For this reason and to provide multiple perspectives of individual needs assessment for this study, the CAFAS was completed by the therapist/care coordinator, though an interview protocol exists to gather and rate this data from a parent interview.

The CAFAS is a widely used instrument that assesses the degree to which a child's emotional, behavioral, or substance abuse disorder is disruptive to his or her functioning in each of several psychosocial domains. The CAFAS can be

completed by a clinician who is working with the child or by a lay interviewer, who uses information obtained through a structured interview.

Reliability and validity. Good inter-rater reliability has been found among a variety of raters including mental health intake workers, providers, lay raters, and graduate students. In a recent study, Hodges and Wong (1996) reported that the most behaviorally oriented scales had the highest reliability, with correlations for the total CAFAS score ranging from .92 to .96 across four different samples. Intra-class correlations for total scores ranged from .84 to .89. Adequate test-retest reliability has also been reported (Cross & McDonald, 1995).

A variety of studies (e.g., Hodges, Lambert, & Summerfelt, 1994) demonstrated the construct, concurrent and discriminant validity of the CAFAS when used with child clinical samples. Correlations between the CAFAS and other measures of emotional and behavioral problems (e.g., Child Assessment Schedule, the Child Behavior Checklist) were significant and suggest good construct validity. Analyses conducted on data from the evaluation of CMHS-funded demonstration projects found expected relationships between the CAFAS Total Score and the number and type of services used, amount of services used, and cost of services within a system of care (Hodges, Doucette, & Liao, 1999). An earlier study found the CAFAS to be a better predictor of service use (e.g., restrictiveness of placement setting, residential versus nonresidential placements, types and costs of services received over time) than other psychological measures (Summerfelt, 1994). In addition, the CAFAS differentiated between clinical and non-clinical

groups as effectively as the Global Level of Functioning and Global Assessment of Functioning Scale, but did not require a clinician to administer. Logistic regression analyses revealed that youth with higher CAFAS scores were more likely to have difficulties in school, problems with the law, and poor social relationships (Hodges & Wong, 1996).

Behavioral and Emotional Rating Scale (BERS)

A primary aim of this study is to assess the adoption of a strengths perspective by the family and primary therapist/care coordinator and to explore the concordance of these ratings of strengths in five domains. As recommended by researchers interested in assessing child behaviors and strengths, multiple perspectives is important to obtain a broader sampling of children's behaviors and strengths across settings (Achenbach, 1993; Epstein, 1999b).

The BERS identifies the emotional and behavioral strengths of children through 52 items (Epstein & Sharma, 1998). Epstein and Sharma described strengths-based assessment as measurement of those emotional and behavioral skills, competencies, and characteristics that create a sense of personal accomplishment; contribute to satisfying relationships with family members, peers, and adults; enhance one's ability to deal with adversity and stress; and promote one's personal, social, and academic development. The BERS is designed to be completed by caregivers or professionals (i.e., teachers or therapists) to rate the behaviors of children ages 5 to 18.

Reliability and validity. The BERS has demonstrated test-retest reliability, inter-rater reliability, and internal consistency (Epstein, Harniss, Pearson, & Ryser, in press). Test-retest reliability coefficients for the BERS subscales ranged from .85 to .99 with a 10-day interval between the two ratings. Inter-rater reliability was tested using a sample of 96 students with emotional and behavioral disorders who were rated by their special education teachers. Cronbach's alpha coefficients for the scales were .83 or above.

To establish content validity, Epstein and Sharma (1998) conducted an extensive literature search, and asked key professionals in the field to submit, categorize, and rank order items based on their relevance to child strengths. Item discrimination and factor analysis were then used to validate the measure and eliminate superfluous items. Five key factors emerged forming the subscales. The BERS was then normed on two national samples: children who did not have emotional and behavioral disorders (n = 2,176) and children with such disorders (n = 861).

Subscales. The BERS contains the following five empirically-derived subscales: (a) Interpersonal Strength refers to a child's ability to control his/her emotions or behaviors in social situations, (b) Family Involvement assesses a child's participation in and relationship with his/her family, (c) Intrapersonal Strength examines a child's view of his/her competence and accomplishments, (d) School Functioning assesses a child's competence in school and classroom tasks, and (e) Affective Strength captures a child's ability to accept affection from others

and express feelings toward others. A total strengths score can also be calculated and compared to national samples for both a normal population, as well as children with serious emotional disturbances.

As the BERS is a recently released instrument, there is a limited body of research in its use in outcome evaluation. Some studies have used the BERS to evaluate and predict specific disorders in children (Ogilvie, 2000); evaluate consistency of reporting of strengths by teachers and parents (Friedman, Leone, & Friedman, 1999) and describe functional improvements (Center for Mental Health Services, 1999). The BERS is standardized, norm-referenced from a strengths-based scale that may be used to develop treatment plans, educational plans, or to assess treatment outcomes. The BERS was used in this study to evaluate the assessment of strengths by both the professional and the family, and to determine the extent of agreement on the child's strengths as measured by BERS across the domains noted above.

CHAPTER IV

RESULTS

For the standardized measures used in this study, scores were computed according to the testing manuals and cleaned, entered, and checked for accuracy in the local and national evaluation database by the evaluation staff of the Partnership project. The evaluation staff at Portland State University exported the data from the MACRO data table to an SPSS (1996) program file and developed syntax to score the BERS total score and subscale scores. The scored values for the Descriptive Information Questionnaire (DIQ), BERS, and CAFAS were also exported to an SPSS file for this study.

To conduct the secondary analysis of the baseline data, the ratings on the Behavioral and Emotional Rating Scale (BERS), Child Behavior Checklist (CBCL) and Child and Adolescent Functional Assessment Scale (CAFAS) were examined for completeness. Cases with incomplete data in the BERS, CAFAS, or CBCL scales were not included in the sample for this analysis. There were initially 116 cases with baseline data available for analysis. Missing data were problematic for the BERS scales as the planned analysis required data from each of the five subscales. For subscales missing one or two items, the mean score for that subscale was substituted as described in the BERS manual (Epstein & Sharma,

1998). For subscales with more than two missing items, the subscale score was deemed invalid and that case was eliminated from the analysis. The cases eliminated through this process resulted in a final study sample of $N = 85$ children for whom all baseline data were complete and who were enrolled in services from January 1999 through February 2002. There were 19 cases excluded from the final sample because of missing data in the BERS subscales, with 17 of those eliminated because of missing data in the School Functioning subscale of the BERS.

The sample for the secondary analysis was limited to those cases with baseline data with complete descriptive data and standard scores, total scores, and subscale scores for the BERS completed within the baseline assessment period by two raters, a parent and a professional assigned as a care coordinator. The 85 cases with complete baseline data from two raters on four instruments comprised 73% of the initial sample of children and families for whom baseline data were collected. These data were imported as variables into the Statistical Package for Social Science (SPSS, 1996) specific to this study in a combined data file containing the scores for the CAFAS, CBCL, and DIQ and the file containing the BERS scores from the parent and care coordinator. The mean scores on the CBCL and CAFAS for all cases with baseline data ($N = 116$) were compared with the study sample to determine that the study sample was comparable to the total served at baseline. The CBCL total problem score for baseline group was ($M = 73.61$, $SD = 7.96$) compared to the final study sample ($M = 74.17$, $SD = 7.59$). The

CAFAS score was 96.67 (*SD* = 44.49) for the total baseline sample and 95.13 (*SD* = 46.00) for the study sample. An analysis of these scaled scores and review of descriptive data determined the study sample was representative of the group of children and families served by the Partnership, and was not statistically different from the initial study sample, $t(82) = .668$, $p = .51$, based on CBCL total score, and $t(76) = -.292$, $p = .771$, based on CAFAS score.

Child and Family Characteristics

The descriptive data and baseline scores were also compared with the national evaluation data for the purpose of comparing the Clackamas sample to the larger sample of children and families served across service sites funded by the Center for Mental Health Services. Descriptive statistics were used to characterize the population being served, compare them with a national sample, and to describe antecedent variables. Child characteristics at baseline included age, gender, family history, severity of problems, referral source, and functional level.

Descriptive characteristics of the children and their families are reported in Table 1 and compared to the National sample data provided by MACRO (Center for Mental Health Services, 2002). The Clackamas baseline data ($N = 85$) was compared to the baseline data from a national sample of youth served through projects funded by the Center for Mental Health Services ($N = 5,262$). All projects provided community-based services to a comparable target population - children with serious emotional and behavioral disorders in need of intensive

services beyond usual and customary outpatient treatment. Eligibility for services was limited to children assessed as having a serious emotional disorder and in need of services from two or more mental health, educational or social services organizations to meet multiple needs. Due to diversity of local projects and goals, there was variability among the target populations being served in relationship to income, ethnicity, and personal and family history, though children and families in the Clackamas sample had much in common with youth and families being served in other communities. These descriptive statistics compare the Clackamas sample to aggegrated data from 63 sites which included some projects focused on communities with a high representation of children of color, including several projects serving primarily Indian children. There is an appreciable difference in racial and ethnic backgrounds, with the Clackamas sample comprising 90% of Euro-American (reported as White) compared to 58% of the national sample. The difference derives primarily from the underrepresentation of African-American (reported as Black) in the Clackamas sample reported as 1.2%, compared to 22% of the national sample. Native Americans comprised 3.6% of the Clackamas sample compared to 12.4% of the national sample. The Clackamas sample does reflect the racial and ethnic composition of the target community and the program was serving children of color and families in poverty at a higher rate than their occurrence in the general population of Clackamas County.

Table 1

Child and Family Characteristics

Child Characteristics	Study Sample % Clackamas Partnership (N = 85)	National Sample % CMHS Grant Communities (N = 5,262)
Male	71.8	68.0
Female	28.2	32.0
Age	12.9	12.3
Race		
Native American or Alaskan	3.6	12.4
Asian	1.2	0.6
Black	1.2	22.0
Pacific Islander	0.0	0.6
White	90.4	58.1
Other	3.6	9.5
Of Hispanic Origin		
Yes	7.1	11.3
Mexican	80.0	64.9
Puerto Rican	0.0	16.3
Cuban	0.0	2.5
Dominican	0.0	2.4
Central American	0.0	2.5
South American	20.0	1.8
Other Hispanic	0.0	9.6
No	92.9	88.7

Descriptive statistics regarding families in the study population generally reflect the national sample in terms of their living environment, but differ in the history of the biological family as shown in Table 2. The study sample has a higher representation of single father families, adoptive parents and wards of the state. The histories of the children in the Clackamas sample appreciably exceed

statistics reported in the national sample in the level of exposure to family violence, mental illness, psychiatric hospitalization of a parent, law violations, and substance abuse.

Table 2

Family Characteristics and Family Risk Factors

	Study Sample % (N = 85)	National Sample % (N = 5,262)
Family Characteristics		
Two biological Parents	20.2	25.7
Biological Mother only	35.7	45.0
Biological Father only	10.7	4.3
Adoptive Parents	8.2	3.4
Foster Parents/State Wardship	14.3	9.8
Siblings	0.0	0.4
Aunt and/or Uncle	2.4	2.0
Grandparents	6.0	5.6
Friend(s)	0.0	0.1
Other	2.4	3.6
Family Risk Factors		
Family Violence	70.9	48.2
Mental Illness	77.2	49.8
Psychiatric Hospitalization	48.4	30.2
Convicted of Crime	58.7	46.1
Substance Abuse	81.0	66.0
Income below $15,000	43.0	49.0

As can be seen in Table 3, the service history of children included in the study sample appreciably exceeds the national sample with regard to previous services received, with higher rates of mental health services and higher levels of

Table 3

Child History and Health Status

	Study Sample %	National Sample %
Child History and Health Status Intake Referral Information		
Corrections	11.8	12.9
Court	3.5	8.9
Schools	15.3	18.5
Mental Health	40.0	25.1
Physical Health	0.0	1.6
Child Welfare	15.3	12.7
Substance Abuse Clinic	0.0	0.2
Caregiver	1.2	9.1
Self	0.0	1.5
Other	12.9	9.7
Previous Services		
Outpatient Services	85.7	64.1
School-based Services	83.3	53.3
Day Treatment	26.5	13.3
Residential Treatment	44.0	26.8
Alcohol/Drug Treatment	15.5	13.3
Child History		
Previous Psych Hospitalization	51.2	25.5
Physically Abused	51.3	27.3
Sexually Abused	40.5	20.7
Runaway	53.0	35.0
Suicide Attempts	24.4	14.9
Substance Abuse	22.6	24.6
Sexually Abusive	16.7	7.4
Child Health Status		
Medication for Physical Problems	36.5	not reported
Medication for Emotional/Behavioral	82.4	not reported
Eligible for Medicaid	40.5	not reported

care, such as residential and day treatment services prior to referral to the Partnership project. The personal history of children served at the study site has approximately twice the incidence of psychiatric hospitalization, physical abuse and sexual abuse compared with the national sample. Though not reported for the national population, it should be noted that a majority of the Clackamas population have received medication for emotional and behavioral problems.

The severity of behavioral and emotional disorders of the children served in the Clackamas project is comparable to the national population based upon the reported standardized scores of problems and functioning levels and equivalent scores on the overall strength quotient, as seen in Table 4. The total BERS score for this comparison is based on standardized scores for the normal population (NEBD score), the norms used for the MACRO study reported in the national sample scores below.

Table 4

Scores on Standardized Instruments at Admission

	Study Sample		National Sample	
	M	*SD*	*M*	*SD*
CAFAS	95.13	46	106.4	NR
CBCL	74.17	7.6	70	NR
BERS (NEBD scoring)				
Parent	84.35	12.4	85.9	NR
Therapist	78.82	12.6	NR	NR

NR = not reported in MACRO 4/2002 Data

Identification of Strengths

Research Question 1: Are there differences between families' and professionals' assessments of strengths and national norms for children with serious emotional disturbances?

Descriptive statistics of mean scores on the five subscales of the BERS were analyzed: Family Involvement (FI), Interpersonal Strength (IS), Intrapersonal Strength (IaS), School Functioning (SF) and Affective Strength (AS). Percentile scores were determined for the means of each subscale by comparison to the norms provided by Epstein and Sharma (1998) for children with emotional and behavioral disorders. Alpha coefficients have been calculated and reported for the study sample and these are comparable to alphas from the normative data from a national sample reported by Epstein and Sharma (see Table 5).

When compared to the norms provided by Epstein and Sharma (1998) for children with emotional and behavioral disorders, the parent ratings of children's strengths were generally above the 50th percentile, ranging from the 50th to 75th percentile. Parent ratings were at the 75% percentile in the Affective Strength (AS) subscale and above the 60th percentile in the subscales of Family Involvement (FI), Intrapersonal Strength (IaS) and School Functioning (SF). The therapists' ratings were consistently lower than the parents' ratings across four of the five subscales, based on percentile values for children with serious emotional disorders. Internal consistency (Alpha) of the individual subscales was computed for parents

and therapists in the sample and is consistent with the normative data, ranging from .78 to .94 for both parents and therapists, indicating a high level of internal consistency of the subscales.

Table 5

Mean Scores of Parent and Therapist Standard BERS Subscale Scores

	Study Sample			National Sample	
Subscale	*M*	*SD*	Alpha	Percentile Scores from National Norms	Alpha
Parent Respondent					
Interpersonal Strength (IS)	10.31	3.12	.92	50	.92
Family Involvement (FI)	11.26	2.78	.82	63	.89
Intrapersonal Strength (IaS)	11.32	3.00	.84	63	.85
School Functioning (SF)	10.06	2.98	.85	50	.85
Affective Strength (AS)	11.72	3.11	.81	75	.84
Total BERS score	106.14	16.53			
Therapist Respondent -					
Interpersonal Strength (IS)	9.68	3.01	.94	50	.92
Family Involvement (FI)	10.67	2.94	.83	58	.89
Intrapersonal Strength (IaS)	9.93	2.96	.88	50	.85
School Functioning (SF)	9.84	2.81	.78	50	.85
Affective Strength (AS)	10.05	2.79	.84	50	.84
Total BERS Score	100.06	15.94			

Note: Higher Scores represent higher ratings of strengths.
N = 85, Normative mean = 10; SD = 3.
Percentile compared to EBD Sample N = 861 as reported by Epstein and Sharma (1998).

Agreement on Ratings of Strengths

Research Question 2: Is there agreement in BERS subscale ratings by parents and professionals regarding strengths of the child across multiple domains?

Parents' and therapists' ratings of strengths across the domains as measured by the BERS were analyzed for strength and direction of the concordance. This analysis follows previous studies (Friedman, Leone, & Friedman, 1999; Harniss, Epstein, Ryser, & Pearson, 1999) that suggested expanding the use of the BERS with multiple informants. Strong relationships have been found in previous research in some but not all the strengths domains. The analysis explores the specific question of concordance between therapist and parent concerning the child's strengths. The ratings were obtained during the assessment and data collection period within the first 30 days of enrollment.

Concordance was analyzed using Pearson's product-moment correlation coefficient as can be seen in Table 6. Cohen's (1988) criteria designate correlations above .5 as indicators of medium correlation. Lack of agreement in rating across domains was expected between parents and therapists. Higher concordance may be partially attributed to the therapists' attention to the parents' descriptions of the child's strengths during the assessment period as therapist raters had limited opportunities for direct observation of the child.

The coefficient values on the diagonal measure the relationships between the parent and care coordinator on the same subscale of the BERS. Three of the five subscales approach or exceed a correlation of .50 indicating above moderate agreement between parents and service providers. A higher level of agreement between parents and therapists was seen in the subscales of Family Involvement

and School Functioning with a moderate level of correlation in the subscales for Interpersonal Strength, Intrapersonal Strength, and Affective Strength.

Table 6

Concordance Among the Five BERS Subscales for Parent and Therapist

	Parents				
	IS	FI	IaS	SF	AS
Therapists					
IS	.456**	.377**	.281**	.305**	.341**
FI	.392**	.562**	.305**	.278*	.465**
IaS	.351**	.400**	.329**	.164	.251*
SF	.287**	.202	.026	.637**	.105
AS	.410**	.467**	.329**	.245*	.416**

FI = Family Involvement; IS = Interpersonal Strength; IaS = Intrapersonal Strength; SF = School Functioning; AS = Affective Strength.
*$p < .05$ **$p < .001$.

The concordance between parents' and therapists' ratings on the same subscale of the BERS, as seen in Table 6, do appear to be substantially greater than for other combinations of subscales, supporting the validity of the subscales as reported by Epstein and Sharma (1998). Concordance of the subscale scores on ratings by parents and therapists on the same subscale are as follows: Interpersonal Strength (IS) .456; Family Involvement (FI) .562; Intrapersonal Strength (IaS) .329; School Functioning (SF) .637; and Affective Strength (AS) .416. These scores are reported on the diagonal of Table 6.

Additional correlations are also reported in Table 6; these measure the relationships across respondents and subscales. The correlations for care coordinator ratings on different subscales is reported below the diagonal and correlations for parent ratings on the same subscales above the diagonal. The values in the correlation matrix range from .026 to .637. Of the 25 correlations in this matrix 18 were statistically significant at the $p < .001$ level. Correlations between subscales for the same group of raters range from .105 to .465 with a mean of .287 for the parents; and from .026 to .467 with a mean of .311 for the therapists.

The lowest correlation between subscales for both therapists and parents was the relationship between ratings on the School Functioning (SF) and Intrapersonal Strength (IaS) subscales. The parents' correlation between the SF and IaS subscales was .164 and the therapists' correlation between these subscales was .026.

Differences on Strengths Ratings

Research Question 3: What are the differences between families' and professionals' ratings of strengths across the domains measured by the BERS?

A repeated measures analysis of variance (ANOVA) was used to examine differences in mean standard strength scores, primarily to examine rater by subscale interactions. A repeated measures ANOVA was conducted using the

BERS subscale scores to determine Rater, Scale, and Rater X Scale Interactions, as shown in Table 7.

Table 7

Repeated Measures Analysis of Variance of BERS Subscale Scores

Source	*df*	*MS*	*F*	*p*
Between Subjects				
Rater (R)	1	171.67	12.36	.001
Error (R)	84	13.89		
Within Subjects				
Scale (S)	4	39.84	7.49	.000
Error (S)	336	5.31		
R x S	4	15.54	6.93	.000
Error (R x S)	336	2.24		

There was significant main effect due to Rater [$F(1, 84) = 12.36$, $p = .001$] across all scales. Parent raters had significantly higher ratings of strengths compared to therapists on all scales. Scale main effects were significant [$F(4, 336) = 7.49$, $p = .000$] supporting the discriminant validity of the subscales. The mean scores of Family Involvement (FI) and Affective Strengths (AS) generally

were the highest of the overall combined ratings and the School Functioning Subscale (SF) the lowest (see Figure 2).

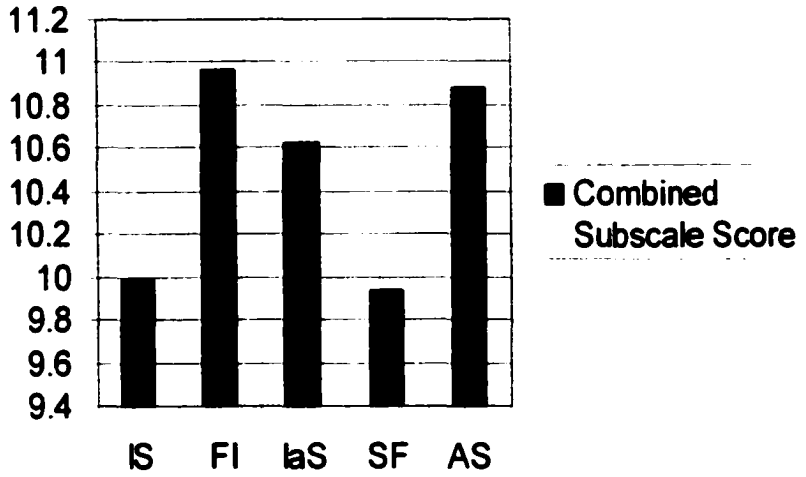

Figure 2. Scale main effects.

The Rater x Scale interaction effect was significant [$F(4, 336) = 6.93$, $p = .000$] (see Figure 3). The difference between therapists and parents was greatest on the Intrapersonal Strength (IaS) and Affective Strength (AS) subscales. The smallest difference was on the School Functioning (SF) subscale.

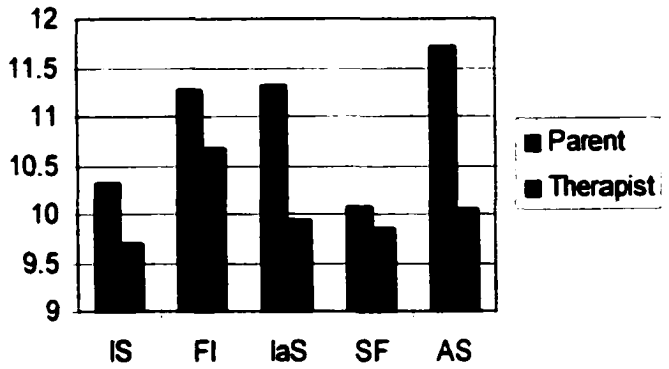

Figure 3. Rater by scale interaction effects.

Post hoc pairwise comparisons were using the *t* test for independent means. Parents' and therapists' scores on the same subscales, when compared, indicated a significant difference on the Intrapersonal Strength (IaS) scores [Mean Difference = 1.39, *SD* = 3.46, $t(84) = 3.70$, $p = .000$]. There was also a significant difference on the Affective Strength (AS) scores between parents' and therapists' scores [Mean Difference = 1.67, *SD* = 3.20, $t(84) = 4.80$, $p = .000$]. There was also a difference on the Family Involvement (FI) scale approaching significance [Mean Difference = .59, *SD* = 2.68), $t(84) = 2.02$, $p = .046$]. These significant findings of difference on subscales ratings support the value of multiple raters in assessing strengths and the importance of examining the rater by subscale differences (see Table 8).

Table 8

BERS Subscale Score Mean Difference Between Parent and Therapist Ratings

Source	Mean Difference	*SD*	*t*	*p*
Interpersonal (IS)	.62	3.20	1.79	.076
Family Involvement (FI)	.59	2.68	2.025	.046
Intrapersonal Strength (IaS)	1.39	3.46	3.70	.000
School Functioning (SF)	.22	2.47	.836	.406
Affective Strength (AS)	1.67	3.20	4.806	.000

NOTE: Mean difference compares mean scores on BERS Subscales from 85 pairs at baseline data collection.

Comparing Strengths and Deficits Ratings

Research Question 4: What is the relationship between behavioral and emotional strengths and functional impairment as reported by the therapist?

The correlation of scores between BERS and CAFAS (therapist ratings) was studied to analyze the relationship between measurement of deficits and strengths as reported by the therapist. The correlation between the total BERS and CAFAS was Pearson's $r = -.609$, $p < .007$. This significant correlation is in the expected direction based on the inverse relationship of the BERS and CAFAS scales, with higher BERS scores indicating more strengths and higher CAFAS scores indicating more functional impairments. The relationship of strengths and deficit scores is further explored in Question 7.

Research Question 5: What is the relationship between behavioral and emotional strengths and behavior problems as reported by the parent?

The correlation between the BERS score from the parent and CBCL from the parent is $r = -.547$, $p < .048$ reaching a statistically significant relationship. This is in the expected direction since the BERS total score is higher based a higher assessment of strengths, the inverse relative to the total behavior problem score of the CBCL, also reported by the Parent. These relationships are further explored in Question 7.

Research Question 6: What is the relationship between behavioral problems as reported by the parent and the functional problems as reported by the therapist?

The association between assessments of behavioral problems (as reported by the family) and functional assessment (as reported by the therapist) was explored to probe the relationship between deficit-based assessments. The internalizing and externalizing subscales of the CBCL and the subscale scores of the CAFAS were also correlated using Pearson's r to determine the relationship between assessment of behavioral problems and functional assessments from the perspectives of the families and the professionals.

The correlation of the total scores of the CBCL and CAFAS ($r = .204$) was not significant. Subscale score correlations on the CAFAS and CBCL are reported in Table 9. The externalizing and internalizing scales of the CBCL were tested for association with the total CAFAS and the subscales of the CAFAS. No significant correlations were seen between CBCL Internalizing subscale and the subscales of the CAFAS. Correlations between the CBCL Externalizing subscale and the Home/Community ($r = .323$, $p < .01$); Behavior Toward Others ($r = .364$, $p < .01$) and the School/Work subscales of the CAFAS ($r = .256$, $p < .05$) were significant.

Table 9

Correlations Between Child Behavioral Checklist (CBCL) Scores and Child and Adolescent Functional Assessment Scale (CAFAS) Scores

	CBCL Subscales	
	Internalizing	Externalizing
CAFAS Scores		
Total CAFAS Score	.097	.249*
CAFAS Subscales		
1. Mood/Emotions	.216	.169
2. Self-Harm	.048	-.007
3. Thinking	.013	.084
4. Home Role	.079	.323**
5. Behavior	.174	.364**
6. Substance Use	.088	.128
7. School/Work	.090	.256**
8. Community Role	-.161	-.061

NOTE: CBCL scores reported by the parent and CAFAS scores reported by therapist at baseline. $N = 73$ pairs; * $p < .05$; ** $p < .001$

Relationship of Child Characteristics and Assessed Strengths

Research Question 7: What are the relationships between recognition of strengths and child characteristics?

Multiple regression analysis, as seen in Table 10, was used to explore the relationships between predictor variables (age, gender, and severity as measured by

CBCL and CAFAS scores) and the dependent variable, assessed strengths (BERS). The total numerical values (raw scores) of the BERS were used for this analysis, as the standardized BERS scores are adjusted for gender differences. Prior to this analysis, scatterplots were examined to determine if the relationship appeared linear or curvilinear indicating a more complex interaction between assessment of strengths and deficits. The scatterplot analysis revealed generally negative but linear relationships between the strengths and deficit scores.

Severity of problems as reported by the parent and functioning as reported by the therapist were used in the separate regression models analyzing the relationships with assessed strengths by that group of raters. In the first regression model, parent problem scores (CBCL externalizing score) were a significant predictor of strengths scores (Coefficient Beta = -.62, $p < .000$). In the second model therapist CAFAS scores were predictive of strengths scores (Coefficient Beta = -.60, $p < .000$). Therapist strengths scores were predicted by gender (Coefficient Beta = .18, $p < .05$) at a level approaching significance. Using the regression procedure, neither gender nor age was predictive of higher strengths scores by parents.

A third model analyzed CAFAS subscale scores. In this model the home subscale of the CAFAS was predictive of therapist strengths score (Coefficient Beta = -.47, $p < .000$) with no other CAFAS subscale or child's characteristics being significant predictors of the strengths score.

Table 10

Summary of Regression Analysis for Variables Predicting Strengths Scores

Variable	R^2	Beta
Prediction of Parents' BERS raw score from Child Characteristics and CBCL Subscales:		
Model 1	.44**	
Externalizing CBCL		-.62**
Internalizing CBCL		-.04
Child's Gender		-.11
Child's Age		.01
Prediction of Therapists' BERS raw score from Child Characteristics and CAFAS Total Score:		
Model 2	.39**	
CAFAS Total		-.60**
Child's Gender		.18*
Child's Age		.13
Prediction of Therapists' BERS raw score from Child Characteristics and CAFAS Subscale Scores:		
Model 3	.55**	
Home		-.47**
Community		-.18
Moods/Emotions		-.13
Substance Abuse		-.09
School/Work		-.08
Child's Gender		.13
Thinking Scale		-.06
Child's Age		-.06
Self-Harm Behavior		-.15
Behavior		-.24

* $p < .05$; ** $p < .001$

CHAPTER V

DISCUSSION

The findings support the primary aim of this study, to explore the assessment of strengths by multiple raters. The results verify that family members do identify and recognize strengths of their children at a higher level than therapists using the same assessment instrument. The second aim, exploring family involvement in assessment, is supported by findings of significant levels of correlation between families and professionals on strengths subscales and on specific subscales of instruments assessing behavior problems. Exploration of areas of difference on assessments across specific subscales of strengths and deficits measurements reveals statistically significant differences in patterns of strengths between family members and professionals revealing an important difference by rater in the assessment of children's strengths in the intrapersonal and affective domains.

Support for the conclusions is presented through a review of the research aims and research questions. Limitations of the study affecting the conclusions are discussed. Theoretical implications of the findings, suggestions for further research, and implications for practice are presented.

A conceptual model was proposed and two practice constructs were investigated: assessments of strengths and participation of the family in assessment. These practice constructs were defined, measured and descriptive and inferential statistics were used to explore some of the constructs in the conceptual practice model and refine its implementation. This study explores these practice constructs through analysis of data collected at enrollment from both the parent and professional. Investigation of a conceptual practice model, as recommended by Hernandez and Hodges (2000), provides a basis for an ongoing analysis of the logic of the proposed model of practice.

The analyses of measurements of strengths and problems from multiple perspectives supports including parent voice in assessment of their children. Using empirically tested instruments as a method for increasing participation of parents during the assessment period was investigated. The results support that parents bring unique information to the assessment process. These findings suggest the utility of using the BERS instrument in combination with deficit-based measures to provide the additional perspectives provided by multiple raters. The findings support the utility of examining both concordance and difference in the analysis of scores on the subscales of the BERS, CAFAS and CBCL. Gathering and reporting subscale scores on these measures can enhance shared communication in assessment and treatment planning and provide a richer source for discourse about the needs of the child. Often measurements used in program evaluation are not routinely integrated in the day to day work of the clinician nor shared with the

family and child. Sharing assessment data in this manner can facilitate communication about strengths, needs, and improvements and enhance participation of both the youth and their family in recognizing strengths and progress. This study provides a data revealing the relationship between supporting the utility of comparing perspectives to increase family and youth participation in both assessment and planning.

Identification of Strengths

Differences were seen between families and professionals in assessing strengths both in comparison to the national norms and in relation to each other. Parents consistently reported a higher level of strengths across all domains. The application of this strengths perspective in children was supported by the use of the strengths-assessment instrument, the *Behavioral and Emotional Rating Scale* (BERS; Epstein & Sharma, 1998) employed in this study. According to Epstein and Sharma, strengths-based assessment involves

> the measurement of those emotional and behavioral skills, competencies, and characteristics that: (a) create a sense of personal accomplishment; (b) contribute to satisfying relationships with family members, peers, and adults; (c) enhance the ability to deal with adversity and stress; and (d) promote personal, social and academic development. (p. 3)

The BERS was developed to measure the strengths that all children possess and with the assumption that children can be motivated by the manner in which significant adults respond to them. This study investigates the use of a strengths

assessment involving both the family and professional using the BERS scale. When adults emphasize strengths, this may lead to more active engagement in appropriate activities and pro-social behaviors on the part of children or youth. These results support the importance of the multiple perspectives in assessing these strengths, as parent and professionals bring significantly different perspectives.

A strengths perspective shared by parents and professionals serves to instill hope and create a context for the family and community to sustain that hope for positive outcomes (Modrcin, 1999). Adoption of a strengths perspective studied with adults can inform practice for children and families. A strengths perspective was found to improve outcomes for adults with serious mental disorders. Services focusing on strengths rather than pathology, use of flexible resources beyond traditional mental health services and fostering a creative atmosphere between clients and providers through training and supervision were associated with positive outcomes (Modrcin, 1988). Identification of strengths and the full involvement of the youth and their family in developing a plan of care are viewed as critical variables to success of a wraparound plan for children and adolescents (Franz, 2000). The results of this study extend these observations and research findings. Through the consistent use of the strengths measure, the opportunity for deeper communication between families and professionals about observed strengths is increased. Exploration of concordance and differences in assessments between families and professionals supports open discourse and increases opportunities to recognize and build on strengths of the child.

Concordance of Family and Care Coordinator

Concordance of Strengths subscale scores was measured and explored by analyzing parent and professional perspectives. The assessment of the care coordinator during the assessment period was informed both by parent report and interaction with the child during the first 30 days of engagement. The level of concordance in these scores can be partially attributed to the care coordinators attending to the parents during the assessment period as the care coordinators have less exposure to the child and therefore fewer opportunities to observe behaviors compared to the parents. A moderate correlation was found between families and professionals on the same BERS subscales indicating a level of agreement on the strengths and assets of the child.

Sharing assessment data enacts an approach recommended by family researchers and advocates in which the family's input is sought and valued at all levels. This practice enacts a paradigm shift from the traditional view of the mental health professional as the expert, with power differentially weighted to the professional and often denied to the family (DeChillo, Koren & Mezera, 1996; McCammon, Spencer, & Friesen, 2001). The level of concordance at baseline supports the assertion that families and professionals are interdependent in completing assessments and planning care on behalf of children with SED and listening is critical to developing genuine mutuality; moving from a traditional stance of power and authority to one of mutual agreement, rapport and effectiveness (Collins & Collins, 1990; Heflinger & Bickman, 1996). This study

gives credence to the influence of parent perspective in assessment of both strengths and problems. Utilizing empirical measures and reporting these scores individually to families and through program level research may be a method to include parental perspectives and increase family *voice* in a systematic manner.

The use of valid and reliable scores from parents provides a tool for assuring parent input in the assessment and provides a baseline measure for measuring progress over time through repeated measures. The use of measures does not replace the need for increasing parental participation through other methods at the program and systems levels, but does provide a useful and verifiable method for assuring parent participation in assessment through consistent use of measures completed by parents and sharing the data reciprocally.

Differences in Assessment of Strengths

Examination of discrepancies in ratings between parents and care coordinators revealed significant differences in subscales related to Intrapersonal Strengths, Affective Strengths and Family Involvement. While the difference in the Family Involvement score may be accounted for by more observation time by the parents, the difference in assessment of Intrapersonal Strengths and Affective Strengths are significant findings. The findings support the importance of incorporating the family's perspective during the assessment period and not relying on the professional as the expert on the affective domains. This finding was different from an a priori expectation that care coordinators might identify more

strengths in areas emphasized in professional training, such as in the affective domains represented by the Affective Strengths and Intrapersonal Strengths subscales. The results support assertions by family members that their input should be heard and heeded, and challenges assumptions that professionals have unique insight in the affective domains. The data provide an opportunity for both professionals and parents to explore differences in perceptions to increase the level of discourse about areas of agreement and difference and thereby support increased participation of the family. Completing and sharing assessment data consistently through accessible, efficient, and relevant tools can support both the helping process and the need to verify outcomes.

Relationships to Strengths and Deficits Scores

Negative correlations between the traditional deficit measures and the Strengths scales supports the utility of the overall total strengths quotient score. Both parents' and therapists' deficit scores correlate negatively with the BERS. In the regression models, the externalizing CBCL subscale predicted strengths with significance and the internalizing subscale was not predictive of higher strengths. The internalizing subscales of the CAFAS also did not predict higher strengths indicating the CBCL or CAFAS subscales reflecting internalizing behaviors may measure domains of behavior independent of perceived strengths. The strong relationships of the strengths scores and externalizing subscales of the CBCL and CAFAS suggest that it may be more difficult for parents and professionals to

identify strengths in youth with higher levels of assessed behavior problems, or that these youth exhibit fewer strengths. These relationships of problem scores and identification of strengths need more study to examine the relationships of externalizing behaviors and strengths assessment.

Relationship of Scores of Problems and Strengths

In comparing parent and therapist scores on the CBCL and CAFAS, a high degree of agreement was seen across the subscales of these instruments indicating that the therapists were attending to the concerns of the parents at intake and had similar assessments of the children independently. This analysis of CBCL and CAFAS scores follows the study by Phillips (1999) which reported a high correlation between the externalizing scale of the CBCL and the CAFAS Home/Community subscales completed by foster parents and caseworkers and support the utility of using the subscales of the CBCL and CAFAS to explore the perspectives of two raters using these instruments, though more study is needed on the relationship of the subscales of these instruments.

Higher deficit scores, notably the Externalizing subscale of the CBCL and the Home Scale of the CAFAS, were predictive of lower Strengths scores. Neither gender nor age predicted a higher Strengths score by families, indicating that gender did not influence the assessment of strengths in a systematic manner for parents.

In the regression analysis, the externalizing subscale of the CBCL was most predictive of parents' strengths scores. For therapists, the CAFAS Home Role subscale had the most predictive value indicating therapists of children acting out in the home environment systematically rate their strengths lower. Female gender was a predictor of a higher strengths rating by therapists.

Limitations of the Study

The sample from the Clackamas Partnership was compared to a national study of CMHS-funded demonstration sites around the country providing intensive care coordination to children with serious emotional disorders and high needs. The findings showed the study sample, while comparable in age, gender and referral sources had twice the rate of previous psychiatric hospitalization (51.2% to 25.5% in the National sample) and much higher rates of history of abuse, runaways, and suicide attempts. Ethnic and racial/minorities were underrepresented in Clackamas compared to the national sample. The parents' assessment of problems as measured by the CBCL was higher than the national sample and the functional impairment level as assessed by the therapists was lower than the national sample. Though the samples were comparable on deficit and strengths scores, extension of these results beyond the study sample are not statistically supported and the findings should be interpreted as exploratory in nature.

Construct validation is useful in the interpretation of the findings, even without a causal connection. The antecedents and processes associated with the

constructs measured through this study were developed through definition of constructs and the conceptual model. A description of the sample was conducted to explore similarities in local and national samples. Caution is exercised in the interpretation of these results beyond the population and treatment range actually sampled, however, this analysis with its articulated and measurable constructs is useful to establish a direction for future research and explores relationships among practice constructs being studied (Cook, 1993). Further analysis of strengths and deficit scores over time would increase our understanding of how perceptions of strengths interact with the relationship of the rater with the child.

Limitations to generalizability of this study is the temporal dimension of these baseline assessments conducted during the first two years of this project. During this period, there was staff training and certification in the CAFAS assessment initially, but rater drift may have occurred due to staff turnover. While the data were generally provided in the first 30 days of engagement in services, the amount and quality of staff contact with families and youth was not included in this research. Variability of the quantity and quality of this participation may affect the BERS scores provided by the care coordinators.

An independent measure of family participation was not included in this study, though a survey of family empowerment and participation was collected for the local evaluation of the project and could be considered for inclusion in future research to assess the quality of participation by the family.

Suggestions for Future Research

This dissertation strives to provide empirical support for use of strengths-based assessment provided by both families and professionals. Researchers have acknowledged difficulty in establishing controlled experiments on wraparound practice methods and have recommended testing of clearly conceptualized impact studies with an articulated logic model and verifiable descriptions of the interventions (Friedman, 1997; Knapp, 1995). Individualized, family-focused, and strengths-based interventions have gained support as service components, but have been insufficiently tested (Lourie, Stroul, & Friedman, 1998).

Future research could include use of these instruments to assess change over time and further examination of the concordance on these measures to determine if changes in agreement or differences in scores may reflect increased involvement of the family in treatment. Direct measurement of family participation could be introduced to the analysis to determine if a relationship with family report of participation and concordance of the assessments might be found. Analysis of other relationships, such as diagnostic categories, is beyond the scope of this study, but would be useful to explore patterns of strengths recognition between families and professionals related to diagnostic categories or other measures of functioning.

Future research could explore alternate hypotheses regarding the perspectives of the family and professional assessments of strengths with some attempt to control to determine if the BERS objectively measures change over time

or may be a reflection of changed perceptions of the family or professional. During the engagement process, each participant influences the perceptions of others. These alternative hypotheses could consider if strengths scores are higher from families because they know them better of if therapists score lower because they are more objective.

Efforts to provide services for children with SED in their own communities, instead of institutional care, requires continued research to determine whether positive outcomes are associated with the proposed practice model. Because the services being provided are comprehensive, individualized, flexible, and strengths-based, they are inherently more difficult to describe and evaluate (Friedman, 1997).

Implications for Practice

Implications of this research for social work practitioners are the findings that families have important and unique information on their children - especially in regards to strengths. This is an important finding supporting when considered in the context of the serious behavior problems of these children and the challenges faced by these families. In spite of these problems, families identify strengths in areas not perceived by professionals.

This study provides empirical support for the validity of family perspective and suggests that collecting and sharing data regarding strengths may be a method to enhance engagement between families and professionals.

For social work administrators, the implications of identifying strengths through an instrument that can be completed by families provides a powerful tool that can be easily introduced and implemented in a variety of settings.

Social work's imperative to influence and reform systems calls for social work practitioners and administrators to lead the way in introducing tools and processes that emphasize strengths over pathology, disease and dysfunction. Social work has a responsibility to support consumer and family participation as a right, not a privilege bestowed upon worthy families. The evidence provided in this study indicates all families have a unique contribution to provide to the assessment of their children.

Critical to the success of services to children and families with the highest needs is the precision of fit between the needs and the intervention provided. It is expected that better outcomes result from a careful matching of the child's and family's strengths and needs with the level of services provided; this is a principle of wraparound practice and of a genuine managed care practice model (Sabin, 1994). The most precise fit between needs and interventions should result in the most efficient and effective care. Consequences of a mismatch between the family's needs and strengths and services provided can mean either over-serving or under-serving the child, resulting in limited positive outcomes, unnecessary costs, more restrictive placement than is optimal, and loss of confidence in the effectiveness of future interventions (Sosna, 1999).

Inclusion of families in assessment and treatment planning, focusing on strengths and providing flexible and effective services and supports to children in lieu of institutional care are critical principles to implement and sustain improved practices in communities. These findings suggest the utility of including multi informant measurement and communication about the findings into the day to day practice of agencies and professionals providing services to children with the highest needs.

Research reveals an essential point about implementing systems of care; changes in the infrastructure of the system must be paralleled by changes in service delivery practices. If change occurs in only one of these areas, the organization of the system and its practices will not be integrated and instead, a new type of fragmentation will occur between principles and actual practice. Bickman's (1996c) study of Stark County, Ohio points to a well-developed infrastructure, with model interagency collaboration, that was apparently producing no positive clinical outcomes. This lack of positive clinical outcomes seemed to be based on a service delivery model that had not evolved along with the rest of the system—one that has remained locked into a 50-minute outpatient therapy model. Verification of implementation of desired practice constructs through empirical measurement is introduced and supported by these results.

The wraparound approach is consistent with an ecological paradigm of social work emphasizing the importance of material assistance, positive feedback, emotional caring and social companionship as mediators or "buffers" to stress and

potentiators of coping abilities (Tracy & Whittaker, 1987). In this paradigm the child is predicted to function best when the service system coordinates most efficiently with the family system (Burns, Schoenwald, et al., 2000). Malysiak (1998) emphasized the family acting as a decision-making participant in this process of ecological strengths enhancement. Key to inclusion of families as essential partners are individualized, intensive, culturally contextualized, and flexible mental health and social services based on the needs, desires, and strengths of children and families. This more precise fit of services and supports contrasts with the usual and customary approach of providing mental health and social services for children with serious emotional disorders through existing service options prescribed by funding streams and categorical eligibility. This study verifies that family participation in assessment provides useful data about domains of the child's functioning and contributes to a strengths perspective.

The purpose of this study has been to advance research through the articulation and measurement of key practice constructs of strengths identification and family participation in assessment associated with positive outcomes but not sufficiently tested. The importance of empirical validation of family participation emphasized in recent literature on promising practices in children's mental health programs includes: (a) the need to define family-provider collaboration in operational terms that can be empirically validated; (b) measurement of how family-provider collaboration can impact proximal and distal outcomes for the individual child as well as the system of care; and (c) assessment of the

relationship of family-provider collaboration to satisfaction, empowerment, and ability to advocate for the child (Simpson, Koroloff, Friesen, & Gac, 1999). Shared assessment and identification of strengths are some components of this collaborative practice model that have been explored in this study.

Adopting a strengths perspective in Social Work practice has gained increased attention as a practice principle. The perspective a professional brings to interaction with a client or family has a profound impact. As compared to medical sciences, social work and mental health interventions are highly influenced by the perspective of the professional, traditionally driven by an expectation to uncover pathology (Graybeal, 2001). In the transaction between families and professionals there is a simultaneous and inseparable operation of the person-environment system directly impacting the child. This formulation requires active participation by family members in treatment planning and decision-making (Heflinger & Bickman, 1996).

The findings fulfill a primary aim of this study - to explore strengths-based assessment from multiple perspectives. Comparing concordance and differences in perceptions of parents and professionals fulfill the aim of exploring the unique contributions of families in the assessment process. Identification of strengths and building on these strengths through participation of the family are principles that can improve practice and support community and home-based care for children with serious emotional disorders.

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APPENDIX A

HUMAN SUBJECTS REVIEW AND APPROVAL

PORTLAND STATE UNIVERSITY

Memorandum

To: Chair, Human Subjects Research Review Committee, Portland State University

CC: Michael Taylor, Clackamas County Partnership, Nancy Koroloff, RRI

From: Barbara J. Friesen

Date: 11/26/2001

Re: Continuation report for research involving human subjects: Clackamas County Partnership National Outcome Evaluation

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Attached are 10 copies of the Continuation Report and accompanying consent forms for the Clackamas County Partnership National Outcome Evaluation.

If you have any questions, or need more information, please contact me at 5-4166 (PSU). I am sabbatical leave this year, but the best place to leave a message is on my PSU voice mail.

Thanks for your help.

RESEARCH AND TRAINING CENTER ON FAMILY SUPPORT AND CHILDREN'S MENTAL HEALTH
POST OFFICE BOX 751 • PORTLAND, OREGON 97207-0751 • (503) 725-4040 • FAX (503) 725-4180 • http://www.rtc.pdx.edu
Regional Research Institute for Human Services, Graduate School of Social Work

Human Subjects Research Review Committee
Continuation Report for Research Involving Human Subjects
Portland State University

The Institutional Review Board (HSRRC) is required by Title 21, Code of Federal Regulations (Part 56.109) and Title 45, Code of Federal Regulations (Part 46.109) to conduct continuing review of ongoing projects not less than once per year. Your assistance in meeting these federal requirements is appreciated. Please complete all required sections and submit required attachments—thank you.

Principal Investigator	Barbara Friesen, Ph.D.	**E-Mail**	friesenb@pdx.edu
Co-Principal Investigator		**E-Mail**	
Other (GA, Project Mgr., etc.)	Beth Langhorst	**E-Mail**	BethLang@co.clackamas.or.us
Department	Social Work: RRI	**Dept. Head**	James Ward: Nancy Koroloff
Mailing Address	Portland State University/RRI	**Campus Ext.**	5-4166
	P.O. Box 751, Portland, OR 97207-0751	**Home/Work #**	503-625-0503
Project Title	Clackamas County Partnership National Outcome Evaluation		

I certify that this report is accurate and that the research activities involving human subjects were conducted as stated in the approved protocol. I will abide by the Federal and University policies related to research involving human subjects.

[X] No

Barbara J. Friesen — *SIGNATURE OF PRINCIPAL INVESTIGATOR*

November 22, 2001 — *DATE*

STEP 1:

Project Funded?	Federal/Federal Pass-Through?	Funding Agency Name:
[X] Yes	[X] Yes	Clackamas County Partnership (contract with PSU); grant funds from the Center for Mental Health Services, Comprehensive Community Mental Health Services for Children and their Families Program, Substance Abuse and Mental Health Services Administration
[ ] No	[ ] No	
[ ] Pending		

STEP 2: Are all activities involving human subjects, data collection and analysis complete?

[ ] Yes — Data analysis was completed as of [Click to enter date]. *Do not proceed to Step 3. Submit only this page to the HSRRC.*

[X] No — Proceed to Step 3.

STEP 3: In the space provided, please type a one-page summary of the project, or attach the summary as a separate document. The summary should both describe the project as it was originally conceived and provide a detailed account of its current status.

This study is an outcome evaluation of the Clackamas County Partnership project to create comprehensive, family driven, culturally competent community-based services for children with serious emotional disturbances. Agencies included in the Clackamas Partnership, a CMHS grantee as of September 1998, are juvenile justice, child welfare, education, mental health, residential treatment centers and private providers. Clackamas County Mental Health serves as the lead agency for the initiative and has entered into a contract with the Regional Research Institute to conduct an evaluation of the Partnership. MACRO International, a consulting company located in Atlanta, Georgia, holds the federal contract for implementation of the national evaluation of all CMHS sites. This evaluation consists of instruments (see attached list) that allow for the collection of standardized information across all participating sites, as required by congressional mandate and is authorized via federal law, Section 565 of the Public Health Service Act. The design and instrumentation for MACRO's evaluation has received federal Office of Management and Budget approval, CMHS IRB approval and MACRO IRB approval. MACRO's major responsibilities include the coordination and oversight for the implementation of the national evaluation.

Data are collected locally by clinical and evaluation staff hired by Clackamas County. Training and oversight for data collection are the responsibility of the Partnership Evaluation Team, lead by Barbara Friesen, Ph.D., Principal Investigator for the evaluation (PSU), Beth Langhorst, Ph.D., site-based evaluator, and Michael Taylor, M.S.W. Site Director (Clackamas Co. Mental Health). Data are electronically transmitted quarterly to MACRO for analysis. Results will subsequently be reported back to the Partnership and also will be aggregated with data from the other grants so that it can be reported to the Centers for Mental Health Services and to Congress. All data are housed at the project site.

Data elements for the local evaluation require collection of information from participating agencies Managed Information Systems (MIS) and the inclusion of an additional instrument—Family Participation Survey—into the rotation of standardized instruments being used for the national evaluation. The additional MIS data reflects data already collected by other agencies and will not alter families' experiences with these agencies. The Family Participation Survey is collected from the entire consenting population, following the same periodicity schedule as the rest of the national evaluation instrumentation. Local analysis of the national evaluation data and data collected specifically for the local evaluation will be analyzed by the principal investigator and other contracted support from PSU, as well as the site-based evaluator. Results will be reported to all local stakeholders (policy-makers, staff, families, and community agencies).

All participating children and families provide information at enrollment in program services. The first cohort—those who enter the study between 10/1/99 and 9/30/00—will be re-interviewed at six month intervals to 36 months. Those children and families who comprise cohort two—entry into the study between 10/1/00 and 9/30/01 will be re-interviewed at 6-month intervals and will be followed to 30 months. Those children and families who comprise cohort 3—entry into services between 10/1/01 and 9/30/02—will be re-interviewed every 6 months and will be followed to 18 months. Follow-up data will be collected regardless of the service status of the child.

We currently have 120 children and youth enrolled in the study and have completed fifty-four 6-month, twenty-six 12-month and eleven 18-month interviews. We will enroll new participants through September of 2002. We have had ten families chose to stop participating in the study, primarily when they moved or finished program services. None have withdrawn their consent for us to use the information already collected. We have made one change in the consent process, separating the agreement for certain measures to be put in the child's clinical record from the consent to be in the outcome study.

STEP 4:

1. Please attach a copy of the current Consent Form/Script/Letter to this report even if it is identical to a previously submitted one or already on file with the HSRRC. Reports submitted without this attachment will be considered incomplete and returned to the investigator.

2. Are you still using Consent Forms/Scripts/Letters with subjects?

   [X] Yes
   [ ] No

3. Do you wish to submit any changes to the Consent Form/Script/Letter for approval during this Continuing Review?

   [X] Yes: Please attach the new version to this report with changes highlighted in bold.
   [ ] No

STEP 5: If more space is required for explanations, please attach a separate document.

1. Please check one:

   [X] Data collection will continue
   [ ] Data collection is complete and the data is being analyzed
   [ ] Other: *Please write in space provided below:*

2. How many subjects were originally planned for inclusion in this study? 270
3. How many subjects have been enrolled so far? 120
4. How many subjects do you still plan to recruit? 100
5. Have any subjects withdrawn from participating in the research project after giving informed consent? (If yes, indicate the number of subjects who have withdrawn and the reasons.)

   [X] Yes 10 Other: *Please write in space provided below:*
   None asked to withdraw information already provided.
   Moved to another area of the state or out of state (5)
   Did not wish to continue with outcome study after finishing with program (4)
   Never engaged in program services (1)

   [ ] No

6. Have you withdrawn any subjects from the research project after they gave informed consent? (If yes, indicate the number of subjects whom you have withdrawn and the reasons.)

☐ Yes #: Reason: *Please write in space provided below:*

☒ No

7. Have there been any complaints about the research? (If yes, please explain.)

☒ Yes Explain: *Please write in space provided below:*
A few participants have complained about the length of the interview, but none have refused to complete it. This is a national evaluation; we have little control over the length of the interview, but have engaged in a number of accommodations, including splitting the interview into 2 sessions, to address participants' (and our) concerns about this issue

☐ No

STEP 6:

Questions A-D relate to minor changes to the application, E-K relate to major changes. If more space is required for explanations, please attach a separate document.

A. Are there any changes in researcher/project director/advisor names, addresses, telephone numbers, or ending date?

☒ Yes Explain: *Please write in space provided below:*
Local site evaluator changed from Erin Mueller, Ph.D., to Beth Langhorst, Ph.D., (503) 722-6913.

☐ No

B. Are there any changes that leave the research population at the same or lower risk than risk(s) already approved?

☐ Yes Explain: *Please write in space provided below:*

☒ No

C. Have additional subjects of the same type of population indicated in the original application been recruited/added?

[X] Yes [redacted]: *Please write in space provided below:*
Only as planned; third cohort will continue to be recruited through September 2002.

[ ] No

D. Are there any other minor changes you wish to include in this report?

[ ] Yes [redacted]: *Please write in space provided below:*

[X] No

E. Are there any changes that leave the research population at a higher risk than risk(s) already approved?

[ ] Yes [redacted]: *Please write in space provided below:*

[X] No

F. Are you adding a subject population different from those already approved?

[ ] [redacted]: *Please write in space provided below:*

[X] No

G. Are you adding questions to a questionnaire or instrument? If yes, please attach a list of added questions or highlight the additions on the instrument.

[ ] [redacted]: *Please write in space provided below:*

[X] No

H. Are you adding any elements that may breach the subjects' confidentiality?

☐ Yes Explain: *Please write in space provided below:*

☒ No

I. Are you adding any deceptive elements to the research or changing the debriefing procedures for previously approved deception?

☐ Yes Explain: *Please write in space provided below:*

☒ No

J Are you changing the way subjects are compensated for participation in research (such as increasing the amount, changing from a lottery to cash, etc.)?

☐ Yes Explain: *Please write in space provided below:*

☒ No

K. Are there any other major changes you wish to include in this report?

☐ Yes Explain: *Please write in space provided below:*

☒ No

Please return this Continuing Review Report and any attachments to:

Mailing Address:
HSRRC
Office of Research and Sponsored Projects (ORSP)
Portland State University
PO Box 751
Portland, OR 97207-0751

Delivery address:
111 Cramer Hall
1721 SW Broadway
Portland, OR 97201
Campus Mail Code: ORSP

For questions or concerns, call (503) 725-8182, or send e-mail to hsrrc@lists.pdx.edu.

**** Did you remember to attach your consent form(s)? ****

CLACKAMAS COUNTY PARTNERSHIP
REGISTRATION AND DESCRIPTIVE INFORMATION
Informed Consent

Purpose
The Center for Mental Health Services in the United States Department of Health and Human Services is sponsoring a national evaluation of programs that are funded to improve community-based services for children and families and a local program evaluation to improve Clackamas County services to children and families. The national evaluation is authorized by Section 565 of the Public Health Service Act. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. (The OMB control number for this project is 0930-0192 [exp. date 09/30/2001]). Any questions concerning this project can be answered by calling **Beth Langhorst at (503) 722-6913** or Barbara Friesen at (503) 725-4166.

Description of Participation
As part of the evaluation, we would like your permission to use the registration and descriptive information you've just provided us as a part of the general evaluation. The outcome evaluation will be discussed with you at another time.

Confidentiality
Special precautions will be taken to protect your family and your child's privacy. The information included in the national evaluation will have no identifying information, including names and addresses.

By law we must report the physical or sexual abuse of any child or if the danger of imminent physical harm is suspected. In addition, staff may inform parents or guardians if their child is in serious physical danger.

Rights Regarding Decision to Participate
I understand that if I agree to participate, I have the right to change my mind and request that evaluation records be destroyed. I also understand that at any time during my participation in the project, it is my right to review the information that I have provided. I understand that any choice to not participate in the evaluation will not affect the services my child and family receive or will receive in the future.

Voluntary Consent
By signing this consent form, I certify that I have read the preceding, or that it has been read to me, and that I understand its content. My questions (if any) have been answered. A copy of this consent form will be given to me.
My signature below means that I freely agree to participate in the project.

Caregiver/Guardian (type or print name in full)_____

Signature of Caregiver/Guardian_____ Date _____

Name of Child (type or print name in full)_____

Signature of Institutional Staff (if appropriate)_____ Date _____

Print Name, Agency and Job Title _____

If you have concerns or problems, please contact:

The Human Subjects Research Review Committee
Office of Research and Sponsored Projects
111 Cramer Hall
Portland State University
(503) 725-8182

CLACKAMAS COUNTY PARTNERSHIP OUTCOME EVALUATION
Informed Consent—Caregiver Version

Purpose
The Center for Mental Health Services in the United States Department of Health and Human Services is sponsoring a national evaluation of programs that are funded to improve community-based services for children and families and a local program evaluation to improve Clackamas County services to children and families. You and your child are invited to participate in this project because your child has received such services. In this project we are interested in finding out about your child's behavior and functioning, the kinds of services you and your child have received, and how you feel about these services. The results of this project will be used to help improve the quality of the services for children and families. The national evaluation is authorized by Section 565 of the Public Health Service Act. Any questions concerning this project can be answered by calling **Beth Langhorst at (503) 722-6913** or Barbara Friesen at (503) 725-4166.

Description of Participation
We will interview you and your child, if your child is 11 or older. These interviews will occur 4 to 7 times depending on when you enter the study. Participation includes an initial interview and follow-up interviews every six months for the duration of the evaluation. We will ask you to continue to participate in the evaluation even if you and your child are no longer receiving services. The interviews will be conducted in your home or at a place that is convenient and comfortable for you. Your interview should take approximately 2 hours to complete. Your child's interview will vary in duration depending on his/her age, but will probably last 1 hour. You will be asked questions about your child's behavior at home, in school and in the community. We also will ask you questions about your family and your experiences with the services your child has received, including mental health and substance use services. Your child will be asked questions similar to the ones you are asked.

As part of the project, we would like your permission to make use of your child's school records, including attendance, disciplinary action, transfer records; juvenile court records; records from the Department of Services to Children and Families; and mental health service records related to your child's care. We will obtain a separate release of information for each school or agency that has provided education or services for your child.

Risks and Benefits
There will be no direct benefit to you or your child from this project. The risk may be the discomfort some people feel when discussing personal matters.

Compensation
If you agree to participate in this project you will receive a $20 gift certificate to a local merchant for each completed set of data in compensation for your time and any costs associated with participating in the project. Your child will receive a $10 gift certificate each time s/he completes a set of data.

Confidentiality
Special precautions will be taken to protect your family and your child's privacy. No agency that you and your child are involved with, including schools, will have access to the information you provide about your perceptions and satisfaction with service. **The CAFAS, which is completed as a part of the intensive services intake process, will be made available to the evaluation. Evaluation instruments that contain clinical information which could be helpful to your child's**

_____ (Caregiver's initials)

mental health treatment can be placed in the mental health record with your consent and the assent of your youth. This information includes the following measures, CBCL, YSR, BERS (completed by Care Coordinator), BERS (completed by caregiver). All forms stored as evaluation information will be coded so that they cannot be associated with individual names. In reports, the information that is collected will never mention individual names.

By law we must report the physical or sexual abuse of any child or if the danger of imminent physical harm is suspected. In addition, staff may inform parents or guardians if their child is in serious physical danger.

Rights Regarding Decision to Participate
I understand that if I agree to participate, I have the right to change my mind and stop participating or withdraw from the project at any time. If I request it, records pertaining to my child and family will be destroyed. I also understand that at any time during my participation in the project, it is my right to review the measures that I have completed. I understand that any choice to not participate in the evaluation will not affect the services my child and family receive or will receive in the future.

Voluntary Consent
By signing this consent form, I certify that I have read the preceding, or that it has been read to me, and that I understand its content. My questions (if any) have been answered. A copy of this consent form will be given to me. My signature below means that I freely agree to participate in the project.

Caregiver/Guardian (type or print name in full)_____

Signature of
Caregiver/Guardian_____Date_____

Name of Child (type or print name in full)_____

Signature of Institutional Staff (if appropriate)_____

Print Name, Agency and Job Title _____Date_____

Project Team's Certification

I certify that I have explained to the above individual the nature of the project as well as the potential benefits and risks associated with participating in the project. I also have answered any questions that have been raised and witnessed the above signature.

Signature of Witness _____Date_____

If you have concerns or problems, please contact:
The Human Subjects Research Review Committee
Office of Research and Sponsored Projects
111 Cramer Hall
Portland State University
(503) 725-8182

CLACKAMAS COUNTY PARTNERSHIP
OUTCOME EVALUATION
Informed Assent/Consent—11-17 years old

We want to know what you think!
AND we'll give you $10.00 for your thoughts!

What: You talk with us about what you think and do when you are at home, in school, and in your neighborhood. We would also like your permission to look at your school records, juvenile court records, and records related to the services you have or are currently receiving. We will get your specific permission for each school or agency we ask for information.

Why: Because you have received or are currently receiving services we need your help to evaluate how effective the Clackamas Partnership is. (Service: you have an IEP, a counselor, a foster parent, probation officer, social worker, or some such person who is working for an agency.) AND, we would like you to help us even if you aren't receiving services anymore.

Where: Where would you like it to be? (at home, at an office, at school?)

When: Every six months for about an hour each time until September 2003 (It could be 4-7 times depending on when you entered the study.)

Who sees this stuff? **The CAFAS, which is completed as part of the intensive services intake process, will be made available to the evaluation. Evaluation information that could be helpful to your mental health treatment (Youth Self Report, Child Behavior Checklist, Behavioral and Emotional Rating Scale) can be placed in your mental health record if you and your caregiver consent.** All other information that you give us will be coded so no one will know your name and it will be kept in a locked cabinet and a secure computer file. No one will be able to find out who you are. If we use any information in a report, the report will not identify any individuals. Other than that, we don't tell ANYONE anything!!!! No one will know you did this (except you, your participating family and us) unless YOU tell them. At any time during your participation in the project you have the right to review the measures that you have completed.

Some bad news: Some questions could be uncomfortable for you to answer. We will ask you if you have had any contacts with the police, if you use any drugs and/or alcohol, whether you get into trouble in school, how well you get along with family and friends, and what you think about any of the services you have had.

Some good news: Participation is definitely up to you. If you don't want to answer a question–DON'T! If you decide this is too much for you, you can stop at any time. You can tell us that you don't want to continue an individual interview or with the whole study. You also can ask us to throw away the information that we've gathered.

Initials_____

Some even better news: When we've finished each completed set of data, we'll give you a $10.00 gift certificate to a local merchant!

What's the catch? (Otherwise known as "the legal stuff".) By law we must report any information that makes us think that someone might hurt you or has hurt you, any information that makes us think that you might hurt someone, and any information that makes us think you might hurt yourself.

Questions? Call **Beth Langhorst (503-722-6913)** or Barbara Friesen (503- 725-4166). Either will be happy to talk to you.

Participant's Consent

I have read this form or it has been read to me. I understand what it says. My questions have been answered and I am not being forced to sign this form. A copy of this form will be given to me.

Please Print Full Name of Participant_____

Signature of Participant_____

Date_____

I have read and understand the preceding information and agree to the participant's interview.

Signature of Caregiver/Guardian_____

Date_____

Signature of Institutional Staff (if appropriate)_____

Date_____

Project Team's Certification

I certify that I have explained the nature and purpose of this project, as well as the potential benefits and risks associated with participating in this project. I also have answered any questions that have been raised. I have witnessed the above signatures.

Signature of Witness_____

Date_____

If you have concerns or problems, please contact:
The Human Subjects Research Review Committee
Office of Research and Sponsored Projects
111 Cramer Hall
Portland State University
(503) 725-8182

CLACKAMAS COUNTY PARTNERSHIP
OUTCOME STUDY
Informed Consent—Young Adult Version
(For youth 18 years or older who reach age 18 during follow-up data collection)

Purpose
The Center for Mental Health Services in the United States Department of Health and Human Services is sponsoring a national evaluation of programs that are funded to improve community-based services for children and families and a local program evaluation to improve Clackamas County services to children and families. You were invited to participate in this project because your have received such services. At that time your family agreed to participate in the project. Now that you have turned 18 and are a legal adult, we need to ask you if you would like to continue to be in the project. In this project we are interested in finding out about how you feel; what you do at home, in school and in the neighborhood; the kinds of services you have received, and how you feel about these services. The results of this project will be used to help improve the quality of the services for children and families. The national evaluation is authorized by Section 565 of the Public Health Service Act. Any questions concerning this project can be answered by calling your local site evaluator **Beth Langhorst (503) 722-6913** or Barbara Friesen at (503) 725-4166.

Description of Participation
We will interview you 4 to 7 times depending on when you enter the study. This study ends in September 2003. Participation includes an initial interview and follow-up interviews every six months for the duration of the evaluation. We will ask you to continue to participate in the evaluation even if you are no longer receiving services. The interviews will be conducted in your home or at a place that is convenient and comfortable for you. Your interview should take approximately 1 hour to complete.

You will be asked questions about your behavior at home, in school and in the community. We also will ask you questions about your family and your experiences with the services you have received, including mental health and substance use services.

As part of the project, we would like your permission to make use of your school records, including attendance, disciplinary action, transfer records; juvenile court records; records from the Department of Services to Children and Families; and mental health service records related to your child's care. Your agreement to participate in this project and your signature on this form provide your permission for the release of any of these records.

Risks and Benefits
There will be no direct benefit to you from this project. The risk may be the discomfort some people feel when discussing personal matters.

Compensation
If you agree to participate in this project you will receive a $10 gift certificate to a local merchant for each completed set of data in compensation for your time and any costs associated with participating in the project.

_____ (Initials)

Confidentiality
Special precautions will be taken to protect your privacy. **Evaluation information that could be useful to your treatment (Child Behavior Checklist, Youth Self Report, Behavioral and Emotional Rating Scale [completed by caregiver]) can be placed in your mental health record. The CAFAS, which is completed as a part of the intensive services intake process, will be made available to the evaluation. Aside from that,** no agency that you are involved with, including schools, will have access to the information you provide. All forms in the project will be coded so that they cannot be associated with individual names. In reports, the information that is collected will never mention individual names.

By law we are required to report the physical or sexual abuse of any child or if the danger of imminent physical harm is suspected.

Rights Regarding Decision to Participate
I understand that if I agree to participate, I have the right to change my mind and stop participating at any time. If I request it, records pertaining to my family and myself will be destroyed. At any time during my participation in the project I have the right to review measures that I have completed. I also understand that any choice to not participate in the evaluation will not effect the services I receive or will receive in the future.

Voluntary Consent
By signing this consent form, I certify that I have read the preceding, or that it has been read to me, and that I understand its content. My questions (if any) have been answered. A copy of this consent form will be given to me. My signature below means that I freely agree to participate in the project.

Youth's Name (please type or print)_____

Youth's signature_____

Date_____

Project Team's Certification

I certify that I have explained to the above individual the nature of the project as well as the potential benefits and risks associated with participating in the project. I also have answered any questions that have been raised and witnessed the above signature.

Signature of Witness_____ Date_____

If you have concerns or problems, please contact:

The Human Subjects Research Review Committee
Office of Research and Sponsored Projects
111 Cramer Hall
Portland State University
(503) 725-8182

CLACKAMAS COUNTY PARTNERSHIP
OUTCOME EVALUATION
Informed Consent for Putting Measures in Clinical Record
To be attached to Informed Consent for National Outcome Evaluation

I consent to have the following measures I have completed as part of the Partnership outcome study included in my child's clinical record at Clackamas County Mental Health Center.

Measure:	**Date Administered:**	**Initials:**	**Date:**
Achenbach Child Behavior Checklist		Caregiver:	
Achenbach Youth Self Report		Caregiver:	
(with Youth consent/ assent)		Youth:	
Behavioral and Emotional Rating Scale (BERS)		Caregiver:	

Voluntary Consent
By signing this consent form, I certify that I have read the preceding, or that it has been read to me, and that I understand its content. My questions (if any) have been answered. A copy of this consent form will be given to me. My signature below means that I freely agree to have the clinical measures I have initialed above included as part of my child's clinical record at Clackamas County Mental Health Center.

Caregiver/Guardian (type or print name in full)

_____

Signature of Caregiver/Guardian_____Date_____

Name of Child (type or print name in full)_____

Signature of Child (if appropriate)_____

Signature of Institutional Staff (if appropriate)_____

Print Name, Agency and Job Title _____Date_____

Project Team's Certification

I certify that I have explained to the above individual the nature of the project as well as the potential benefits and risks associated with participating in the project. I also have answered any questions that have been raised and witnessed the above signature.

Signature of Witness _____Date_____

Summary of Evaluation Questionnaires

(To be given to caregivers and youth when reviewing consent forms)

NAME OF QUESTIONNAIRE		WHAT DOES IT MEASURE?	WHO COMPLETES IT?	WHERE IS IT KEPT?
DIQ	Descriptive Information Questionnaire	Descriptive information about family	Caregiver	Evaluation Record Clinical Record
ROLES-R	Restrictiveness of Living Environments and Placements Stability Scale, Revised Version	Youth's living arrangement(s)	Caregiver	Evaluation Record
CAFAS	Child and Adolescent Functional Assessment Scale	Youth's functioning at school, home, in the community, behavior towards others, handling of emotions, and substance use	Therapist	Clinical Record * Evaluation Record
SUS-AB	Substance Use Survey, Parts A and B	Youth's use of alcohol and drugs	Youth	Evaluation Record
DS	Delinquency Survey	Youth's social functioning, delinquent behavior, and legal problems	Youth	Evaluation Record
EQ	Education Questionnaire	Child's educational information	Caregiver	Evaluation Record
CBCL	Child Behavior Checklist	Caregiver's perceptions of youth's behavioral and emotional functioning, social competence and feelings	Caregiver	Evaluation Record Clinical Record**
YSR	Youth Self Report	Youth's perceptions of social competence and behavioral and emotional functioning	Youth	Evaluation Record Clinical Record***
BERS	Behavioral and Emotional Rating Scale (Caregiver)	Caregiver's perception of child's behavioral and emotional strengths of self, with family, and at school	Caregiver	Evaluation Record Clinical Record**
BERS	Behavioral and Emotional Rating Scale (Care Coordinator)	Care Coordinator's perception of child's behavioral and emotional strengths of self, with family, and at school	Therapist	Evaluation Record
FRS	Family Resource Scale	Caregiver's perception of the adequacy of the material and emotional resources available to the family	Caregiver	Evaluation Record
FAD	Family Assessment Device (Caregiver)	Caregiver's perception of family functioning, how well family interacts, communicates, and works together	Caregiver	Evaluation Record
FAD	Family Assessment Device (Youth)	Youth's perception of family functioning, how well family interacts, communicates, and works together	Youth	Evaluation Record
CGSQ	Caregiver Strain Questionnaire	Caregiver's strain related to the special demands associated with caring for a child with emotional or behavioral issues	Caregiver	Evaluation Record
FSQ-A	Family Satisfaction Questionnaire, Abbreviated Version	Caregiver's satisfaction with services	Caregiver	Evaluation Record
YSQ-A	Youth Satisfaction Questionnaire, Abbreviated Version	Youth's satisfaction with services	Youth	Evaluation Record
MSSC	Multi-Sector Service Contacts	Types and frequency of services children and families receive	Caregiver	Evaluation Record
FPS	Family Participation Survey	Family participation in services	Caregiver	Evaluation Record

* Required for intensive services ** with caregiver consent *** with youth consent/assent

Revised 11/15/01

APPENDIX B

ASSESSMENT INSTRUMENTS

[redacted]

DATE: _____ / _____ / _____ **CARE COORDINATOR:** _____
Month Day Year

Name: _____ **Age:** _____

Date of Birth: _____ **Sex:** _____ **School:** _____

Name of Legal Guardian: _____ **Phone:** _____

Address: _____
Street *City* *State* *Zip Code*

Nominating Source: _____ **Phone:** _____
Name *Affiliation*

Person administering the interview (DIQINT)

Name: _____ Phone: _____

Agency: _____

1 = Service Provider
2 = Data Collector

Method of administering the interview (DIQMETH)
1 = In person
2 = Telephone

Language of interview (DIQLANG)
1 = English
2 = Spanish
3 = Other

I am going to ask you some questions about *(child's name)*'s background and family and about services which *(child's name)* has received. Please answer these questions as best you can, and try to be as complete as possible in your answers.

1. **When is *(child's name)*'s birth date?** ___ ___/___ ___/___ ___
Month Day Year

2. **Is *(child's name)* a boy or girl ?**
1 = Boy
2 = Girl

3. **Is *(child's name)* of Hispanic or Latino *cultural/ethnic* background?**
1 = No
2 = Yes

3a. ***[IF YES]* Which group best describes his/her Hispanic or Latino *cultural/ethnic* background? Is he/she .....**
1 = Mexican, Mexican-American, or Chicano
2 = Puerto Rican
3 = Cuban
4 = Dominican
5 = Central American
6 = South American
7 = Other Hispanic origin *(Please specify)*: _____

4. **Which *racial/ethnic group(s)* best describes *(child's name)*? Is he/she .....**
[NOTE TO INTERVIEWER: Circle all that apply.]

1 = American Indian or Alaska Native
2 = Asian
3 = Black or African American
4 = Native Hawaiian or Other Pacific Islander
5 = White
6 = Other *(Please specify)*: _____

5. **What is the zip code of the address where *(child's name)* currently lives?** _____

6. **What agency referred *(child's name)* to the Partnership?**
[NOTE TO INTERVIEWER: To aid the respondent, you may prompt with site-specific agency names for each type of agency. Use CARD 1, if necessary.]

1 = Corrections
2 = Court
3 = School
4 = MH agency/Clinic/Provider
5 = Physical health care agency/Clinic/Provider
6 = Child Welfare/Child protective services
7 = Substance abuse clinic/provider
8 = Caregiver
9 = Self (youth referred himself or herself)
10 = Other *(Please specify)*: _____

7. **What were the problems leading to *(child's name)* being referred for services?**
[NOTE TO INTERVIEWER: Write down the problems exactly as the respondent says them, then circle the codes below which best describe the problems.]

_____

_____

_____

1 = Eating disorders	12 = Theft	23 = Hyperactive-impulsive
2 = Sleep disorders	13 = Runaway	24 = Attention difficulties
3 = Somatic complaints	14 = Sexual assault	25 = Over-dependence on adults
4 = Sad	15 = Threat to life of others	26 = Bladder difficulties
5 = Anxious	16 = Extreme verbal abuse	27 = Alcohol/substance abuse
6 = Self-injury	17 = Fire setting	28 = Sexual acting out
7 = Suicide attempt	18 = Cruelty to animals	29 = Truancy
8 = Suicide ideation	19 = Inappropriate bowel movements	30 = Police contact
9 = Social contact avoidance	20 = Non-compliance	31 = Academic problems
10 = Physical aggression	21 = Strange behavior	32 = Poor self-esteem
11 = Property damage	22 = Poor peer interaction	33 = Other problems *(Please specify)*:_____

_____

8. **Before today, has *(child's name)* received any mental health services for the problems that led to the referral?**
1 = No
2 = Yes

[NOTE TO INTERVIEWER: If necessary, clarify for the respondent that this can include any services received for the problems, including services delivered through the Partnership OR services delivered in other ways, such as through other agencies.]

8a. *[IF YES]* When did these services begin? ___ ___/___ ___/___ ___
Month Day Year

I would like to ask you some questions about services related to *(child's name)*'s emotional and behavioral problems that *(child's name)* may have received in the past 12 months.

Did *(child's name)* receive.....

9. **Outpatient services?** These services often include evaluation or assessment; individual, group, or family therapy; and/or case management. Case management is sometimes also called service coordination or care coordination. 1 = No 2 = Yes

10. **School-based services?** These services often include educational assessment or testing; a self-contained special education classroom; a resource room; a one to one classroom aide; and/or an Individualized Education Plan (IEP). 1 = No 2 = Yes

11. **Day treatment?** Day treatment is intensive, non-residential services which last for at least 5 hours a day. These services often include special education, vocational counseling, and/or therapy. These services may be provided in a variety of settings including schools, mental health centers, hospitals or other community locations. 1 = No 2 = Yes

12. **Residential treatment or inpatient psychiatric hospitalization services?** These services are often provided in an inpatient hospital setting for observation and treatment or in other out-of-home treatment facilities or centers. These places typically serve 10 or more children, have 24-hour staff supervision, and can offer a full array of treatment interventions. 1 = No 2 = Yes

13. **Alcohol or Substance Abuse Therapy?** These are outpatient and/or inpatient/residential services specifically for the assessment and treatment of alcohol, drug, and other substance abuse-related problems. 1 = No 2 = Yes

Now I would like to ask some questions about *(child's name)*'s history.

14.	**Has *(child's name)* ever had a previous psychiatric hospitalization?**	1 = No	2 = Yes
15.	**Has *(child's name)* ever been physically abused?**	1 = No	2 = Yes
16.	**Has *(child's name)* ever been sexually abused?**	1 = No	2 = Yes
17.	**Has *(child's name)* ever run away without his/her caregiver knowing where he/she was?** *[NOTE TO INTERVIEWER: This could be the current caregiver or a past caregiver.]*	1 = No	2 =Yes
18.	**Has *(child's name)* ever attempted suicide?**	1 = No	2 = Yes
19.	**Does (child's name) have a history of substance abuse including alcohol and drugs?**	1 = No	2 = Yes
20.	**Has *(child's name)* ever been sexually abusive to others?**	1 = No	2 = Yes

Now I would like to ask some questions concerning *(child's name)*'s **family history.**
[NOTE TO INTERVIEWER: Biological family should be considered to include biological parents, biological siblings, as well as other extended biological family members such as grandparents, uncles, or aunts "related by blood" and not by marriage.]

21. **Is there a history of domestic violence/spousal abuse in** *(child's name)*'s **biological family but** *(child's name)* **was not the direct target of the violence?** 1 = No 2 = Yes

22. **Is there a history of mental illness in** *(child's name)*'s **biological family?** 1 = No 2 = Yes

22a. *[IF YES]* **Has one of** *(child's name)*'s **biological parents ever had a psychiatric hospitalization?** 1 = No 2 = Yes

23. **Has one of** *(child's name)*'s **biological parents ever been convicted of a crime?** 1 = No 2 = Yes

24. **Is there a history of substance abuse in** *(child's name)*'s **biological family?** 1 = No 2 = Yes

24a. *[IF YES]* **Has one of** *(child's name)*'s **biological parents ever received treatment for substance abuse?** 1 = No 2 = Yes

25. 666 *[NOTE TO INTERVIEWER: Question #25 is skipped at baseline as it is not applicable.]*

Now I'd like to ask you a few general questions about *(child's name)*'s **family.**

26. **What is your relationship to** *(child's name)*?

1 = Biological parent	5 = Sibling (biological, step, etc.)	9 = Other family relative
2 = Adoptive/Stepparent	6 = Aunt or uncle	10 = Friend (adult friend)
3 = Foster parent	7 = Grandparent	11 = Other *(Please specify):*
4 = "Live-in" partner of parent	8 = Cousin	_____

26a. **What is your gender, male or female?** 1 = Male 2 = Female

27. **Who has legal custody of** *(child's name)*?

1 = Two biological parents OR 1 biological and 1 stepparent	5 = Foster parent(s)	9 = Friend (adult friend)
	6 = Sibling(s)	10 = Ward of the State
2 = Biological mother only	7 = Aunt and/or uncle	11 = Other *(Please specify):*
3 = Biological father only	8 = Grandparent(s)	_____
4 = Adoptive parent(s)		

28. **Has** *(child's name)* **lived in your household for the past 6 months, for the entire period?**
1 = No 2 = Yes *[GO TO QUESTION #29]*

28a. *[IF NO]* **For how many months in the past 6 months did** *(child's name)* **live with you?** _____

28b. *[IF ZERO MONTHS]* **For how many days in the past 6 months did you have daily interaction with** *(child's name)*? _____

29. **What is the annual household income of** ***(child's name)*****'s family?**
[NOTE TO INTERVIEWER: Prompt respondent to consider all sources of pre-tax (gross) income, including wages, child support, alimony, and public assistance. The family household income should include the pre-tax incomes of all individuals who live with the child and contribute financially to the child's care. The child's family should be considered to be the family with whom the child has lived for the majority of the past 6 months. For example, if the child has lived with a foster family for most of the past 6 months, we are interested in knowing the foster family's income. Use CARD 2, if necessary]

1 = Less than $5,000	6 = $25,000 - $34,999
2 = $5,000 - $9,999	7 = $35,000 - $49,999
3 = $10,000 - $14,999	8 = $50,000 - $74,999
4 = $15,000 - $19,999	9 = $75,000 - $99,999
5 = $20,000 - $24,999	10 = $100,000 and over

30. **What is the highest grade in school that you completed?** *[Circle appropriate category]*

0-11 = Kindergarten - 11th grade	15 = Bachelor's degree
12 = High school diploma or GED	16 = Master's degree
13 = Associate degree	17 = Professional school degree
14 = Some college, no degree	18 = Doctoral degree

30a. What is your age? _____

31. **Is** ***(child's name)*** **a Medicaid recipient?** 1 = No 2 = Yes

32. **Do you or your family have to pay for at least part of** ***(child's name)*****'s behavioral/emotional services?** 1 = No 2 = Yes

33. **Including** ***(child's name)*****, what is the total number of people in the household where** ***(child's name)*** **is currently living?** _____

34. **Including** ***(child's name)*****, what is the total number of children in the household where** ***(child's name)*** **is currently living?** _____

35. **What is the total number of adults (over 19 years old) in the household where** ***(child's name)*** **is currently living? Include** ***(child's name)*** **in this total if** ***(child's name)*** **is over 19.** _____

36. **Does** ***(child's name)*** **have recurring or chronic physical health problems such as allergies, asthma, migraine headaches, etc.?** 1 = No *[GO TO QUESTION #37]* 2 = Yes

36a. Please describe the recurring health problems that he/she has.

_____

_____

_____

36b. Has ***(child's name)*** **taken medication related to his/her recurring physical health problems in the last 6 months?** 1 = No *[GO TO QUESTION #37]* 2 = Yes

36c. What are the names of the medications?

_____

_____

_____

In addition to physical health problems, sometimes a doctor or psychiatrist prescribes medication for children to help reduce their emotional or behavioral symptoms. For example, Ritalin is prescribed for Attention Deficit Disorder.

37. Has *(child's name)* taken any medication related to his/her emotional or behavioral symptoms in the last 6 months? 1 = No *[END OF QUESTIONNAIRE]* 2 = Yes

37a. What are the names of the medications?

_____

_____

_____

Thank you for answering these questions! *[END OF INTERVIEW]*

PRELIMINARY DSM-IV DIAGNOSIS: ***Complete using historical information, if necessary. Circle the primary diagnosis.***

Axis I	**A**	___ ___ ___ . ___ ___	_____
	B	___ ___ ___ . ___ ___	_____
	C	___ ___ ___ . ___ ___	_____
Axis II	**A**	___ ___ ___ . ___ ___	_____
	B	___ ___ ___ . ___ ___	_____
Axis III	_____		
Axis IV	_____		
Axis V	**CGAS/GAF =** ___ ___		

BERS

Behavioral and Emotional Rating Scale

A Strength-Based Approach to Assessment

SUMMARY/RESPONSE FORM

Section I: Identifying Information

Name _____

Parent/Guardian _____

School _____ Grade ____

Rater's Name _____

Relationship to Child _____

Examiner's Name and Title _____

	Year	Month
Date of Rating	____	____
Date of Birth	____	____
Age	____	____

Section II: Results of the BERS

	Raw Score	%ile	Std. Score
I. Interpersonal Strength (IS)	___	___	☐
II. Family Involvement (FI)	___	___	☐
III. Intrapersonal Strength (IaS)	___	___	☐
IV. School Functioning (SF)	___	___	☐
V. Affective Strength (AS)	___	___	☐
Sum of Standard Scores			___
			Quotient
BERS Strength Quotient		___	☐

Section III: Other Pertinent Information

Test Name	Date of Testing	Standard Score	Equivalent Quotient
1.			
2.			
3.			
4.			
5.			

Who referred the child? _____

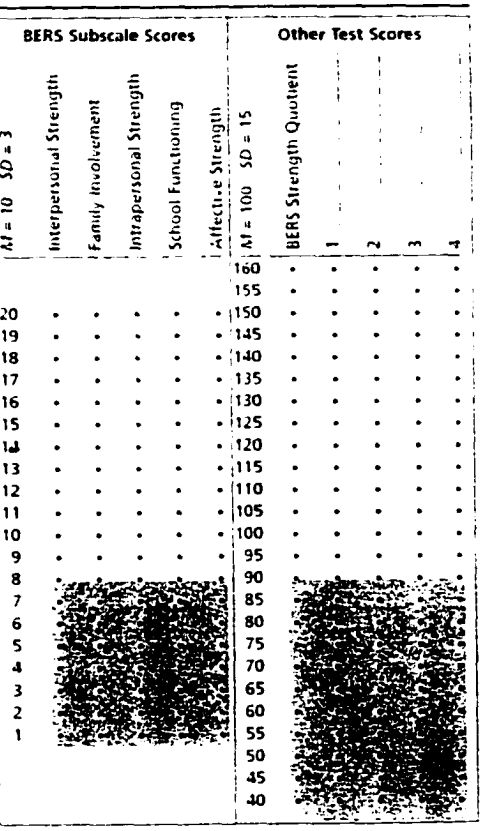
What was the reason for referral? _____

Parental permission obtained on _____ (date)

BERS results included in staffing/planning conference?

☐ Yes ☐ No

Section IV: Profile of Standard Scores



Additional copies of this form (#8462) may be purchased from PRO-ED, 8700 Shoal Creek Boulevard, Austin, TX 78757-6897
512/451-3246, Fax 512/451-8542

Section V: Response Form

Directions: The *Behavioral and Emotional Rating Scale* (BERS) contains a series of statements that are used to rate a child's behaviors and emotions in a positive way. Read each statement and circle the number that corresponds to the rating that best describes the child's status over the past 3 months. If the statement is *very much like* the child, circle the 3; if the statement is *like* the child, circle the 2; if the statement is *not much like* the child, circle the 1; if the statement is *not at all like* the child, circle the 0. Rate each statement to the best of your knowledge of the child.

Statement	very much like the child	like the child	not much like the child	not at all like the child	IS	FI	IaS	SF	AS
1. Demonstrates a sense of belonging to family	3	2	1	0					
2. Trusts a significant person with his or her life	3	2	1	0					
3. Accepts a hug	3	2	1	0					
4. Participates in community activities	3	2	1	0					
5. Is self-confident	3	2	1	0					
6. Acknowledges painful feelings	3	2	1	0					
7. Maintains positive family relationships	3	2	1	0					
8. Demonstrates a sense of humor	3	2	1	0					
9. Asks for help	3	2	1	0					
10. Uses anger management skills	3	2	1	0					
11. Communicates with parents about behavior at home	3	2	1	0					
12. Expresses remorse for behavior that hurts or upsets others	3	2	1	0					
13. [illegible]	3	2	1	0					
14. [illegible]	3	2	1	0					
15. Interacts positively with parents	3	2	1	0					
16. Reacts to disappointments in a calm manner	3	2	1	0					
17. [illegible]	3	2	1	0					
18. [illegible]	3	2	1	0					
19. Participates in church activities	3	2	1	0					
20. Demonstrates age-appropriate hygiene skills	3	2	1	0					
21. [illegible]	3	2	1	0					
22. [illegible]	3	2	1	0					
23. Discusses problems with others	3	2	1	0					
24. Completes school tasks on time	3	2	1	0					
	Column subtotals								

Statement	very much like the child	like the child	not much like the child	not at all like the child	IS	FI	IaS	SF	AS
25. Accepts the closeness and intimacy of others	3	2	1	0					
26. Identifies own feelings	3	2	1	0					
27. Identifies personal strengths	3	2	1	0					
28. Accepts responsibility for own actions	3	2	1	0					
29. Interacts positively with siblings	3	2	1	0					
30. Loses a game gracefully	3	2	1	0					
31. Completes homework regularly	3	2	1	0					
32. Is popular with peers	3	2	1	0					
33. Listens to others	3	2	1	0					
34. Expresses affection for others	3	2	1	0					
35. Admits mistakes	3	2	1	0					
36. Participates in family activities	3	2	1	0					
37. Accepts "no" for an answer	3	2	1	0					
38. Smiles often	3	2	1	0					
39. Pays attention in class	3	2	1	0					
40. Computes math problems at or above grade level	3	2	1	0					
41. [illegible]	3	2	1	0					
42. [illegible]	3	2	1	0					
43. Respects the rights of others	3	2	1	0					
44. Shares with others	3	2	1	0					
45. [illegible]	3	2	1	0					
46. [illegible]	3	2	1	0					
47. Studies for tests	3	2	1	0					
48. Talks about the positive aspects of life	3	2	1	0					
49. [illegible]	3	2	1	0					
50. [illegible]	3	2	1	0					
51. Attends school regularly	3	2	1	0					
52. Uses note-taking and listening skills in school	3	2	1	0					
				Column subtotals					
				Previous page column subtotals					
				Total Raw Score					

Section VI. Key Questions

1. What are the child's favorite hobbies or activities? What does the child like to do? _____

2. What is the child's favorite sport(s)? _____

3. In what school subject(s) does the child do best? _____

4. Who is this child's best friend(s)? _____

5. Who is this child's favorite teacher(s)? _____

6. What job(s) or responsibilities has this child held in the community or in the home? _____

7. At a time of need, to whom (e.g., parent, teacher, friend, relative) would this child turn for support? _____

8. Describe the best things about this child. _____

Section VII. Interpretations and Recommendations

CHILD BEHAVIOR CHECKLIST FOR AGES 4–18

For office use only
ID #

Please Print

CHILD'S FULL NAME: FIRST | MIDDLE | LAST

SEX: ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE: Mo _____ Date _____ Yr _____

CHILD'S BIRTHDATE: Mo _____ Date _____ Yr _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. (*Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.*)

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

THIS FORM FILLED OUT BY

☐ Mother (full name) _____

☐ Father (full name) _____

☐ Other—name & relationship to child _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a _____	☐	☐	☐	☐	☐	☐	☐	☐
b _____	☐	☐	☐	☐	☐	☐	☐	☐
c _____	☐	☐	☐	☐	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do *not* include listening to radio or TV.)

☐ None

	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
	Don't Know	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average
a _____	☐	☐	☐	☐	☐	☐	☐	☐
b _____	☐	☐	☐	☐	☐	☐	☐	☐
c _____	☐	☐	☐	☐	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

	Compared to others of the same age, how active is he/she in each?			
	Don't Know	Less Active	Average	More Active
a _____	☐	☐	☐	☐
b _____	☐	☐	☐	☐
c _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include *both* paid and unpaid jobs and chores.)

☐ None

	Compared to others of the same age, how well does he/she carry them out?			
	Don't Know	Below Average	Average	Above Average
a _____	☐	☐	☐	☐
b _____	☐	☐	☐	☐
c _____	☐	☐	☐	☐

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Please Print

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. For ages 6 and older—performance in academic subjects. ☐ Does not attend school because _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects—for example: computer courses, foreign language, business. Do *not* include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Does your child receive special remedial services or attend a special class or special school? ☐ No ☐ Yes—kind of services, class, or school:

3. Has your child repeated any grades? ☐ No ☐ Yes—grades and reasons:

4. Has your child had any academic or other problems in school? ☐ No ☐ Yes—please describe:

When did these problems start?

Have these problems ended? ☐ No ☐ Yes—when?

Does your child have any illness or disability (either physical or mental)? ☐ No ☐ Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food — ***don't*** include sweets (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe): _____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70 Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81 Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe). _____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101 Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

CHILD AND ADOLESCENT FUNCTIONAL ASSESSMENT SCALE

NAME _____ ID # _____ DATE __/__/__ AGE ___ SEX ☐ BOY ☐ GIRL

ASSESSMENT
☐ INTAKE / ☐ SCREENING
☐ 3 MO ☐ 15 MO
☐ 6 MO ☐ 18 MO
☐ 9 MO ☐ 21 MO
☐ 12 MO ☐ 24 MO
☐ EXIT FROM SERVICES
☐ OTHER _____

TIME PERIOD RATED
☐ LAST MONTH
☐ LAST 3 MONTHS
☐ OTHER _____

YOUTH'S CAREGIVER(S) (CHECK ALL THAT APPLY)
☐ BIO. MOTHER ☐ STEPMOTHER
☐ BIO. FATHER ☐ STEPFATHER
☐ ADOPTIVE MOTHER ☐ ADOPTIVE FATHER
☐ GRANDPARENT ☐ OTHER _____

RATER:
NAME _____
☐ CASE MANAGER (OR TEAM LEADER)
☐ TREATING THERAPIST
☐ INTAKE WORKER
☐ NON-TREATING CLINICIAN
☐ LAY INTERVIEWER/RESEARCHER
☐ OTHER _____

SOURCES OF INFORMATION:

- IN-PERSON CONTACT WITH:
  ☐ PARENT
  ☐ YOUTH
  ☐ SCHOOL PERSONNEL
  ☐ FOSTER (OR SURROGATE) PARENT
  ☐ JUVENILE JUSTICE, POLICE
  ☐ SOCIAL WELFARE (SERVICES)
  ☐ MENTAL HEALTH WORKER
  ☐ PUBLIC HEALTH WORKER
  ☐ OTHER _____
- TELEPHONE CONTACT WITH:
  ☐ PARENT
  ☐ YOUTH
  ☐ SCHOOL PERSONNEL
  ☐ FOSTER (OR SURROGATE) PARENT
  ☐ JUVENILE JUSTICE, POLICE
  ☐ SOCIAL WELFARE (SERVICES)
  ☐ MENTAL HEALTH WORKER
  ☐ PUBLIC HEALTH WORKER
  ☐ OTHER _____
- REVIEW OF DOCUMENTS
  ☐ SCHOOL
  ☐ JUVENILE JUSTICE, POLICE
  ☐ SOCIAL WELFARE (SERVICES)
  ☐ MENTAL HEALTH
  ☐ PUBLIC HEALTH
  ☐ OTHER _____

YOUTH'S LIVING ARRANGEMENT (CHECK ALL THAT APPLY)
☐ FAMILY HOME
☐ LIVING WITH OTHERS IN A PRIVATE HOME
  ☐ LIVING WITH NON-CUSTODIAL PARENT
  ☐ LIVING WITH RELATIVES
☐ OUT OF HOME
  ☐ FOSTER CARE
  ☐ GROUP HOME
  ☐ JUVENILE DETENTION/JAIL
  ☐ OTHER RESIDENTIAL SETTING
☐ OTHER _____
☐ UNKNOWN

YOUTH'S LOCATION(S) DURING RATING PERIOD
☐ LIVING WITHIN COMMUNITY
☐ LIVING OUTSIDE COMMUNITY
☐ UNKNOWN

SERVICES RECEIVED (CHECK ALL THAT APPLY)
☐ OUTPATIENT
  ☐ EVALUATION, ASSESSMENT DIAGNOSIS
  ☐ INDIVIDUAL THERAPY
  ☐ MEDICATION MONITORING
  ☐ GROUP THERAPY
  ☐ FAMILY/PARENTAL/MARITAL THERAPY
  ☐ ALCOHOL/DRUG THERAPY
☐ INTENSIVE COMMUNITY-BASED SERVICES
  ☐ DAY TREATMENT/PARTIAL HOSPITALIZATION
  ☐ HOME-BASED SERVICES
  ☐ WRAPAROUND SERVICES
  ☐ RESPITE SERVICES
  ☐ CRISIS-STABILIZATION
  ☐ OTHER _____
☐ RESIDENTIAL PROGRAMS
  ☐ PSYCHIATRIC INPATIENT
  ☐ THERAPEUTIC FOSTER CARE
  ☐ RESIDENTIAL TREATMENT CENTER
  ☐ DRUG AND/OR ALCOHOL PROGRAM
  ☐ OTHER RESIDENTIAL
☐ NONE
☐ UNKNOWN

INSTRUCTIONS: REFER TO THE TRAINING MANUAL. BE SURE TO RATE THE YOUTH'S MOST SEVERE LEVEL OF DYSFUNCTION FOR THE TIME PERIOD SPECIFIED ABOVE (E.G., THE LAST MONTH). THE CAFAS IS DESIGNED AS A MEASURE OF FUNCTIONAL STATUS AND SHOULD NOT BE USED AS THE SOLE CRITERIA FOR DETERMINING ANY CLINICAL DECISION, INCLUDING NEED OR ELIGIBILITY FOR SERVICES, INTENSITY OF SERVICES, OR DANGEROUSNESS TO SELF/OTHERS

CAFAS SCORING SUMMARY

YOUTH'S FUNCTIONING

ROLE PERFORMANCE
(HIGHEST OF SUBSCALE SCORES) ____
SCHOOL/WORK ____
HOME ____
COMMUNITY ____

BEHAVIOR TOWARD OTHERS ____

MOODS/SELF HARM
(HIGHER OF SUBSCALE SCORES) ____
MOODS/EMOTIONS ____
SELF-HARMFUL BEHAVIOR ____

SUBSTANCE USE ____

THINKING ____

TOTAL FOR YOUTH ____
(ADD THE FIVE SCALE SCORES)

LEVELS OF OVERALL DYSFUNCTION BASED ON THE YOUTH'S TOTAL SCORE

☐ 0-10	YOUTH EXHIBITS NO OR MINIMAL IMPAIRMENT
☐ 20-30	YOUTH LIKELY CAN BE TREATED ON AN OUTPATIENT BASIS, PROVIDED THAT RISK BEHAVIORS ARE NOT PRESENT
☐ 40-70	YOUTH MAY NEED CARE WHICH IS MORE INTENSIVE THAN OUTPATIENT AND/OR WHICH INCLUDES MULTIPLE SOURCES OF SUPPORTIVE CARE
☐ 80 & HIGHER	YOUTH LIKELY NEEDS INTENSIVE TREATMENT, THE FORM OF WHICH WOULD BE SHAPED BY THE PRESENCE OF RISK FACTORS AND THE RESOURCES AVAILABLE WITHIN THE FAMILY AND THE COMMUNITY

RISK BEHAVIORS: ITEMS ENDORSED WHICH SUGGEST RISK TO YOUTH OR OTHERS
☐ SELF-HARM: MOODS, 11; SELF HARM, 42-48
☐ AGGRESSION: SCHOOL, 3 & 4; HOME, 43; COMMUNITY, 68; BEHAVIOR, 80
☐ SEXUAL BEHAVIOR: COMMUNITY, 69 & 77; BEHAVIOR, 90
☐ FIRESETTING: COMMUNITY, 71 & 78

PRIMARY CAREGIVER RESOURCES _____ MATERIAL NEEDS
_____ FAMILY/SOCIAL SUPPORT

CAFAS PROFILE YOUTH'S FUNCTIONING YOUTH'S NAME ________________ ID# __________ DATE _/_/_

Level of Impairment	Role Performance School/Work	Role Performance Home	Role Performance Community	Behavior Toward Others	Moods/ Self Harm Moods/ Emotions	Moods/ Self Harm Self-Harmful Behavior	Substance Use	Thinking
SEVERE	1 2 3A 4A 5 6 7 8 9 10 11	41 42 43A 44 45 46 47 48 49 50	66 67 68A 69S 70 71F 72	88 89A 90S 91 92	116 117 118 119H 120	142H 143H 144H 145H	154 155 156 157 158 159 160 161 162 163 164	182 183 184 185 186
MODERATE	12 13 14 15 16 17 18 19 20 21	51 52 53 54 55 56	73 74 75 76 77S 78F 79	93 94 95 96 97 98 99 100 101 102	121 122 123 124 125 126 127	146H 147H 148H	165 166 167 168 169 170 171	187 188 189 190 191 192
MILD	22 23 24 25 26 27	57 58 59 60 61	80 81 82 83	103 104 105 106 107 108 109 110	128 129 130 131 132 133 134 135	149 150	172 173 174 175	193 194 195 196 197
MINIMAL/NO	28 29 30 31 32 33 34 35 36 37 38 39	62 63 64	84 85 86	111 112 113 114	136 137 138 139 140	151 152	176 177 178 179 180	198 199

For each scale, mark the item number(s) which corresponds to those marked on the CAFAS form and fill in the circle indicating severity level. A profile is yielded by connecting the filled circles. Alphabet letters next to item numbers refer to high behaviors (A = Aggression, F = Firesetting, H = Self Harm, S = Sexual)

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major or persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
ROLE PERFORMANCE SCHOOL/ WORK SUBSCALE ☐	Out of job or school due to behavior (e.g., asked to leave or refuses to attend) 001 Expelled or equivalent from school 002 Judged to be a threat to others because of aggressive potential (i.e., resulting from youth's actions or statements), monitoring or supervision needed 003 Harmed or made serious threat to hurt a teacher/peer/ co-worker/supervisor 004 Unable to meet minimum requirements for behavior in classroom (either in regular or specialized classroom in public school or equivalent) without special accommodations 005 Chronic truancy resulting in negative consequences (e.g., detention, loss of course credit, failing courses or tests, parents notified) 006 Chronic absences, other than truancy, resulting in negative consequences (e.g., loss of course credit, failing courses or tests, parents notified) 007 Disruptive behavior, related to poor attention or high activity level, persists despite the youth having been placed in a special learning environment or receiving a specialized program or treatment 008 Failing all or most classes 009 Dropped out of school and holds no job 010	Non-compliant behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity 012 Inappropriate behavior which results in persistent or repeated disruption of group functioning or becomes known to authority figures other than classroom teacher (e.g., principal) because of severity and/or chronicity 013 *Frequently truant* (i.e., approximately once every two weeks or for several consecutive days) 014 Frequent absences from school (i.e., approximately once every two weeks or for several consecutive days) due to impairing behavior and excluding truancy or physical illness 015 Regarding work performance, missed days or tardiness results in reprimand or equivalent 016 Behavior is disruptive, related to poor attention or high activity level, resulting in individualized program or specialized treatment being needed or implemented 017 Receiving a reprimand, warning, or equivalent at work 018 Grade average is lower than "C" and is not due to lack of ability or any mental or physical disabilities 019 Failing at least half of courses and this is not due to lack of ability or any mental or physical disabilities 020	Non-compliant behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth's activities so as to avoid predictable difficulties, more than other youth 022 Inappropriate behavior results in teacher or immediate supervisor bringing attention to problems or structuring youth's activities so as to avoid predictable difficulties, more than other youth 023 Occasionally disobeys school rules, with no harm *to others or to property*, more than other youth 024 Problems in school, related to poor attention or high activity level, are present but are not disruptive to the classroom (can be managed in the regular classroom, with the youth able to achieve satisfactorily) 025 School/work productivity is less than expected for abilities due to failure to execute assignments correctly, complete work, hand in work on time, etc 026	Reasonably comfortable and competent in relevant roles 028 Minor problems satisfactorily resolved 029 Functions satisfactorily even with distractions 030 School grades are average or above 031 Schoolwork is commensurate with ability and youth is mentally retarded 032 Schoolwork is commensurate with ability and youth is learning disabled 033 Schoolwork is commensurate with ability and youth is a slow learner 034 Schoolwork is commensurate with ability and youth has a learning impairment due to maternal alcohol or drug use 035 In a mostly vocational program and doing satisfactorily 036 Graduated from high school or received GED 037 Dropped out of school and is working at a job or is actively looking for a job 038
	EXCEPTION 011	EXCEPTION 021	EXCEPTION 027	EXCEPTION 039
	Explanation			

Could Not Score 040

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
ROLE PERFORMANCE HOME SUBSCALE ☐	Not in the home due to behavior in the home (*if* youth were in the home, extensive management by others would be required in order for youth to be maintained in the home) . **041** Extensive management by others required in order to be maintained in the home. **042** Deliberate and serious threats of physical harm to household members.. **043** Repeated acts of intimidation toward household members.. **044** Behavior and activities are beyond caregiver's influence almost all the time (i.e., serious and repeated violations of expectations and rules, such as curfew).. **045** Behavior and activities have to be constantly monitored in order to ensure safety in the home. **046** Supervision of youth required, which does or would interfere with caregiver's ability to work or carry out other roles... **047** Run away from home overnight more than once and whereabouts unknown to caregiver... **048** Deliberate and severe damage to property in the home (e.g., home structure, grounds, furnishings). **049**	Persistent failure to comply with reasonable rules and expectations within the home (e.g., bedtime, curfew), active defiance much of the time . **051** Frequent use of profane, vulgar, or curse words to household members . **052** Repeated irresponsible behavior in the home is potentially dangerous (e.g., leaves stove on) **053** Run away from home overnight and likely whereabouts are known to parents, such as friend's home. **054** Deliberate damage to the home.. **055**	Frequently fails to comply with reasonable rules and expectations within the home. **057** Has to be "watched" or prodded in order to get him/her to do chores or comply with requests. **058** Frequently "balks" or resists routines, chores, or following instructions, but will comply if caregiver insists.. **059** Frequently engages in behaviors which are intentionally frustrating or annoying to caregiver (e.g., taunting siblings, purposeful dawdling) **060**	Typically complies with reasonable rules and expectations within the home.. **062** Minor problems satisfactorily resolved **063**
	EXCEPTION **050**	EXCEPTION **056**	EXCEPTION **061**	EXCEPTION **064**
	Explanation:			

Could Not Score. **065**

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
ROLE PERFORMANCE COMMUNITY SUBSCALE ☐	Confined related to behavior which seriously violated the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, murder, drive-by shooting). **066** Substantial evidence of, or convicted of, serious violation of the law (e.g., stealing involving confrontation of a victim, auto theft, robbery, mugging, purse snatching, fraud, dealing or carrying drugs, break-ins, murder, drive-by shooting)... **067** Involvement with legal system because of physically assaultive behavior or threatening with a weapon... **068** Involvement with legal system because of sexually assaultive behavior or inappropriate sexual behavior... **069** Deliberate and severe damage of property outside the home (e.g., school, cars, buildings)... **070** Deliberate firesetting with malicious intent... **071**	Serious and/or repeated delinquent behavior (e.g., stealing without confronting a victim as in shoplifting, vandalism, defacing property, taking a car for a joyride)... **073** On probation or under court supervision for an offense which occurred during the last 3 months... **074** On probation or under court supervision for an offense which occurred prior to the most recent 3 month period... **075** Currently at risk of confinement because of frequent or serious violations of the law... **076** Has been sexually inappropriate such that adults have concern about the welfare of other children who may be around the youth unsupervised. **077** Repeatedly and intentionally plays with fire such that damage to property or person could result... **078**	Minor legal violations (e.g., minor driving violations, unruly conduct such that complaint was made, trespassing onto neighbor's property, or harassing neighbor). **080** Single incidents (e.g., defacing property, vandalism, shoplifting) **081** Plays with fire on more than one occasion... **082**	Youth does not negatively impact on the community. **084** Typically able to resolve minor problems **085**
	EXCEPTION **072**	EXCEPTION **079**	EXCEPTION **083**	EXCEPTION **086**
	Explanation			

Could Not Score: **087**

☐	**ROLE PERFORMANCE SCORE** = Highest of SCHOOL/WORK, HOME, COMMUNITY subscores

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
BEHAVIOR TOWARD OTHERS ☐	Behavior consistently inappropriate or bizarre. 088 Behavior so disruptive or dangerous that harm to others is likely (e.g., hurts or tries to hurt others, such as hitting, biting, throwing things at others, using or threatening to use a weapon or dangerous object) 089 Attempted or accomplished sexual assault or abuse of another person (e.g., used force, verbal threats, or, toward younger youth, intimidation or persuasion) 090 Deliberately and severely cruel to animals 091	Behavior frequently/typically inappropriate and causes problems for self or others (e.g.,fighting, belligerence, promiscuity)... 093 Inappropriate sexual behavior in the presence of others or directed toward others... 094 Spiteful and/or vindictive (e.g., deliberately and persistently annoying to others, intentionally damaging personal belongings of others)... 095 Poor judgment or impulsive behavior resulting in dangerous or risky activities that could lead to injury or getting into trouble... 096 Frequent display of anger toward others, angry outbursts... 097 Frequently mean to other people or animals 098 Predominantly relates to others in an exploitative or manipulative manner (e.g., uses/cons others) 099 Involved in gang-like activities in which others are harassed, bullied, threatened, etc... 100 Persistent problems/ difficulties in relating to peers due to antagonizing behaviors (e.g., threatens, shoves). 101	Unusually quarrelsome, argumentative, or annoying to others... 103 Poor judgment or impulsive behavior that is age-inappropriate and causes inconvenience to others... 104 Upset (e.g., temper tantrum) if cannot have or do something immediately, if frustrated, or if criticized... 105 Easily annoyed by others and responds more strongly than other children, quick-tempered... 106 Does not engage in typical peer recreational activities because of tendency to be ignored or rejected by peers 107 Difficulties in peer interactions or in making friends due to negative behavior (e.g., teasing, ridiculing, picking on others)... 108 Immature behavior leads to poor relations with same-age peers or to having friends who are predominantly younger 109	Relates satisfactorily to others... 111 Is able to establish and sustain a normal range of age-appropriate relationships... 112 Occasional disagreements are resolved reasonably 113
	EXCEPTION 092	EXCEPTION 102	EXCEPTION 110	EXCEPTION 114
	Explanation			

Could Not Score 116

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
MOODS/ SELF-HARM MOODS/ EMOTIONS SUBSCALE (Emotions = anxiety, depression, moodiness, fear, worry, irritability, tenseness, panic, anhedonia) ☐	Viewed as odd or strange because emotional responses are incongruous or inappropriate (unreasonable, excessive) most of the time 116 Fears, worries, or anxieties result in poor attendance at school (i.e., absent for at least one day per week on average) or marked social withdrawal (will not leave the home to visit with friends) 117 Depression is associated with academic incapacitation (i.e., absent at least one day a week on average or, if made to attend school, does not do work) or social incapacitation (i.e., isolates self from friends) 118 Depression is accompanied by suicidal intent (i.e., really wants to die) 119	Marked changes in moods that are generally intense and abrupt 121 Depressed mood or sadness is persistent (i.e., at least half of the time), with disturbance in functioning in at least one of the following areas: sleeping, eating, concentration, energy level, or normal activities. If only irritability or anhedonia (i.e., marked diminished interest or pleasure in typical activities) is present, there should be disturbance in two or more areas 122 Youth worries excessively (i.e., out of proportion) and persistently (i.e., at least half of the time), with disturbance in functioning manifested by at least one of the following: sleep problems, tiredness, poor concentration, irritability, muscle tension, or feeling "keyed up" 123 Fears, worries, or anxieties result in the youth expressing marked distress upon being away from the home or parent figures, however, the youth is able to go to school or engage in some social activities 124 School-age children require special accommodations because of worries or anxieties (e.g., sleeping near parents, calling home) 125 Emotional blunting (i.e., no or few signs of emotional expression, emotional expression is markedly flat) 126	Often anxious, fearful, or sad, with some related symptom present (e.g., nightmares, stomachaches) 128 Disproportionate expression of irritability, fear, or worries 129 Very self-critical, low self-esteem, feelings of worthlessness 130 Easily distressed if makes mistakes 131 Sad, withdrawn, hurt, or anxious if criticized 132 Sad (or depressed or anhedonic) or anxious in at least one setting for up to a few days at a time 133 Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love) 134	Feels normal distress, but daily life is not disrupted 136 Considers self to be an "OK" person 137 Can express strong emotions appropriately 138 Experience of sadness and anxiety are age-appropriate 139
	EXCEPTION 120	EXCEPTION 127	EXCEPTION 135	EXCEPTION 140

MOODS/ SELF-HARM SELF-HARMFUL BEHAVIOR SUBSCALE ☐	Non-accidental self-destructive behavior has resulted in or could result in serious self-injury or self-harm (e.g., suicide attempt with intent to die, self-starvation) 142 Seemingly non-intentional self-destructive behavior has resulted in or could likely result in serious self-injury (e.g., runs out in the path of a car, opens car door in moving vehicle), and youth is aware of the danger 143 Has a clear plan to hurt self 144	Non-accidental self-harm, mutilation, or injury which is not life-threatening but not trivial (e.g., suicidal gestures or behavior without intent to die, superficial razor cuts) 146 Talks or repeatedly thinks about harming self, killing self, or wanting to die 147	Repeated non-accidental behavior suggesting self-harm, yet the behavior is very unlikely to cause any serious injury (e.g., repeatedly pinching self or scratching shin with a dull object) 149	Behavior is not indicative of tendencies toward self-harm 151
	EXCEPTION 145	EXCEPTION 148	EXCEPTION 150	EXCEPTION 152
	Explanation			Could Not Score 153

	MOODS / SELF-HARM SCORE = Higher of MOODS/EMOTIONS and SELF-HARMFUL BEHAVIOR subscores

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
	THESE CATEGORIES APPLY TO YOUTH OF ALL AGES.			
SUBSTANCE USE (Substances = alcohol or drugs) ☐	Lifestyle centers on acquisition and use (e.g., preoccupied with thoughts or urges to use substances, cravings for substances, uses in the morning)... 164 Dependent on continuing use to maintain functioning (e.g., likely to experience withdrawal symptoms such as feeling sick, headaches, nausea, vomiting, shaking, etc.)... 165 Failing or expelled from school related to effects of usage 166 Fired or losing job related to effects of usage 167 Frequently intoxicated or high (e.g., more than two times a week)... 168 Use of substances results in serious negative consequences (e.g., injured, doing illegal acts, failing classes)... 169 Is pregnant or is a parent and is a drug user... 160 Is pregnant or is a parent and gets drunk or routinely uses alcohol... 161 Has blackouts, drinks alone, or cannot stop drinking once started... 162	Uses in such a way as to interfere with functioning (i.e., job, school, driving) in spite of potential serious consequences (e.g., traffic violations, work or school absences or tardiness, misses out on activities, uses on school days or before work/school) 165 Gets into trouble because of usage (e.g., argues, fights with family or friends, in accident, trouble with teachers, picked up by police, breaks rules, misses curfew)... 166 Behavior potentially endangers self or others because of usage (e.g., injury, experiencing physical health problems, vulnerable to date rape) 167 Friendships change to mostly substance users 168 High or intoxicated once a week... 169	Infrequent excess and only without serious consequences... 172 Regular usage (e.g., once a week) but without intoxication or being obviously high 173	No use of substances... 176 Substance use is denied; unable to confirm 177 Has only "tried" them, does not use them... 178 Occasional use with no negative consequences 179
	IF YOUTH IS 12 OR YOUNGER, USE THESE ADDITIONAL CATEGORIES			
	For 12 years or younger, uses regularly (once a week or more)... 163	For 12 years or younger, occasional use without intoxication and without becoming obviously high 170	For 12 years or younger, has used substances more than once 174	
	EXCEPTION 164	EXCEPTION 171	EXCEPTION 175	EXCEPTION 180
	Explanation:			

Could Not Score 181

YOUTH'S NAME _____ ID# _____

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
THINKING ☐	CANNOT ATTEND A NORMAL SCHOOL CLASSROOM, DOES NOT HAVE NORMAL FRIENDSHIPS, AND CANNOT INTERACT ADEQUATELY IN THE COMMUNITY DUE TO ANY OF THE FOLLOWING. a. Communications which are impossible or extremely difficult to understand due to incoherent thought or language (e.g., loosening of associations, *flight of ideas*) 182 b. Speech or nonverbal behavior is extremely odd and is noncommunicative (e.g., echolalia, idiosyncratic language) 183 c. Strange or bizarre behavior due to frequent *and/or disruptive* delusions or hallucinations, can't distinguish fantasy from reality 184 d. Pattern of short-term memory loss/disorientation *to time or place most of the time* 185	FREQUENT DIFFICULTY IN COMMUNICATION OR BEHAVIOR, OR SPECIALIZED SETTING OR SUPERVISION NEEDED DUE TO ANY OF THE FOLLOWING a. Communications do not "flow," are irrelevant, or disorganized (i.e., more than other children of the same age) 187 b. Frequent distortion of thinking (obsessions, suspicions) 188 c. Intermittent hallucinations that interfere with normal functioning 189 d. Frequent, marked confusion or evidence of short term memory loss 190 e. Preoccupying cognitions or fantasies with bizarre, odd, or gross *themes* 191	OCCASIONAL *DIFFICULTY IN COMMUNICATIONS, IN BEHAVIOR, OR IN INTERACTIONS WITH* OTHERS DUE TO ANY OF THE FOLLOWING. a. Eccentric or odd speech (e.g., impoverished, digressive, vague) 193 b. Thought distortions (e.g., obsessions, suspicions) 194 c. Expression of odd beliefs or, if older than eight years old, magical thinking 195 d. Unusual perceptual experiences not qualifying as pathological hallucinations 196	Thought, as reflected by communication, is not disordered or eccentric 198
	EXCEPTION 186	EXCEPTION 192	EXCEPTION 197	EXCEPTION 199
	Explanation:			

Could Not Score: 200

RECORD ADDITIONAL COMMENTS, CONCERNS, QUESTIONS OR EXPLANATIONS HERE:

YOUTH'S NAME _____ ID# _____

CAREGIVER BEING RATED: PRIMARY FAMILY

CAREGIVER BEING RATED	RELATIONSHIP TO CHILD	ID#	INFORMANT	YOUTH PLACEMENT	RATER	DATE	ADM#

	Severe Impairment *Severe disruption or incapacitation* (30)	Moderate Impairment *Major/persistent disruption* (20)	Mild Impairment *Significant problems or distress* (10)	Minimal or No Impairment *No disruption of functioning* (0)
CAREGIVER RESOURCES: Material Needs ☐	Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely 201	Frequent negative impact on youth's functioning OR a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met... 203	Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met... 206	Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning... 207 Able to use community resources as needed 208
	EXCEPTION 202	EXCEPTION 204	EXCEPTION 206	EXCEPTION 209
	Explanation:			Could Not Score: 210

CAREGIVER RESOURCES: Family/ Social Support ☐	Sociofamilial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands... 211 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.)... 212 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home... 213 Youth is subjected to sexual abuse in the home by a caregiver... 214 Youth is subjected to physical abuse or neglect in the home by a caregiver... 216 Caregiver "kicks" youth out of the home, without trying to make other living arrangements... 216 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect... 217 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized... 218 Severe or frequent domestic violence takes place in the home... 219 Caregiver contributes to delinquency of youth by being involved in unlawful behavior or approving of youth being involved in potentially unlawful behavior... 220	Youth's developmental needs cannot be adequately met because youth's needs/ developmental demands exceed family resources... 222 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition)... 223 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)... 224 Family members are insensitive, angry and/or resentful to the youth... 225 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of youth; does not know youth's friends)... 226 Failure of caregiver to provide emotional support to youth who has been traumatized or abused... 227 Domestic violence, or serious threat of domestic violence, takes place in the youth's home... 228	Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy... 230 Frequent family arguments and/or misunderstandings resulting in bad feelings... 231 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity... 232 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit... 233	Family is sufficiently warm, secure, and sensitive to the youth's major needs 235 Parental supervision is adequate 236 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system 237
	EXCEPTION 221	EXCEPTION 229	EXCEPTION 234	EXCEPTION 238
	Explanation:			Could Not Score: 239

The Family/Social Support Subscale contains ideas and wording adapted from a measure developed by Sattenberg, Shaffer, Williams and Spitzer

YOUTH'S NAME _____ ID# _____

CAREGIVER BEING RATED: NON-CUSTODIAL FAMILY OR PARENT NOT LIVING IN CHILD'S HOME

CAREGIVER BEING RATED	RELATIONSHIP TO CHILD	ID#	INFORMANT	YOUTH PLACEMENT	RATER	DATE	ADM#

	Severe Impairment *Severe disruption or incapacitation* (30)	**Moderate Impairment** *Major/persistent disruption* (20)	**Mild Impairment** *Significant problems or distress* (10)	**Minimal or No Impairment** *No disruption of functioning* (0)
CAREGIVER RESOURCES: Material Needs ☐	Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely 240	Frequent negative impact on youth's functioning *OR* a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met 242	Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met 244	Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning 246 Able to use community resources as needed 247
	EXCEPTION 241	EXCEPTION 243	EXCEPTION 245	EXCEPTION 248
	Explanation			Could Not Score 249
CAREGIVER RESOURCES: Family/ Social Support ☐	Social/familial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands 250 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.) 251 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home 252 Youth is subjected to sexual abuse in the home by a caregiver 253 Youth is subjected to physical abuse or neglect in the home by a caregiver 254 Caregiver "lacks" youth out of the home, without trying to make other living arrangements 255 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect 256 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized 257 Severe or frequent domestic violence takes place in the home 258 Caregiver contributes to delinquency of youth by being involved in unlawful behavior or approving of youth being involved in potentially unlawful behavior 259	Youth's developmental needs cannot be adequately met because youth's needs/ developmental demands exceed family resources 261 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition) 262 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.) 263 Family members are insensitive, angry and/or resentful to the youth 264 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of child; does not know child's friends) 265 Failure of caregiver to provide emotional support to youth who has been traumatized or abused 266 Domestic violence, or serious threat of domestic violence, takes place in the youth's home 267	Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy 269 Frequent family arguments and/or misunderstandings resulting in bad feelings 270 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity 271 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit 272	Family is sufficiently warm, secure, and sensitive to the youth's major needs 274 Parental supervision is adequate 275 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system 276
	EXCEPTION 260	EXCEPTION 268	EXCEPTION 273	EXCEPTION 277
	Explanation			Could Not Score 278

The Family/Social Support Subscale contains ideas and wording adapted from a measure developed by Sellenberg, Shaffer, Williams and Spitzer

YOUTH'S NAME _____ ID# _____

CAREGIVER BEING RATED: SURROGATE CAREGIVER

CAREGIVER BEING RATED	RELATIONSHIP TO CHILD	ID#	INFORMANT	YOUTH PLACEMENT	RATER	DATE	ADM#

	Severe Impairment *Severe disruption or incapacitation* **(30)**	**Moderate Impairment** *Major/persistent disruption* **(20)**	**Mild Impairment** *Significant problems or distress* **(10)**	**Minimal or No Impairment** *No disruption of functioning* **(0)**
CAREGIVER RESOURCES: Material Needs ☐	Youth's needs for food, clothing, housing, medical attention, or neighborhood safety are not being met such that severe risk to health or welfare of youth is likely 279	Frequent negative impact on youth's functioning OR a major disruption in the youth's functioning due to youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met. 281	Occasional negative impact on the youth's functioning due to the youth's needs for food, housing, clothing, medical attention, or neighborhood safety not being met. 283	Basic material needs are arranged for or adequately met so that there is no disruption in the youth's functioning. 285 Able to use community resources as needed 286
	EXCEPTION 280	EXCEPTION 282	EXCEPTION 284	EXCEPTION 287
	Explanation			Could Not Score 288

CAREGIVER RESOURCES: Family/ Social Support ☐	Sociofamilial setting is potentially dangerous to the youth due to lack of family resources required to meet the youth's needs/demands... 289 Gross impairment in parental judgment or functioning (may be related to psychosis, substance abuse, severe personality disorder, mental retardation, etc.)... 290 Caregiver is frankly hostile, rejecting, or does not want youth to return to the home... 291 Youth is subjected to sexual abuse in the home by a caregiver... 292 Youth is subjected to physical abuse or neglect in the home by a caregiver... 293 Caregiver "kicks" youth out of the home, without trying to make other living arrangements... 294 Youth currently removed from the home due to sexual abuse, physical abuse, or neglect... 295 Failure of caregivers to provide an environment safe from possible abuse to a youth previously abused or traumatized... 296 Severe or frequent domestic violence takes place in the home... 297 Caregiver contributes to delinquency of youth by being involved in unlawful behavior or approving of youth being involved in potentially unlawful behavior 298	Youth's developmental needs cannot be adequately met because youth's needs/ developmental demands exceed family resources. 300 Marked impairment in parental judgment or functioning (may be related to emotional instability, psychiatric illness, substance use, physical illness, criminal activities, or other impairing condition). 301 Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)... 302 Family members are insensitive, angry and/or resentful to the youth... 303 Marked lack of parental supervision or consistency in care (e.g., frequently does not know whereabouts of youth; does not know youth's friends) 304 Failure of caregiver to provide emotional support to youth who has been traumatized or abused. 305 Domestic violence, or serious threat of domestic violence, takes place in the youth's home... 306	Family not able to provide adequate warmth, security or sensitivity relative to the youth's needs. Support from other sources outside the immediate family are unable to compensate for this inadequacy. 308 Frequent family arguments and/or misunderstandings resulting in bad feelings. 309 Family relations are characterized by poor problem solving, poor communication, or emotional insensitivity 310 Family not able to provide adequate supervision, firmness, or consistency in care over time relative to the youth's needs; no other supports compensate for this deficit... 311	Family is sufficiently warm, secure, and sensitive to the youth's major needs. 313 Parental supervision is adequate... 314 Even though there are temporary problems in providing adequate support to the youth, there is compensation from the wider social support system 315
	EXCEPTION 299	EXCEPTION 307	EXCEPTION 312	EXCEPTION 316
	Explanation:			Could Not Score 317

The Family/Social Support Subscale contains ideas and wording adapted from a measure developed by Setterberg, Shaffer Williams and Spitzer