



Colorado RCCF Outcome Measures Study

Prepared by: Policy Studies Inc.
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RCCF OUTCOME MEASURES STUDY: FINAL REPORT

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The points of view expressed in this document are those of the authors and do not necessarily represent the official positions or policies of the Colorado Health Foundation.

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It is not possible here to recognize and thank all the individuals involved. However, the authors wish to acknowledge the contributions of a few key people whose efforts were especially important to the study's success.

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in and data entry to reporting outcomes and extracting data for analysis. The system, which is still being used by some of the RCCFs that participated in this study long after the study has concluded, can be traced to his development efforts.

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- Khanh Nguyen, Colorado Health Foundation
- Skip Barber, Colorado Association of Family and Children's Agencies, Inc.
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EXECUTIVE SUMMARY

INTRODUCTION

Colorado's Department of Human Services has a long-standing interest in outcomes measurement for youth in out-of-home placements. This has been demonstrated by its continued efforts to encourage, facilitate, and support studies and convene committees to discuss and propose recommendations for appropriate outcomes measurement tools and a process to implement those tools for agencies providing out-of-home placement services. Despite these efforts, other priorities and constraints (e.g., budget, staffing, federal requirements, state policies, differing interests across State divisions and counties, and oversight) have limited progress at the state level toward reaching consensus about and hence in developing a consistent approach to assessment and outcomes measurement.

In late 2006, the Colorado Association of Families and Children's Agencies (CAFCA), in collaboration with and funding from the Colorado Health Foundation (CHF), began a multi-year study of outcomes for youth in out-of-home residential placements. Grounded in system-wide aims to improve services to those youth and their families and inform public policy at the state level to effect positive, systemic change in service delivery to all youth in out-of-home care, the purpose of the study was to examine the effectiveness of behavioral health services for children in residential placement. Primary among the study goals was to develop and use tools that would provide a more in-depth description of the population of youth in residential care (e.g., their characteristics, placement history, problem severity) and outcomes than were available with current statewide databases. (The study followed on the heels of reductions in Medicaid reimbursement for residential care services. Both CAFCA and CHF viewed these reductions as an opportunity to learn better the merits and limitations of residential services as they affected outcomes for vulnerable youth.)

The scope of the study included overall design and planning (e.g., developing instruments, collecting data, managing project implementation and ongoing operations, compiling and analyzing data); executing the plan and the tasks in that plan, and reporting the study results. The study's architects assembled a steering committee to provide guidance, complete study tasks, and oversee study implementation.

STUDY OBJECTIVES

This study had four primary objectives:

- Design a set of tools to measure the outcomes youth achieve in out-of-home placements
- Develop a web-based data collection and reporting system that service providers – Residential Child Care Facilities (RCCFs) in this our study – can use to:
 - ✓ Capture and record in a systematic fashion the characteristics of the youth they serve, the services they deliver to those youth, and the outcomes they achieve from those services;
 - ✓ Manage and monitor service delivery;
 - ✓ Extract and evaluate data on individual youth; and
 - ✓ Develop reports of findings.

- Develop an aggregate profile of youth in out-of-home placements.
- Measure and analyze outcomes for the population of youth served by the participating RCCFs.

STUDY FINDINGS

Outcomes Measurement Tool

After reviewing multiple outcomes assessment tools, the Steering Committee selected the Child and Adolescent Needs and Strengths (CANS) scale as its preferred measurement tool. A key factor in its decision was the ability to use the CANS for both treatment planning and outcomes assessment. In practice, the tool worked well for both purposes.

- Treatment Planning: the CANS is designed to facilitate treatment planning at admission and at discharge. The dimensions of need are easily scored to determine severity and establish priorities for treatment at admission. Also, the scoring can be color-coded – as was done in this study – to highlight the needs that should be included in the treatment plan. The multiple dimensions of the CANS also allow the clinician to identify areas of strength on which treatment services are able to build.

At discharge, reapplication of the CANS can identify the dimensions that still need attention and help the clinician to recommend post-residential treatment options and services.

- Outcomes Measurement: Outcomes measurement using the CANS proved to be very straightforward. This study was able to use the CANS successfully to assess outcomes by measuring change from admission to discharge and even beyond discharge from the RCCF when clinicians were able to complete four and twelve month follow-up interviews and re-administer the CANS.

Residential Outcomes Collection and Reporting System (ROCRS)

Developing an outcomes measurement system from scratch was an enormous undertaking. CAFCA's members, all Residential Child Care Facilities, had only a basic foundation upon which to build a system and no blueprint for action. ROCRS was critical to the study's success and took many months to design and program once the data collection instruments were developed. Some of the major challenges the system had to address included (1) system security and access to personal information on each youth in placement; (2) lengthy, complex data collection instruments that included required and non-required fields, skip patterns, and checks for completion; (3) management reports that the ROCRS administrators at each facility could use to check for data quality and completeness and duplicate entries, and edit the information where needed; (4) canned aggregate outcomes reports that individual agencies could print from the system, and (5) a data export function agencies could use to extract their facility's data for more specialized analyses.

Now, five years after the study was conceived, CAFCA has a proven, web-based system with which to capture, record, extract and report a wide range of data on the youth in out-of-home placements. Furthermore, the system is in the public domain and thus could easily be adapted by Colorado as its standard approach to outcomes measurement for all out-of-home placements. Based on the time and resource

requirements to design, build, implement, and train staff in the use of the system and its functions, ROCRS was arguably the most important product from this study. While refinements and updates are needed for the long-term (e.g., improved functionality, additional reports and reporting capability) and to improve the system's ease of use, this work was foundational for building data consistency, including mostly required data elements across multiple agencies.

The Profile of Study Youth

A chief goal of the study was to develop a profile of youth at admission to residential placement, both in terms of their demographic (e.g., age, race/ethnicity) and social (e.g., placement history, delinquency status, diagnoses) backgrounds, and their service needs. In addition to the CANS, which therapists used to assess the youth's needs and strengths, the study developed instruments to gather information about the number and types of diagnoses, and systematically capture some of the information RCCFs were already gathering but not necessarily recording on every youth admitted to their facilities.

The analysis had mostly complete information for 1,207 youth at admission. In terms of background characteristics, the profile yielded the following general findings:

- A higher proportion of admitted youth were males (58.7%) than females. They were predominantly Caucasian (69.7%), and teenagers (i.e., the average age for the youth was 15.6 years; slightly higher for males and slightly lower for females). A slight majority (51.9%) had been adjudicated delinquent at the time of their RCCF admission.
- The parental rights of most of the youths' biological parents were still intact (76.1%) and the majority of those parents were supportive of the residential placement and wanted the child eventually to return home. Yet, at the time of RCCF admission, most of the youth had not come from living with their primary caretakers, but from another out-of-home placement. (Only 15.4 percent of youth had been living at home with their primary caregiver prior to their RCCF placement.)
- Almost all youth (97.7%) had a history of some trauma experiences. Of the 13 trauma items listed on the CANS, more than 50 percent of youth had experienced trauma in seven of the items from sexual abuse (53.3%) to traumatic grief (78.0%). Almost a third of youth (31.3%) had a history of four or more types of trauma experiences. There were no statistically significant differences in the prevalence of traumatic experiences based on the youth's age or gender, although youth from homes where the parental rights were terminated/pending had experienced significantly more traumatic events than youth from homes where the parental rights were intact.
- The diagnostic profile showed that most youth (81.0%) had more than one diagnosis at admission. The prevalence of Axis I and Axis II disorders was markedly different for males and females, with males statistically more likely than females to have conduct/antisocial behavior disorder and development delay/mental retardation and females statistically more likely than males to have mood and personality disorders. The majority of youth (80.0%) had GAF scores of 50 or less, indicating they had serious symptoms or serious impairment of functioning.

We used the CANS data to develop a clinical profile of youth at admission. Clinicians use a four-point scale (0 to 3) to score each CANS item, with “0” indicating no evidence of need and “3” indicating a dangerous or disabling level of need. There is more than one approach to assessing a youth’s severity of need using these scores. The most basic approach is to calculate an overall score for each domain using all the individual item scores within that domain. Using that approach, the highest possible score is 30 indicating that a youth had a dangerous level of need on each of the items within a domain. The analysis of CANS data showed the following:

- On average, all the CANS domains indicated a need for attention. However, the overall scores were well below the maximum threshold. The behavioral-emotional needs scale showed the highest level of severity with an overall score of 11.3 (out of 30) and the trauma scale showed the lowest level of severity with an overall score of 8.4.
- In terms of child and caregiver strengths; the CANS overall score for caregivers was substantially higher than the score for child strengths.

In some regards, the overall average scores understate the severity of need youth present at admission because they include the scores for those youth and those items where there is no evidence of need. As a result, the study also looked at the severity of need in terms of the proportion of actionable items (i.e., items with scores of 2 or 3) within each scale. That perspective helped underscore the complexity of the problems youth in residential care present and thus the challenge to therapists in addressing the range of youth needs. Thus, for example:

- 87.8 percent of the 15 items in the Life Domain scale had youth with actionable scores of 2 or 3.
- 87.5 percent of the 13 items in the Behavior Emotional Needs Domain scale had youth with actionable scores of 2 or 3.
- More than half of the items in each of the eight domains had actionable items. The proportions ranged from 52.9 percent for the Caretakers Strength Scale to 87.8 percent for the Life Domain Scale.
- Nine of thirteen prior trauma experiences were identified for 30 percent or more of the youth, the most common being Traumatic Grief, Emotional Abuse, and Neglect, Physical Abuse, and Family Violence.

This approach to assessment would enable us to control for severity at the outset of treatment in future outcomes measurements, a difficult but important component of analyzing outcomes within an array of youth who have differential risks and strengths.

Youth Treatment Outcomes

We limited our outcomes analysis to 467 youth for whom we had complete data at both admission and discharge. Our analysis of data for these youth included the following key facts:

- Half of the discharged youth (51.1%) met at least 70 percent of their treatment goals and slightly less than half of caretakers (46.7%) met at least 70 percent of their goals.
- More than half (56.8%) of the discharged youth completed the residential treatment program successfully. Only a small proportion (7.2%) were removed from placement against the advice of the RCCF provider.
- At discharge, the RCCF provider recommended almost two-thirds of the youth (64.7%) for a less restrictive placement. Return home to live with the primary caretaker was the most frequent recommendation for youth in this group and 40.8 percent of youth reportedly did return home after their discharge.
- RCCF providers also recommended a lower frequency of treatment services for youth post-discharge; only 18 percent were recommended for day treatment. The majority of youth were recommended for services to occur 1-2 days per week, such as individual therapy/counseling and outpatient family therapy.

Providers reported that their recommendations for placement settings and service needs were followed by the referring agency 89 percent of the time.

The CANS data from admission and discharge allowed us to measure changes in the youth's needs and strengths between those time periods. We measured these changes using three approaches suggested by Dr. John Lyons who developed the CANS.

- Actionable needs and strengths within each of seven domains: Trauma Symptoms, Life Functioning, Emotional/Behavioral Health, Risk Behaviors, Child Strengths, Caregiver Strengths, and Transition to Adulthood. This is the broadest of the three approaches to measuring change and provides a picture of which domains exhibited the greatest density of need and change from admission to discharge.

The analysis showed that at admission, almost all the items in four domains had scores that were actionable (i.e., more than 90% of the items were actionable) and more than half of the items in the other three domains were actionable (the range was 58% of items in the Trauma Symptoms domain to 77% of items in the Life Functioning domain). At discharge, the proportion of actionable items had decreased significantly from admission in all seven domains.

- Actionable item scores for all items within each of the seven domains. There are multiple actionable items within each of the seven domains that are used to calculate an aggregate score for the domain. Thus, in addition to changes in the domain scores, we looked at change within each of the actionable items in each domain.

For two domains – Risk Behaviors and Child Strengths – the proportion of youth with actionable items decreased significantly from admission to discharge for all items within the domain. The other five domains showed decreases in the proportion of youth with actionable items from admission to discharge in all or most of the items within them, but not all the changes were significant. The

Trauma Symptoms and Transition to Adulthood domains showed the fewest significant changes between the two assessment periods.

- Reliable Change. The Reliable Change Index is a more rigorous indicator of change than statistical significance because it requires that the difference between a youth's scores at admission and discharge exceed the reliable change index.

The percentage of youth with reliable change varied considerably among the CANS domains ranging from a low of 15 percent for Trauma Symptoms to a high of 28 percent for Child Strengths. Overall, 20 percent of the youth in this study showed reliable change from admission to discharge in four of the seven CANS domains; 20 percent being the threshold Dr. Lyons suggests should be expected as an outcome from treatment. The proportions of youth with reliable change in the other three domains were close to this threshold (15%, 17% and 18%).

As a final benchmark, we calculated the percentage of youth who had reliable change on at least one measure in this study and compared it to the reliable change findings from a study of wraparound services Dr. Lyons completed in Indiana. Although the dimensions included in this calculation differed slightly between the two studies, the overall measures of reliable change were almost identical, 54 percent for our Colorado study and 56 percent for the Indiana study.

As a result of our study findings, we think that the CANS can be a powerful tool to assess the level of service need across many levels of functioning, assist in developing approaches to treat those needs, and measure the outcomes that result from treatment. We encourage Colorado to look more closely at the CANS tool and consider implementing the tool statewide to assess the level of treatment needs for the youth it places in out-of-home care. Given the challenges of implementing and sustaining special studies, we also strongly recommend that such an implementation be integrated into required elements of the statewide database to ensure timely and complete data.

CHAPTER I: INTRODUCTION

INTRODUCTION

In 2006, the Colorado Association of Families and Children’s Agencies (CAFCA), in collaboration with (and funding from) the Colorado Health Foundation (CHF), began a multi-year study of outcomes for youth in out-of-home, residential placements. The purpose of the study was to examine the effectiveness of behavioral health services for children in residential placement with the goals of (1) describing the population of youth in residential care (e.g., their characteristics, placement history, problem severity); (2) improving services to those youth and their families; and (3) informing public policy at the state level to effect positive, systemic change in service delivery to all youth in out-of-home care. The study followed on the heels of reductions in Medicaid reimbursement for residential care services, which forced providers to do more with less. Both CAFCA and CHF viewed these reductions as an opportunity to explore the merits and limitations of residential services as they affected outcomes for vulnerable youth.

BACKGROUND TO THE STUDY

Standardizing outcome measurement has been a challenge in the field of child welfare and other child-serving sectors, nationally and in Colorado, for many years. There are numerous factors that make standardization difficult, including wide variations in facility size, ethnic distribution of youth in placements/settings, the severity and type of youths’ disorders and behaviors, treatment needs and models, financing (sources and limits), and the availability of alternative and complementary services. Despite these difficulties, there are several reasons outcomes for youth in out-of-home placements are needed:

- To provide accountability to payors of out-of-home services,
- To set reimbursement rates for services,
- To assess the cost effectiveness of services,
- To identify opportunities to improve the quality of care provided by residential facilities,
- To increase the use of evidence-based practice,
- To document outcomes for individual youth, and
- To prepare treatment plans.

Colorado Child Welfare Research

Knowing the reasons for measuring outcomes does not necessarily help identify what those measures should be. The 2002 performance audit report from the Colorado Office of the State Auditor recommended that the Colorado Department of Human Services (CDHS) develop (1) outcome measures that will measure youth progress and program success and (2) a monitoring system to track outcomes experienced by youth.¹ The

¹ Colorado Office of the State Auditor (January 2002), Performance Audit of Residential Treatment Center Rate Setting and Monitoring, Report Control #1406 (Office of the State Auditor: Denver, Colorado).

report did not, however, specify which outcome measures were preferred, only that the measures should allow for comparisons across out-of-home care facilities.

Colorado's child welfare system has a history of ongoing interest in outcomes measurement, beginning with the first Colorado Outcomes Work Group, which was initiated in 1993 and continued until 1999. The focus of this collaboration of state, county, and local community partners was "... to develop an outcomes-based model for delivering, managing, and evaluating child welfare services."² This effort included providing partners with (1) the conceptual underpinnings of outcomes-based practice, (2) extensive analysis of the CWEST database to describe the service pathways for youth and families, and (3) the provision of training and technical support for outcomes pilot projects in six Colorado counties.

This was an extremely useful project that provided CDHS with specific recommendations for the department as it moved toward implementation of Trails, Colorado's State Automated Child Welfare Information System,³ and a stronger outcomes orientation. These included recommendations to:

- Use measures that fit the reasonable expected outcomes of specific interventions,
- Provide extensive technical support throughout the system,
- Support a shift in agency culture, which in turn would guide the thinking and practice of staff, and
- Provide continuous access to data for state and county managers.

These recommendations apply to evaluation and outcomes measurement at all organizational levels, including the program level.

CDHS has also invested considerable resources in tracking and meeting the outcomes requirements for the U.S. Department of Health and Human Services' Child and Family Services Review (CFSR), which measures state level outcomes in the areas of safety and permanency. Measures include, among others: (1) the frequency of re-entry into the child welfare system, (2) the incidence of repeat abuse, (3) the number of children who are re-unified with family, and (4) the length of time children spend in the system. It also offers a broad look at how the child welfare system is performing. Since it is tied to federal funding, interest in the CFSR and its measures is naturally very high among all partners in Colorado's child welfare system. It is, however, neither program nor child specific.

CDHS reintroduced the Outcomes Work Group in 2004 and developed a draft list of outcome goals and measures for youth in residential placements that included the following measures on which state child welfare staff gathered information for a year using Trails:

- Average rated change in problem severity,
- Improvement in total problem severity score,

² Potter, C.C. (1999) Final Report: Colorado Outcomes Work Group (University of Denver, Graduate School of Social Work: Denver, Colorado).

³ Colorado Trails is a very large depository of historical information of youth placed in care by the Colorado Division of Child Welfare and the Division of Youth Corrections.

- Improvement in overall level of functioning,
- Improvement in overall strengths, and
- Percentage of leave reasons that are positive.

These were not the main outcome measures residential care providers mentioned in a 2002 study as important. The top three were (1) no further criminal involvement, (2) school accomplishments, and (3) the ability to live in a less restrictive environment. They were, however, the data available in the Colorado Trails system and thus more easily accessible than the other three measures.⁴

Trails data were also the main information source for a more recent study of outcomes for Colorado youth in out-of-home placements, the Applied Research in Child Welfare (ARCH) project.⁵ The study, led by staff from the Social Work Research Center at Colorado State University, was designed to give child welfare professionals and policy-makers information on provider outcomes and costs. For outcomes, the study looked at entry and exit scores on the Colorado Client Assessment Record (CCAR) and correlated the difference in these scores with permanency at discharge, reentry to out-of-home care, number of placements and placement days, and the discharge placement.

With specific regard to outcomes for youth in residential placements, the study found wide variability in treatment approaches and in youth outcomes among residential providers and concluded that residential treatment is effective for youth under the right therapeutic conditions. Although this conclusion may seem rather modest, it reflects some of the limitations of Colorado Trails in terms of the completeness, consistency, timing, and accuracy of the data in Trails. Specifically, many items are not required and the best measure of clinical outcomes, the CCAR, is not necessarily completed before various interventions begin and when they end, making the measurement of treatment-specific outcomes unreliable. Furthermore, no information is collected on parental involvement, of particular concern when assessing residential and other high intensity services. Therefore, while Colorado Trails is the only database available at this time, it may not be particularly well-suited to an analysis of certain important outcomes.

⁴ Potter, op. cit., footnote 2.

⁵ Winokur, Marc and Crawford, Craig (December 2009) Outcome Study of Out-of-Home Care in Colorado Final Report (Social Work Research Center, Colorado State University; Ft. Collins, Colorado).

In developing a more comprehensive set of data to evaluate youth outcomes, the advice that guided our study came from a survey of residential facilities conducted in 1999 by the American Association of Children's Residential Centers.⁶ In asking about outcome measurement and evaluation, the responding facilities advised others to:

- Keep it simple,
- Involve stakeholders in the design,
- Listen to needs of the consumers of data,
- Collect relevant data, and
- Provide timely feedback.

Our study attempted to keep these factors in mind as we designed data collection instruments, developed and implemented the data collection system, and defined how the study findings would inform Colorado's needs for information – and the field of child welfare generally – about outcomes for youth in residential placements.

Child Adolescent Needs and Strengths Scale (CANS)

The primary tool the Steering Committee selected for the study assessment was the Child Adolescent Needs and Strengths Scale. The committee saw several advantages to this tool over other instruments in use around the country. First, the CANS is a multi-purpose tool that can be used to assess a youth's needs and strengths at the time of placement, develop a treatment plan to address those needs and build on the strengths, and periodically reassess the youth's progress in meeting treatment goals while in placement. Second, the CANS is widely used around the U.S. – currently used in 25 states – for monitoring service outcomes in child welfare, mental health, juvenile justice and early intervention situations. Third, although lengthy, the CANS is easily adapted to meet the specific requirements of administrators (e.g., state program, placement agency), clinicians/therapists in agency settings (e.g., group homes, residential facilities), and researchers. Fourth, the instrument is in the public domain and can be used free of charge. Finally, CANS training was available on line although the initial CANS training for this study was conducted in person. We discuss the CANS in greater detail in Chapter II.

⁶ American Association of Children's Residential Treatment Centers (1999), *Outcomes in Children's Residential Treatment Centers: A National Survey* (AACRC: Washington, D.C.).

PROJECT ORGANIZATION

A chart displaying the basic organizational relationships among the outcome measures study collaborators is provided below. As Exhibit 1 illustrates, the study had four key partners: The Colorado Health Foundation, the Colorado Association of Family and Children's Agencies, Policy Studies Inc. and the residential child care facilities that participated in the study.

Colorado Health Foundation (CHF)

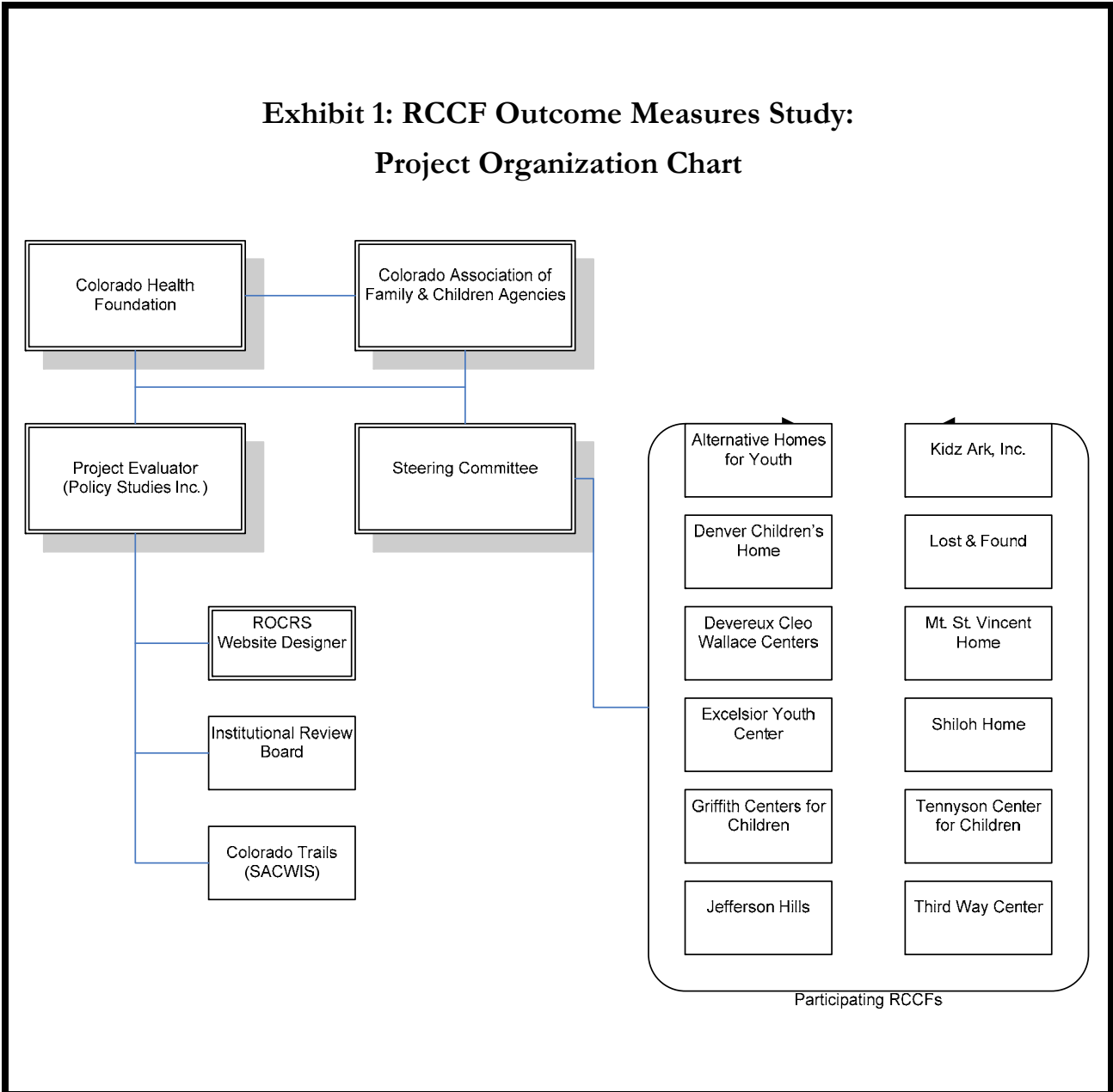
The Colorado Health Foundation provided funding and organizational support for the project. At the time the study began, child welfare issues were a CHF funding priority and the Foundation financially supported some individual residential facilities through its grants programs. Yet, it also was interested in taking a broader view of the residential care system and the outcomes of youth placements in that system. As a result, it worked closely with the director and staff at the Colorado Association of Family and Children's Agencies (CAFCA) to design a study that addressed the outcomes of youth in residential care and that would leave behind a tool that the child welfare field as a whole could use to assess outcomes and to effect improvements.

Colorado Association of Family and Children's Agencies (CAFCA)

CAFCA provided overall project direction and management to the outcome measures study. As an association of residential child care facilities (RCCFs), it recruited participation in the study from its member agencies and managed the implementation and ongoing operations of the study. That included assigning one staff person to work with individual participating RCCFs to ensure their staff received appropriate training, to monitor compliance with the data collection/entry protocols, to address issues and concerns RCCFs raised during the study, and to keep everyone informed about study progress.

An initial study task included forming a steering committee that would provide oversight and direction to study activities. A larger purpose of the committee, however, was to make decisions about what instrument(s) all participating RCCFs would use to measure outcomes.

Exhibit 1: RCCF Outcome Measures Study: Project Organization Chart



Policy Studies Inc. (PSI)

Under a separate contract, CHF hired PSI to provide evaluation support for the outcome measures study. This support included completing two main tasks: (1) developing a web-based, online data collection and reporting system to capture outcomes data from the youth in residential care at the participating RCCFs and

(2) designing an evaluation approach for collecting, cleaning, compiling and analyzing the outcomes data. In addition, PSI provided support to the study's steering committee (e.g., instrument design, quality control oversight) and worked with programming staff at the state to capture information from Colorado Trails.⁷

PSI staff designed and implemented ROCRS, Residential Outcomes Collection and Reporting System, for the outcome measures study. The web-based, online system required a major development effort and is a hallmark of the project. In fact, it was designed to be a system RCCFs could use beyond the study end date to capture outcomes on their youth and track the effectiveness of their service delivery. ROCRS has the ability to add users and the system architects hoped ROCRS would attract interest from the state in adopting and expanding the system to statewide use as a tool to measure outcomes for all types of out-of-home placements.

Since the evaluators had access to confidential information about youth in placement – although not access to information about specific youth – they worked with an Institutional Review Board (IRB) to ensure the study met appropriate standards for data security and confidentiality. IRB approval was elicited throughout the study's operational period.

Participating Residential Child Care Facilities (RCCF)

Twelve RCCFs, about 46 percent of Colorado's licensed RCCFs, eventually participated in the study by key entering data to ROCRS, the web-based online data collection and reporting system. The study actually began with more participating RCCFs, but some agencies dropped out of the study for a variety of reasons.⁸

As part of the data collection effort, the evaluators designed a survey to capture some descriptive information about the participating RCCFs. (A copy of that survey is attached in Appendix A.) All the participating RCCFs were somewhat different in terms of their (1) organizational/operational structure (e.g., the year they began business, their accreditation), (2) size (e.g., number of residents, number of staff secure beds), (3) the types of cases they would and would not accept, and (4) the services they offered.

All of the participating RCCFs were operating as private, non-profit facilities and while most of them were formed during the 1970s, three were founded over 100 years ago. Only one of the RCCFs was not yet accredited by a national organization, as shown in Exhibit 2 below, although had applied for it. Most of the remaining RCCFs were accredited by the Council of Accreditation (COA). Two RCCFs were accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF), respectively.

⁷ PSI staff worked extensively with analysts in both divisions to select data elements from Trails that likely would be complete, valid, and reliable. We then worked with Trails programmers to develop an extract that would capture those elements.

⁸ The reasons RCCFs left the study varied and included closure of the facility and the director's or facility board's decision to drop out.

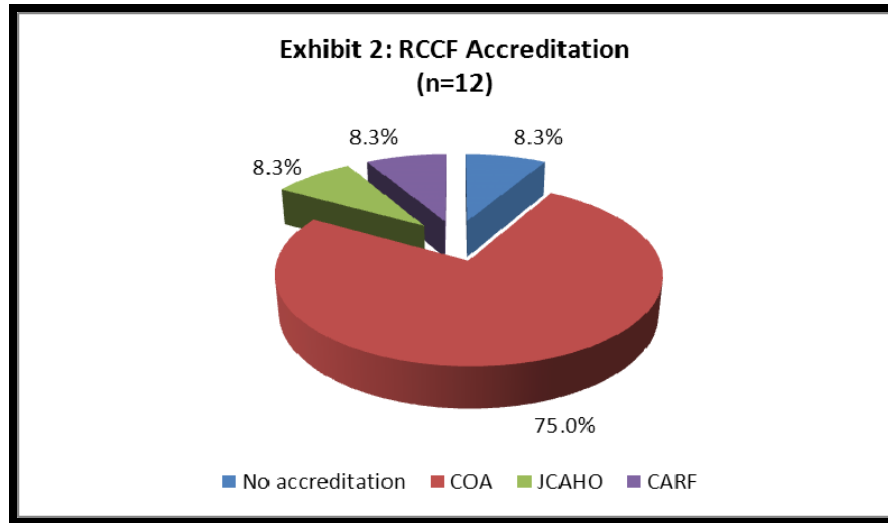


Exhibit 3 displays the cases the participating RCCFs did not accept. All the RCCFs accepted many of the case types (n=8 case types) and all but one RCCF did not accept youth who needed medical detoxification services. Between these two extremes, various numbers of RCCFs did not accept certain youth. However, more than a majority of RCCFs accepted almost all the case types listed in the survey. The three exceptions were (1) youth who were actively suicidal, (2) pregnant youth, and (3) non-ambulatory youth.

Further information about the RCCFs’ resident populations is provided in Exhibit 4. Specifically, the exhibit displays the source of cases (i.e., what program referred the youth to the RCCF placement?), the total number of residents served in a fiscal year, and the residents’ average length of stay. All of the RCCFs in this study accepted youth referred from county child welfare agencies, but at least one RCCF did not accept one of the other sources. In fact, referrals from Colorado other public, non-Medicaid agencies were only accepted by one RCCF.

The RCCFs also varied in terms of their census of youth they admitted in a fiscal year and in the youths’ length of stay in the facility. Some of the RCCFs were relatively small and in an average fiscal year serve only a small number of youth, while others were larger. The average RCCF served 173 youth in a fiscal year. Similarly, the youths’ length of stay in the facilities varied greatly, ranging from 1 day to 76.5 months. Clearly, the RCCFs included in the study serve a diverse group of youth.

Exhibit 3: Number of Participating RCCFs that DO NOT accept Certain Case Types (n=12)

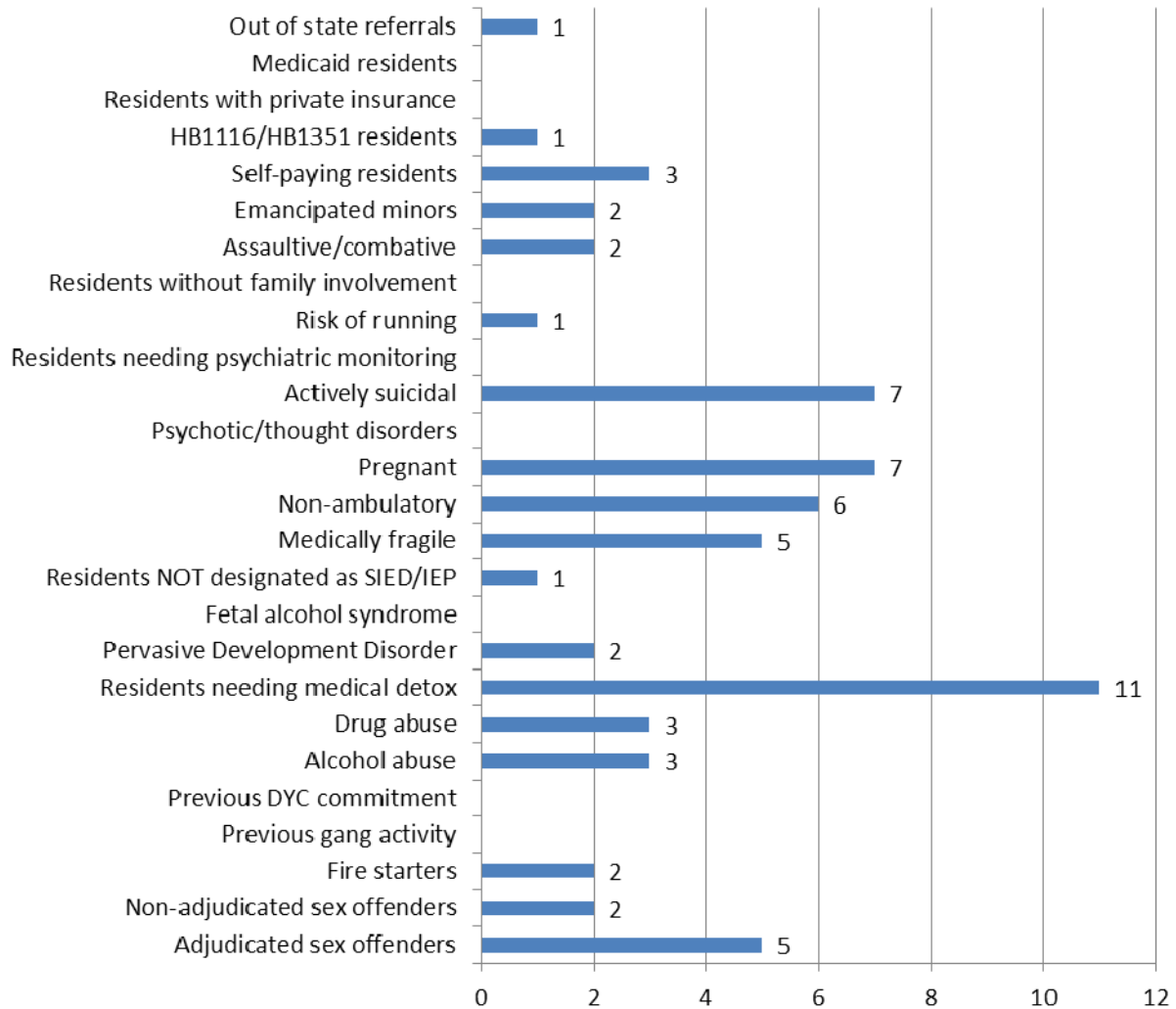


Exhibit 4: Basic Data about RCCF Youth
(Number of RCCFs)

RCCF Resident Background	Minimum	Maximum	Mean
Total residents (12 months)	37	395	173
<u>Residents by Source¹</u>			
• Colorado DYC	0	241	59 (n=7)
• Colorado County Child Welfare	24	220	96 (n=11)
• Colorado Mental Health (HB 1116, HB 1351, MHASA)	0	19	5 (n=9)
• Colorado other public, non-Medicaid (e.g., CHAMPUS)	0	10	10 (n=1)
• Colorado private pay	0	12	5 (n=6)
• Non-Colorado	0	177	61 (n=5)
Length of stay in RCCF ²	1 day	2,325 days (76.5 mo.)	212 days (7.0 mo.)

¹ The mean number of residents by source is computed only on those RCCFs that had at least one resident from that source. For that reason, the exhibit shows the number of RCCFs on which the means are calculated.

² Average length of stay is calculated for all youth discharged during the facility's fiscal year. Ten RCCFs also reported a median length of stay (LOS); five reported a median LOS below 200 days and the other five reported a median LOS of more than 200 days.

The information about the services RCCFs offered and who provided those services is displayed in Exhibits 5 and 6. The availability of some services varied (Exhibit 5). Among evidence-based services, almost all responding RCCFs (90%) offered dialectical behavioral therapy although only 30 percent offered functional family therapy, multi-systemic therapy and applied behavior analysis. Similarly, among the specialized services, 50 percent or more of RCCFs offered animal-assisted and eye movement desensitization and reprocessing (EMDR) services, but less than 50 percent offered equine or wilderness/adventure services. All the RCCFs had on-site schools and more than a majority (58.3%) also offered attendance at off-site public schools.

All the facilities offered at least one of the post-discharge services listed in the survey, although no single service was offered by all the facilities. Nevertheless, although three facilities offered only 1 or 2 of the post-discharge services, seven facilities offered four or more of the services.

The post-discharge service offered by the most facilities (75.0%) was day treatment and the service offered by the least number of facilities was tracking for DYC youth (8.3%). Majorities offered transitional programs (58.3%), outpatient therapy (58.3%), home-based after care (58.3%), and community-based family services (50.0%).

**Exhibit 5: RCCF Service Provision
(Number and percent of RCCFs)¹**

Services	Frequency (n=)	Proportion (%)
<u>Evidence-based services</u>	(n=10)	(n=10)
• Applied Behavior Analysis	3	30.0%
• Aggression Replacement Training	4	40.0%
• Dialectical Behavioral Therapy	9	90.0%
• Functional Family Therapy	3	30.0%
• Multi-systemic Therapy	3	30.0%
• Positive Behavior Support	4	40.0%
• Other ²	2	20.0%
<u>Specialized services</u>	(n=12)	(n=12)
• Equine	5	41.7%
• Wilderness/adventure	4	33.3%
• Ropes course/experiential	3	25.0%
• Animal assisted	6	50.0%
• EMDR	7	58.3%
• Other ³	5	41.7%
<u>School facilities</u>	(n=12)	(n=12)
• On site	12	100.0%
• Off site (public school)	7	58.3%
• Off site (facility/agency other than public school)	2	16.7%
• Evidence-based curriculum	4	33.3%
• North central accreditation	5	41.7%
<u>Services provided after discharge</u>	(n=12)	(n=12)
• After school/evening program	—	—
• Foster care/therapeutic foster care	3	25.0%
• Transitional programs	7	58.3%
• Community-based family services	6	50.0%
• Day treatment	9	75.0%
• Respite care	3	25.0%
• Outpatient therapy	7	58.3%
• Home-based after care	7	58.3%
• Tracking for DYC youth	1	8.3%
• Other ⁴	2	16.7%

¹ Multiple response questions; thus, proportions will exceed 100 percent.

² Other: the only other evidence based service mentioned was cognitive behavioral therapy. One agency reported not providing any evidence-based services and one other agency did not answer the question.

³ Other: (1) dialectical behavioral therapy (n=3), (2) sex offender therapy, (3) specialized therapies (e.g., art, sand, family mirror).

⁴ Other: (1) free weekly individual or family therapy for 90 days post-discharge, (2) on-site school slots offered for placements that public schools want to make.

RCCFs used a combination of their own staff, contractors and volunteers to deliver the services they offer (Exhibit 6). Most of the services listed in the survey were provided primarily by RCCF staff. This included 100 percent of milieu therapy services and community activities and only somewhat less than that for family therapy (91.7% of RCCFs used their own staff to provide this service), community/restorative justice services (83.3%), educational groups (81.8%), individual therapy (75%), and recreational therapy (75%).

Exhibit 6: Services Available to Children/Youth in Participating RCCFs (Percent of Participating RCCFs) ¹					
Service Type	Who Provides Service? ²				
	RCCF staff	Contractor staff	Both RCCF & Contractor staff	Volunteers ²	Service not provided
Assessment (including psychological testing) (n=12)	25.0%	—	75.0%	—	—
Individual therapy/counseling (n=12)	75.0%	—	25.0%	—	—
Group therapy (e.g., offense-specific therapy, sexual safety, grief & loss, problem solving, substance abuse) (n=12)	66.7%	—	33.3%	66.7%	—
Family therapy (n=12)	91.7%	—	8.3%	—	—
Educational groups (e.g., teen parenting, smoking cessation, independent living skills, early childhood development) (n=11)	81.8%	—	18.2%	—	—
Psychiatric services and medication management (n=12)	33.3%	41.7%	25.0%	—	—
Expressive therapy (n=12)	58.3%	—	25.0%	8.3%	16.7%
Special services (physical, occupational, speech) (n=12)	—	58.3%	25.0%	—	16.7%
Recreational therapy (sports, yoga) (n=12)	75.0%	—	16.7%	—	8.3%
Vocational therapy (n=12)	41.7%	16.7%	25.0%	—	16.7%
Mentoring (n=12)	41.7%	8.3%	16.7%	66.7%	—
Community services/restorative justice services (n=12)	83.3%	8.3%	8.3%	—	—
Faith/spirituality services (n=12)	50.0%	8.3%	8.3%	66.7%	8.3%
Milieu therapy (n=12)	100.0%	—	—	—	—

Exhibit 6: Services Available to Children/Youth in Participating RCCFs
(Percent of Participating RCCFs)¹

Service Type	Who Provides Service ²				
	RCCF staff	Contractor staff	Both RCCF & Contractor staff	Volunteers ²	Service not provided
Services delivered in the client's home (n=11)	50.0%	—	27.3%	—	18.2%
Community activities (n=11)	100.0%	—	—	1.0%	—
Urinalysis (n=12)	58.3%	25.0%	16.7%	—	—

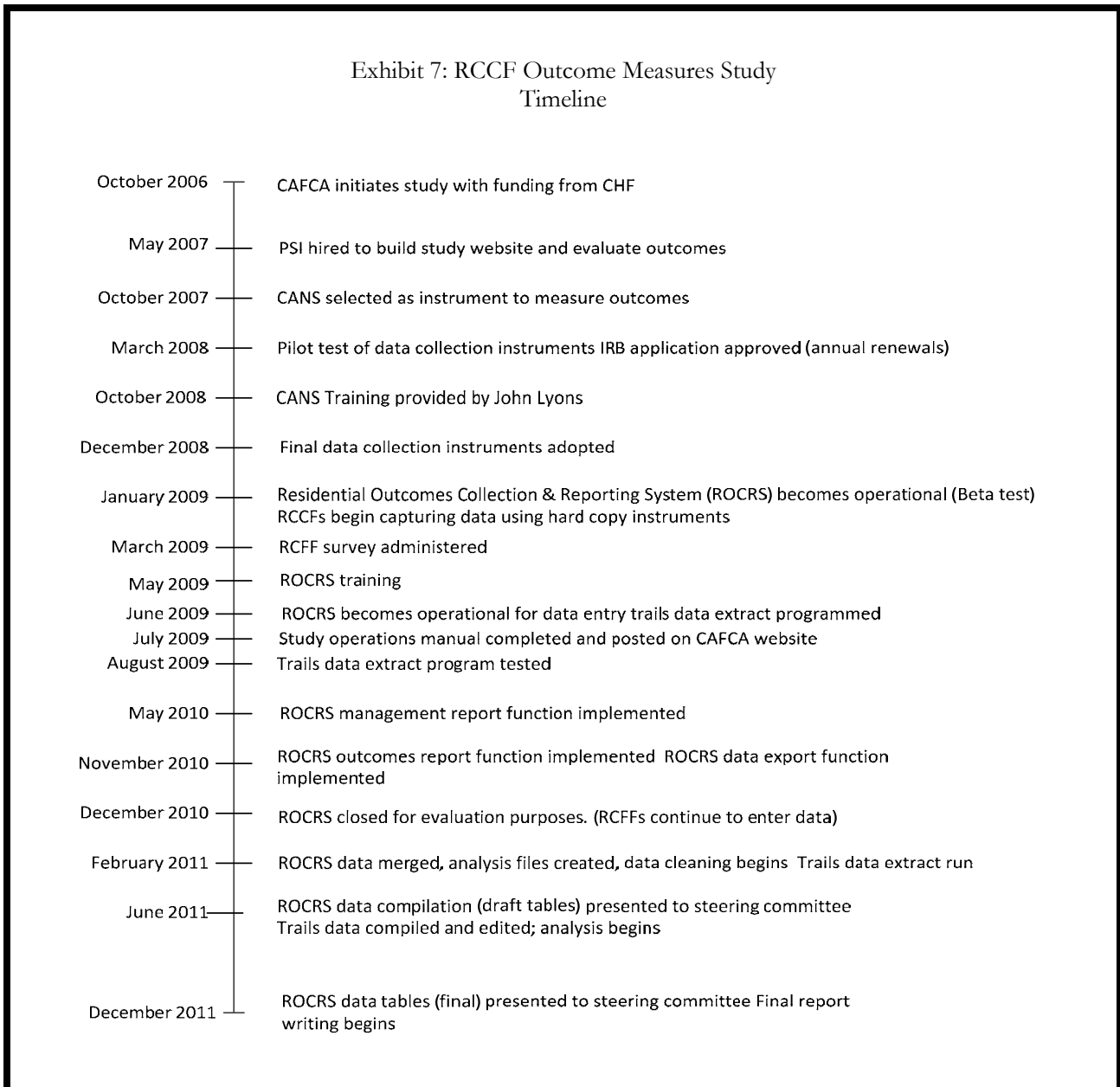
¹ Proportions read across the rows, but exclude the proportion of RCCFs that use volunteers.

² Many RCCFs supplement their service provision by using volunteers.

Several RCCFs used volunteers to supplement their service delivery, particularly for group therapy (66.7% of RCCFs use volunteers to supplement staff services), mentoring (66.7%) and faith/spirituality services (66.7%).

PROJECT APPROACH AND IMPLEMENTATION

The timeline of project activities is displayed in Exhibit 7 below.



The exhibit captures the major milestones in the project from project initiation to the final report writing and illustrates that the project proceeded through a series of linked stages. These stages included (1) instrument design, testing and training; (2) website design, training and implementation; (3) data collection; and (4) data extraction, compilation and analysis. Each of these major stages embraced other requirements. For example, since the study was dealing with confidential information about youth, it required approval from an Institutional Review Board (IRB) and agreements among the major partners with regard to sharing of and access to information. The study also required a set of protocols, which all participating RCCFs adopted, that specified the criteria for a youth's inclusion in the study, obtaining consent for inclusion in the study, who would administer the CANS assessment and key enter the data, and who would follow up with the youth after discharge. The committee deliberated on each of these issues.

Instrument Development

Instrument development was governed largely by the project steering committee. The inclusive nature of the project, involving diverse RCCFs as well as representation from other stakeholder groups (e.g., state, counties), along with the study's expressed interest in developing a set of instruments that could eventually be used by the state to measure outcomes in all out-of-home placements, resulted in a lengthy, deliberative development process. Thus, for example, the committee required about six months to select the outcomes measurement tool (CANS) after reviewing the strengths and weaknesses of multiple options. It took another ten months to refine the CANS tool for use in the study, design instruments to capture other valuable data (e.g., non-CANS information), test all the instruments, and provide training to the therapists who would be key entering the data to the study website.

ROCRS Website

Development of the study website to collect, manage, and report the data entered by each participating RCCF could not be completed until the data collection instruments were designed and tested. The developer was able to complete some features of the website (e.g., reserve the site, address access and security issues, develop different web pages to hold consent forms) while waiting for the development and design of the final instruments, but the majority of the design and development work required final forms. The resulting website is scalable, extensible and maintainable.

- **Scalable:** there is no limit to the number of RCCFs – or other out-of-home placement facilities – that could use the website as a data collection, management and reporting system. Each facility had access only to its own data and security protocols were designed into the system.
- **Extensible:** ROCRS is built in a modular fashion so that other functions (e.g., tracking, reporting, search routines) could be added to the site. Since ROCRS does not use off-the-shelf software, however, some programming would be needed to add functions.

- Maintainable: ROCRS is hosted by a third party that provides some limited maintenance of the site. During the study, the ROCRS administrator provided technical assistance to users, especially during the site's implementation period. The need for assistance grew less as users became familiar with the website's functions (e.g., consent forms, tracking basic child identity information such as the date of birth, Medicaid IDs); read the study protocols (e.g., key-entering and saving data on the study youth, when to complete different forms, when to follow up); learned to navigate the different web screens (e.g., different areas associated with admission, discharge and follow up); and learned to manage their facility's data (e.g., look for inconsistencies, duplicate entries, missing information).

Once ROCRS was operational, the website designer ran a series of training sessions for staff at the participating RCCFs who would be key entering data. These were train-the-trainer sessions so that as the RCCFs hired new staff, the website training could be completed in house by each agency using someone already trained on ROCRS.

Data Collection, Management and Reporting

Each participating RCCF key-entered and managed its own data. CAFCA provided a project coordinator who served as a liaison to the evaluators and the website designer. She assisted the RCCF administrators managing the study for their facility and attempted to resolve issues prior to escalating them to the website administrator. The website supported the RCCF staff in the data collection effort by designing easy-to-complete instruments, creating management and outcomes reports, and developing a data export function so that each facility could extract its information for analysis. Appendix B includes screen shots of the ROCRS website pages and the functions the website supported.

The CANS was the primary tool used to gather key information for the outcomes. The completion of the CANS forms required training to ensure consistency in how different staff were recording the information on the youth in placement. Dr. Lyons provided the initial training on the CANS instrument over two days to the clinicians who would be key entering the data. These staff were expected to train new staff hired by the facilities, although the study also made the CANS training available on line. We transferred the web-based training used by Illinois to a secure website at one of the participating RCCFs for the duration of the study and new clinicians completed their training and testing on that site. In addition, we created an operations manual for the study that CAFCA loaded to its website. That manual can be accessed at <http://www.cafca.net/outcome-study.html>. The facilities restricted data entry to those clinicians who had completed the training and became CANS certified.

A key feature of the data collection included following up with the youth several months – the study protocol required follow up at 4 and 12 months post discharge – after they were discharged from the RCCF. The RCCFs assumed responsibility for this data collection, but it proved to be time-consuming and difficult because clinicians did not always know how to contact the youth (or the parents) post-discharge to complete the follow-up survey and occasionally the youth/parents refused to complete the survey.

Data Extraction, Compilation and Analysis

Data extraction for analysis proved to be complex requiring us to merge multiple tables from each RCCF. The website designer provided an Entity Relationship Diagram (ERD) to facilitate the effort to create a single data analysis file. We exported the tables from the ROCRS website, merged the data into a single Excel file using SQL Server and then uploaded the data into SPSS, a statistical software package, for analysis.

In addition to the data RCCF staff entered into ROCRS, we also gathered information from Colorado Trails for those youth who were placed in care by Division of Child Welfare or the Division of Youth Corrections. The website designer developed a short extract of key information the state programming staff needed to match the study case in Trails and download the data. We merged the information from that download with the ROCRS data into our single data analysis file.

ORGANIZATION OF THE REPORT

In addition to this introduction, this report includes four chapters. Chapter II includes a detailed analysis of the instruments the Steering Committee selected and developed for this study. The main instrument we selected was the Child and Adolescent Needs and Strengths (CANS) scale, which we tailored somewhat to meet the study's needs. We also designed additional instruments to capture information not available on the CANS (e.g., prior placement history, child demographics, discharge reason and setting).

Chapter III presents a profile of youth at admission to the participating residential facilities. This includes some basic descriptive information, including:

- Demographic information about the youth (e.g., age, gender, ethnicity)
- Placement information (e.g., placing county and funding authority)
- Placement history (e.g., prior placement, delinquency status), and
- Information about the youths' caretakers.

Chapter III also presents a profile of the severity of the youth's issues at admission. This includes the diagnostic characteristics of the youth and their CANS scale scores. Finally, the chapter includes selected information about Colorado youth who were in the Colorado Trails system.

Chapter IV provides information about youths' outcomes. We measured outcomes by comparing CANS score at admission and discharge. For those youth with whom clinicians were able to complete follow-up interviews either at four or twelve months post-discharge, we were able to compare CANS scores for a longer period, from admission through the follow-up period. The chapter presents the outcomes data from three perspectives: (1) changes in domain scale scores from admission to discharge, (2) changes in the type and number of actionable items, and (3) reliable change, which compares the changes from admission to discharge against a Reliable Change Index.

The last chapter, Chapter V, summarizes and discusses the principal study findings and makes recommendations for ongoing outcomes measurement for youth in residential treatment and for expanding the application of the CANS instrument to other out-of-home placements.

CHAPTER II: STUDY INSTRUMENTS AND DATA COLLECTION

INTRODUCTION

The measurement of outcomes not only requires that you have a set of metrics and tools to assess those outcomes but that (1) you know the outcomes you want to achieve, (2) you are able to design and implement a set of service strategies and tactics to achieve those outcomes, and (3) you have baseline information about the population you are trying to serve.

Knowing the outcomes you want to achieve is an issue of what vision child and family-serving policy makers and practitioners have for the systems of care that exist to deliver services. A vision is a picture and a set of values that emphasize positive possibilities for the future. A vision is aspirational, yet achievable and describes a long-term future for Colorado's human services system. Arguably, policy makers and practitioners do have a vision for the system that meets these criteria. Furthermore, we believe that vision is shared among professionals in the child welfare, human services and health care systems.

The systems of care that have developed around that shared vision have been shaped by a number of factors, including (1) laws and statutes at the federal and state level that govern operations, (2) the expectations of stakeholders in the system, (3) findings from research into promising practices, (4) technological breakthroughs that have improved the kinds of services offered, (5) other trends in the industry (e.g., treatment modalities, higher costs of residential care) and (6) changes in the external context, such as economic and fiscal circumstances. These factors shaped the list of services the RCCFs in this outcome measures study offered to their residents.

A shared, common vision of success for youth placed in out-of-home care and a set of strategies and tactics for addressing the complex service needs of youth are important factors in achieving positive outcomes. But who are the youth in residential care? Are we placing youth appropriately based on their needs? This chapter describes the selection and design of the data collection instruments and the data collection tools, methods, and protocols the study used to address these questions.

SELECTING THE PRIMARY STUDY INSTRUMENT

The Steering Committee began the process of reviewing and selecting the primary instrument to document treatment outcomes in late Fall 2006. During the process, the committee decided on some key factors they wanted an outcomes instrument to include.

- The focus of the study and instrument should be on client as opposed to program outcomes;
- The selected instrument must have been accepted in the professional community for assessing youth with complex behavioral problems; and
- The instrument should be able to measure change over the average length of stay in residential care in Colorado, about three to nine months.

The committee seriously considered three instruments: (1) the Child and Adolescent Functional Assessment Scale (CAFAS), (2) the Child and Adolescent Needs and Strengths-Mental Health (CANS-MH), a version of the CANS that included additional mental health dimensions; and (3) the Child Behavior Checklist (CBCL).

Since clinical staff from participating RCCFs would be conducting the assessments of youth in their care, the Steering Committee used a strong collaborative approach to select the primary instrument, with PSI acting as a member of and consultant to the Steering Committee. During the selection period, which extended through October 2007, the committee gathered and considered information from several sources, including presentations by participating agency staff who were using the instruments, discussions with the instrument developers, scholarly articles that examined the strengths and weaknesses of the instruments, and evaluation studies that reported on the outcomes measured by the instruments.

Additional factors that emerged as key to the selection of the final instrument included:

- the breadth of child and family domains assessed;
- the inclusion of a strengths assessment;
- documented validity and reliability;
- the instrument's cost and whether permission was required to use it;
- staff resources needed to implement the assessment with fidelity, including training; and
- the usefulness or relevance of the instrument and reports to agencies beyond the duration of the study.

Ultimately, the committee selected the CANS-MH.⁹ Chief among the reasons for this selection included (1) its cost (free), (2) its ease of completion, (3) its treatment planning orientation that requires the clinician to identify problem areas that need action and strengths that need to be built, (4) its historical use in child welfare settings, (5) the fact that the training could be completed online by staff with a wide range of education and experience, and (6) the fact that customized content and database approaches were allowed and supported by the developer. While the concept of communimetric measurement was not discussed, this approach was a clear fit with the overall values and principles expressed by the Steering Committee.¹⁰

THE CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

Background

History and Development of the CANS. The CANS is a tool that serves dual critical purposes as: (1) a structured assessment of youth and their families by the service provider and (2) the foundation for creating a service plan based on actions providers need to take to reduce problems as well as use and build strengths. The CANS is, foremost, a communimetric measure, which is described by John Lyons as a tool that "...

⁹The CANS-MH is copyrighted by the Praed Foundation, 1999 (<http://praedfoundation.org>).

¹⁰Lyons, J.S. (2010) *Communimetrics, A Communication Theory of Measurement in Human Service Settings* (Springer Verlag).

represents a shared meaning and understanding of behavioral and functional assessment factors and constructs by providers and consumers with a direct path to service planning.”¹¹

The CANS evolved from early work in Illinois in 1995, which aimed to simplify provider judgments recorded in medical records in order to predict high intensity service needs. The initial goal of this work was to reduce statewide expenditures for expensive services by determining the best treatment and placement modality for the state’s youth in residential care. The tool developed for the project, the Childhood Severity of Psychiatric Illness (CSPI), yielded a reliable and valid method for recommending residential versus community placement. These placement decisions were supported by positive outcomes and proved to be a foundation for developing an easy-to-use, four-point measurement, reporting and service planning system.

With the introduction of a companion tool, the Child and Adolescent Strengths Assessment (CASA), in 2000, there grew a greater understanding of the need to measure strengths and to use this information in the development of individualized treatment planning. The first version of the CANS, which was implemented in Florida, was the result of integrating the CSPI with the strengths assessment.

Communimetrics. Two pivotal changes in the instrument occurred when the CANS was adapted for use in the Allegheny County, Pennsylvania system-of-care project. Both changes were a result of the system-of-care principle requiring that youth and families be full participants in all aspects of the planning and delivery of services. The first change was in the instrument’s language so that professionals and family members would have a shared understanding of the assessment and allow them to communicate effectively with each other about service needs and planning. The second change, related to the first change, was that the assessment levels were explicitly associated with action levels. This change helped parents and professionals gain a mutual understanding of what behaviors and strengths would be targeted by the service plan, particularly for youth who were being discharged from intense services. These two changes indicated a shift of the CANS to a communicative measure.

Dr. Lyons describes the principles of communimetrics as follows:

- Each item in the CANS has implications for differential action, with implications for planning services. In traditional psychometrically designed instruments, multiple items are combined to form scales with reliable internal consistency. Usually, individual items within these scales are not considered sufficiently reliable to use as measures or to suggest action.
- Levels of each item are immediately translatable into action. This allows service providers to set priorities in planning services.
- Measurement must remove the context of treatment provision. By removing the context – which includes the services already in place, culture and development – measurement can reflect the ongoing need for support and intervention. In many traditional assessments, the rating takes the current treatment and environment into account, often mediating the level of need.

¹¹ Ibid., page 94.

- Measurement is descriptive and minimizes cause–effect assumptions. This allows the “what” to inform the treatment plan and treatment priorities, with the “why” to come in later to inform the interventions.
- Observation windows can be superceded by the action levels. The assessment should reflect the need for action even if the observation occurs outside the usual window (i.e., 30 days).
- Information integrated from all available sources. This is a necessary part of the assessment and planning process.

CANS Rating and Measurement Approach. Though the inclusion of specific domains is customizable, the basic design of the CANS includes about 40 ratings in Problem Presentation, Risks, Functioning, Care Intensity and Organization, Family/Caregiver Needs and Strengths, and Child Strengths. Each rating asks the service provider to assess the level of need or strength of the dimension, with each level associated with a recommended action, as shown below in Exhibit 8.

Exhibit 8: CANS Ratings and Actions for Needs and Strengths			
Score	Ratings for Needs	Ratings for Strengths	Action
0	No Evidence	Centerpiece strength	<i>no need for action/ support strength</i>
1	Mild degree	Strength can be use in planning/treatment	<i>need for watchful waiting to see whether action is needed (i.e., flag it for later review to see if any circumstances change) or prevention planning/support and build strength</i>
2	Moderate degree ¹	Strength identified - potentially useful-must be built	<i>need for action/ build strength</i>
3	Severe or profound ¹	No strength identified	<i>need for either immediate or intensive action/ build strength</i>

¹ Items that are scored as a “2” or “3” are referred to as Actionable. Items that are scores as a “0” or “1” are non-Actionable with regard to treatment planning and intervention, even though they may be important.

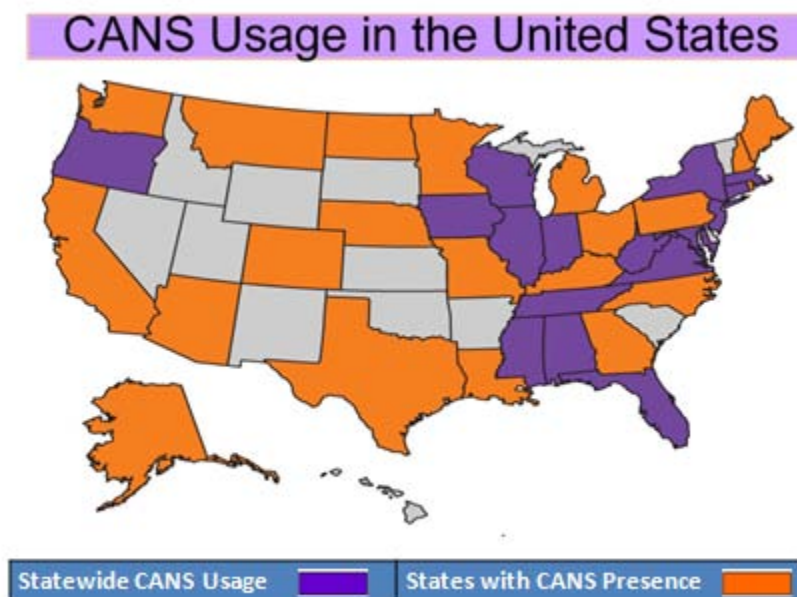
In addition to the core items, there are several Extension Modules (i.e., Trauma, Developmental Disabilities, Substance Abuse, Delinquency, Fire Setting, Runaway, Sexual Aggression, and Danger to Others) that are triggered when the core item receives an Actionable rating (i.e., “2” or “3”). Each module presents the rater with a set of more specific questions. A full discussion of the development of the CANS and the communimetric approach to measurement is available in Dr. Lyons’s 2010 book. A full discussion of Total

Clinical Outcomes Measurement (TCOM) of which the CANS is a primary component, is available in a 2004 article written by Dr. Lyons.¹²

Although there is no charge for using the CANS, individuals who use the tools must be trained and certified annually, as described later in this chapter.

Use of the CANS. The developmental process to design the CANS as an instrument that can be customized based on the needs of the system or community reflects the concept of incremental system change that has been found to be most effective for measuring change over time.¹³ As a result, communities have been able to stage implementation as local policies have demanded or allowed.

Various versions of the CANS are being used worldwide. In the United States, the CANS is used statewide by at least 16 states. An additional 22 states use the CANS in one or more jurisdictions within their states (Exhibit 9 below).¹⁴



¹²Lyons, J. S. (2004) “Redressing the Emperor: Improving our Children’s Public Mental Health Service System” (New York, NY: Praeger).

¹³Lyons (2010), op. cit., footnote 10.

¹⁴The 16 states that use the CANS are Alabama, Connecticut, Florida, Indiana, Illinois, Iowa, Maryland, Massachusetts, Tennessee, Virginia, West Virginia and Wisconsin. The 22 states where one of more jurisdictions use the CANS are Alaska, Arizona, California, Colorado, Delaware, Georgia, Kentucky, Louisiana, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, Texas, and Washington. The following link provides a map documenting current CANS use in the U.S. and Canada: <http://www.praedfoundation.org/Map/CANS%20Map.ppt.pps>.

The context and depth of CANS implementation varies from its use in single projects to a statewide Total Clinical Outcomes Management (TCOM) model. The populations for which the CANS is used also varies, including youth defined by an agency (e.g., child welfare, juvenile justice, mental health), by a treatment setting (e.g., residential), by specific diagnoses (e.g., autistic spectrum disorders, complex trauma), or by exposure (e.g., commercial sexual exploitation).

As mentioned earlier, the origins of the CANS lie in a successful Illinois project designed to determine whether youth in residential treatment in Illinois were placed appropriately. Work in this area continued with the development of algorithms that recommend the level of mental health services and placement setting for youth. The algorithms incorporate requirements for specific severity and action levels in multiple key domains for each level of treatment or placement. This approach differs, necessarily, from assessing youth after the onset of placement. Rather, youth are assessed prior to placement with the results used to inform treatment planning and placement. While the design of the current study precluded implementing this strategy as part of treatment planning, we applied the algorithms to the study youth as an exploratory effort toward understanding how a decision model might inform Colorado’s broader system of out-of-home placements.

Description of the Colorado CANS for Current Study

Starting with the CANS-MH, we worked with the Steering Committee and in collaboration with Dr. Lyons to finalize the needs and strengths dimensions the Colorado study would use. The nine core assessment dimensions and six extended modules of the Colorado CANS are listed below in Exhibit 10. The same CANS items were collected at admission, discharge, and at follow-up. The full instrument and accompanying manual are included in Appendix C.

Exhibit 10: Colorado CANS Core Needs and Strengths Dimensions and Extended Modules			
Core Dimensions	# of Items	Extended Modules ⁴	# of Items
Trauma Experiences ¹	13	Developmental Disability	7
Traumatic Stress Symptoms ¹	5	Substance Abuse	6
Life Domain Functioning	13	Violence & Resiliency	14
Acculturation	4	Sexually Abusive Behavior	12
Child Behavior/Emotional Needs	13	Runaway	8
Child Risk Behaviors	12	Juvenile Justice	12
Transition to Adulthood ²	8		
Child Strengths	10		

Exhibit 10: Colorado CANS Core Needs and Strengths Dimensions and Extended Modules			
Core Dimensions	# of Items	Extended Modules ⁴	# of Items
Caregiver Strengths ³	13		
Total Core Items	91		

¹ Trauma Experiences is usually included as an Extended Module. Owing to the frequency with which traumatic experiences are reported for this population, the Steering Committee elected to include this in the CANS Core.

² For youth who were 17 years or age or older.

³ For youth with an available caregiver.

⁴ Only completed if youth was scored as a “2” or “3” (i.e., Actionable) on a designated Core item.

In addition to the CANS items, we worked with the Steering Committee to develop three sets of non-CANS items that also were completed at admission, discharge, and follow-up. These items are described later in this chapter.

Outcomes using CANS data

While the CANS has many unique characteristics, it also demonstrates characteristics of more traditional psychometric tools, including face, construct, utility, and newly emerging documentation-of-decision validity, as well as reliability and internal consistency. These features allow for different strategies to be used to measure and assess outcomes, described briefly below and in more detail in Chapter IV where we present and discuss study outcomes.

- Change in Actionable items. As described earlier (Exhibit 8), each CANS item is scored from 0 to 3. Items scored as a “2” or “3” are categorized as Actionable. Items scored as a “0” or “1,” even though they may be important, are Non-actionable with regard to treatment planning and intervention.

Several measurement options are possible with this approach:

- ✓ Calculate the percentage of all youth for whom each item is Actionable at admission and discharge.
- ✓ Calculate the percentage of youth who move from Actionable to Non-actionable from admission to discharge.
- ✓ Calculate the percentage of items that are Actionable at admission and discharge within each domain.
- Change in CANS dimensions/scales. Combining items into scales allows us to profile and describe outcomes more succinctly. A common way to assess whether items can be combined into scales is to

calculate their internal consistency or how well the items function as a group or set.¹⁵ The nine dimensions of the Colorado CANS ranged from 0.69 to 0.95 on Cronbach's Alpha, adequate for comparing average scale scores at admission and discharge.

- We followed Dr. Lyons's recommended method to calculate CANS Scale Dimension Scales, which is to average the item ratings in a dimension and multiply by 10. The result is a scale ranging from 0 to 30. The scores are calculated so that lower scores indicate *fewer* problems and *more* strengths and higher scores indicate *more* problems and *fewer* strengths. The average scores at admission and discharge for all youth are compared to determine whether any differences are statistically significant.
- ✓ *Calculating a Reliable Change Index (RCI) for CANS Dimension Scales and the percentage of youth with reliable change.* Reliable Change measures change at the individual level and is considered by some professionals to be a more rigorous indicator of clinical change than statistically significant change for the group. Reliable change requires that the difference between the two measures, in this case admission and discharge, exceed the Reliable Change Index (which is calculated using the reliability, standard deviation, and standard error of the measure), indicating that the change is less likely to reflect the unreliability of the measure.^{16,17} We calculated an RCI for each scale. (Chapter IV includes the results of this calculation for youth served in the study.)

CANS Training and Certification

CANS users are usually required to attend specialized training and be certified. Training can be accomplished through a live or online session. Training is followed by a certification process that requires trainees to complete CANS assessments based on case studies. Several states have developed online utilities for training and certification.

Following the design of the Colorado CANS, the Steering Committee developed a training strategy for clinicians in participating RCCFs who would be completing the CANS instrument. With 17 participating agencies, including several with multiple residential sites, we knew that large numbers of clinical staff needed training and certification. Staff turnover, which can be high in human service agencies, particularly in residential settings, was a consideration as well. Thus, a staged training approach was designed. The initial training was provided in person by Dr. Lyons in Colorado. More than 100 direct service, supervisory, and administrative staff representing all provider agencies, as well as one of the evaluators attended the training.

¹⁵ Cronbach's Alpha is the most common statistic used to represent internal consistency or the extent to which items correlate with one another. Numbers vary between 0 and 1, with higher numbers indicating higher consistency. While there is no specific cut-off, many consider a Cronbach's Alpha of .070 or higher as adequate.

¹⁶ <http://www.psyc.org/stats/rcsc1.htm>

¹⁷ Jacobson, Neil S. and Paula Truax (1991) "Clinical Significance: A Statistical Approach to Defining Meaningful Change in Psychotherapy Research" in *Journal of Consulting and Psychology*, Vol 59. No 1:12-19 00224)06X/91 (American Psychological Association. Inc.).

http://www.personal.kent.edu/~dfresco/CRM_Readings/JCCP_Jacobson_ClinSIG.pdf.

The study used two strategies to meet the CANS long-term training needs: online instruction and in-person instruction at each RCCF facility. To facilitate the on-site training at each RCCF, an in-person Train-the-Trainer training was provided by Dr. Lyons. Again, all participating agencies were represented at the in-person training, ensuring that there would be ongoing availability of in-person training and support within each agency. To ensure the sustainability of access to training, however, online training and certification was needed. The resources to develop and manage a specialized site to support this function in Colorado were not available. However, the Illinois Department of Children and Family Services (IDCFS), which had created a training utility, graciously provided long-term access to Colorado providers. A drawback to this approach was that the online utility did not include training on the Extended Modules; thus, the agencies participating in the Colorado study provided the support and training for these components. Individual agencies were (and continue to be) responsible for ensuring that all CANS users receive approved training and are certified, including tracking the training and certification of their staff.

In collaboration with the Steering Committee, we prepared and distributed a Colorado CANS User Manual and print versions of all CANS forms to all participating agencies. The manual and forms are available on the CAFCA Outcomes Study Website (www.cafca.net/outcome-study.html).

NON-CANS ITEMS

It was important to provide youth and system-specific context for the CANS assessment. Thus, the data collection instrument included questions in the following areas.

At Admission

- The current placement, including the funding authority (i.e., funding source for placement), and expected length of stay in placement).
- Child welfare and delinquency involvement.
- Caregiver information, including with whom the child lives, adoption history, agreement with current treatment plan, expectations for the youth returning home, expected involvement in treatment and visiting, proximity and access to the treatment center.
- Placement history, including the number and types of placement, and runaway history.
- Mental health history, including suicide attempts, homicidal threats, psychiatric hospitalizations, DSM IV diagnosis and GAF, and psychometric medications prescribed.
- Juvenile justice history, including adjudications and types of crimes.

At Discharge

- Discharge conditions, including the reason for discharge, whether it was against the recommendation of the provider, and the discharge setting or discharge placement.
- The percent of youth and/or family treatment goals were met.
- The amount of services provided in each of almost 20 service areas.

- Caregiver participation in treatment.
- Overnight hospitalizations and runs.
- Suicide attempts and homicidal threats.
- DSM IV diagnosis and GAF, psychotropic medications prescribed.
- Criminal activity (new charges).
- Recommended post-discharge services.

At Follow-up (4 and/or 12 months after discharge)

- Setting/placement in which the youth lives.
- Out-of-home placements/settings since discharge.
- Amount of services received since discharge.
- Other services that would have been helpful.
- Overnight hospitalizations and runs.
- Suicide attempts and homicidal threats.
- Use of illegal drugs.
- Psychotropic medications prescribed.
- Criminal activity (new charges).
- Employment.
- Unplanned parenthood.

As for the CANS items, we prepared and distributed a User Manual and print versions of all non-CANS forms to the participating agencies. The manual and forms are available on the CAFCA Outcomes Study Website (www.cafca.net/outcome-study.html).

Trails Data

An important enhancement to the information gathering described above, which was conducted by residential providers, was the incorporation of youth-specific information from the Colorado Department of Human Services' Trails Database. Access to the Trails information first required executing formal business and HIPAA agreements with the state. It then required the evaluators to develop specific instructions for what Trails variables the study would capture and the criteria for data capture, and Trails programmers to design the data abstract. The final data extract provided information in the following areas for the period of one year prior to each youth's entry into the study's residential agency and for one year after the youth's discharge from the study residential agency, if the youth qualified (i.e., where the youth's discharge from the study agency had occurred at least 12 months prior to the study end date).

Division of Child Welfare (DCW)

- Socio-demographic data, including custody and adoption history;
- Disabilities;
- Placement history, including the number and types of placements and the number of days in those placements;
- Last/most recent placement information, including the type of placement, length of stay, and reason for discharge;
- Removal manner and conditions;
- Permanency goal(s); and
- Most recent Colorado Client Assessment Record (CCAR).

Division of Youth Corrections (DYC)

- Socio-demographic data;
- Placement history, including the number and types of placements, number of days in placement, and escapes;
- Colorado Juvenile Risk Assessment (CJRA) data; and
- Most recent CCAR.

DATA COLLECTION

PSI subcontracted with a database developer to design and build an online data collection system – the Residential Outcomes Collection Reporting System (ROCRS) – to capture the CANS and non-CANS items described above. The design and implementation of the database was an extensive process that started immediately after the Steering Committee selected the outcome instrument and included all the data collection forms. The website design process, which continued for more than a year, was collaborative and included opportunities for the evaluators and Steering Committee to review and add items and pilot test the system’s interfaces and functionality. Despite ongoing challenges that require improvements for long-term efficient functionality, the system served the study purposes and is described below.

The Residential Outcomes Collection Reporting System (ROCRS)



(The ROCRS website banner)

Several factors were important to consider in the design of a data collection strategy, including

- Access for 17 agencies with multiple locations and teams;
- Security and confidentiality;
- Ease of use; and
- Local/onsite access to data.

The ROCRS online website includes several key features – Administrative and Security, Consent, Client Search, Information and Assessment Forms, Reporting, Export, and Support – that we describe below. The website developer delivered group and individual training on the features and use of the website to participating agencies. (Screen shots of the ROCRS web pages are attached in Appendix B.)

The data from the Colorado Trails system were not captured directly on or recorded in ROCRS, but were gathered outside of ROCRS. Thus, the ROCRS website designer created a data extract file of youths' episodes of care that met certain criteria (e.g., child's name, date of birth, Medicaid or Trails ID number) and we sent that file to the state. The state matched the file against Trails records based on the program they developed specifically for the outcomes study. The state sent the matched file to the evaluators and they merged the data with the ROCRS data as part of their final analysis.¹⁸

Administrative and Security

The Administrative module allows the Study Administrator from each participating agency to create and delete user accounts for users at their site, including security levels. This module also allows each site to post site-specific messages to their users that appear when users log into the system. No agency has access to information from any other agency using the system.

¹⁸ It is important to note that the evaluators had no ability to verify the accuracy of the Trails data. They had taken care in their collaboration with state staff to select variables that the staff considered complete and reliable. However, they had no means of returning to Trails to check for missing information or other gaps in the data Trails returned to them.

Consent

Consent captured whether the caregiver consented to participate in the study, including allowing access to Trails data (and the reason for not giving consent, if applicable). Each agency was responsible for determining how to obtain consent from caregivers (or youth if the youth was of age). As the evaluator, PSI worked with an Institutional Review Board (IRB) to ensure that the study complied with all federal and state requirements for this type of study. IRB approval for the study was facilitated by the fact that the study was not testing any experimental approaches to treatment and we did not have direct access to information participating agencies collected on the youth at their facility. This was always a retrospective study of data captured by the agencies on youth in their care.

Child Search, Information, and Assessment Forms

The data collection section of the ROCRS website consists of four components:

- Search for a Child: This utility allows users to search the database on several possible keys to determine if the child has been recorded in the ROCRS database for that agency. At this time, ROCRS is an episode-oriented system where each episode is treated as a separate entry or record in the system. Owing to complex confidentiality and programming issues, it is not possible to identify youth with multiple admissions to multiple agencies except with the exported data.
- Child Information Record: This utility captures information about youth that will usually not change, including the youth's Trails and Medicaid ID numbers, gender, date of birth, race/ethnicity and Hispanic heritage.
- Admission, Discharge and Follow-up Forms: This utility contains the non-CANS items described earlier in this chapter.
- CANS Admission, Discharge, and Follow-up Forms: All of these forms are identical so that a youth's outcomes in placement can be tracked over time.

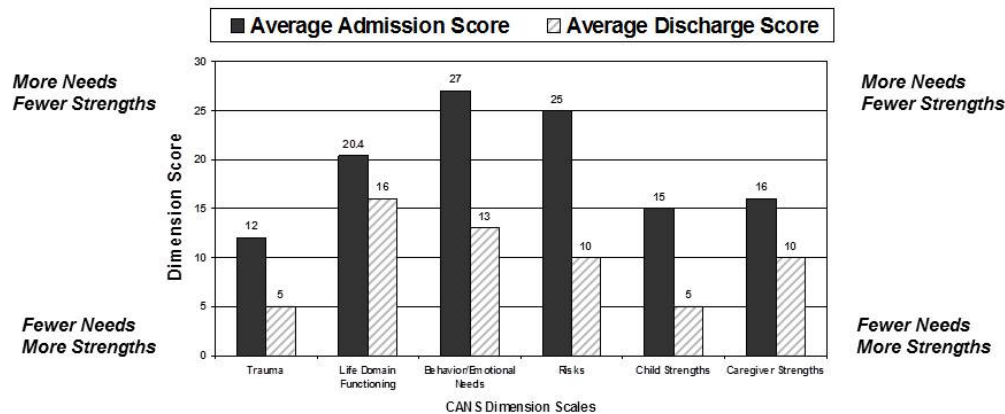
Reports

- Client-Level Reports: ROCRS users can print hard copies of a youth's individual assessments at all time periods from the Forms pages. Reports for individual youth are only accessible to authorized staff from the agency where the youth was placed.
- Monitoring and Tracking Reports: These reports allow agency-level study administrators to manage the data collection at their agency. They can track data entry at the agency and client levels to determine whether necessary forms have been completed in a timely manner. One of the reports is an error report that identifies, for example, potential duplicate data forms for youth (e.g., multiple CANS forms for the same youth), errors in data entry (e.g., name misspellings), incomplete information (e.g., a CANS form was not saved as complete), and mismatched or missing identification numbers.

- The Outcomes Report: This report displays (1) the number of episodes with discharge forms saved, (2) selected aggregate demographic and program information (e.g., average length of stay in placement), and (3) the average CANS scale scores at admission and discharge displayed as a PowerPoint Chart. A sample is provided in Exhibit 11 below.

Exhibit 11: RCCF Outcomes Study Report Sample
Report Type: Aggregate Average CANS Dimensions – Scale Scores at Admission and Discharge

[selection criteria]
 Average Scores range from 0 to 30, with higher numbers indicating more problem severity and fewer strengths



Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that goes from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths (0 or 1 on individual items. Lyons, JS (2009) *Communitometrics. A communication theory of measurement for human services*. New York: Springer.

Export

The export utility allows agency-designated users to export client-level data for youth in their agency only. The files are exported by data module and must be merged with SQL Server or a similar database utility using a key that links the modules to one another (e.g., generally the client ID or form number).

Support

The final module provides a form users can complete and submit on-line to request support for access or functionality issues (e.g., trouble shooting, system outages, access problems, password resets).

Data Collection Protocols

The study's data collection periods included admission (to the study RCCF), discharge (from the study RCCF), and four and twelve months after discharge from the study RCCF. The CANS and non-CANS items

were collected by clinicians and case managers at admission and discharge. Agency staff also were expected to attempt to contact caregivers at four and twelve months after discharge from the study setting. Non-CANS items were to be completed at both follow-up periods, but if the CANS was completed at four months, its completion at twelve months was optional.

The evaluators and Steering Committee members developed study protocols, policies, and guidelines. Some policies were standardized across agencies (e.g., when a case could be deleted, whether a break in an episode of care required the agency's staff to complete a new admission form). Other policies could be customized by the participating agencies (e.g., who at the agency would complete various modules on the forms, who would complete follow-up surveys post discharge). It is beyond the scope of this report to detail all the policies the Steering Committee developed, but they include policies in the following areas:

- Consent requirements and documentation;
- Administrative protocols for opening cases and determining who was responsible for completing study forms;
- Ensuring that staff had appropriate CANS and ROCRS website training, and tracking that the training had occurred;
- Time windows for data collection for Admission, Discharge and Post-Discharge Follow-up;
- Data collection protocols for four- and twelve-month post-discharge, including who would attempt to contact the caregiver and how the interview would be conducted to enable completion of the CANS and non-CANS items;
- Assignments, instructions, and monitoring for four- and twelve-month follow-up data collection, including documenting how many attempts were made and the result of those attempts; and
- Overall study tracking and monitoring procedures.

DATA CAPTURE AND AVAILABILITY

The primary source of information for this study was the Residential Outcomes Collection and Reporting System (ROCRS). As described above, ROCRS is the website designed to capture the same data on RCCF youth from all participating facilities. The protocol for data collection in ROCRS specified the points in time when therapists should capture information. This included (1) at admission for non-CANS data and within 30 days of admission for the CANS assessment, (2) at discharge for both the CANS and non-CANS data, and (3) at two points in time – 4 months and 12 months – post-discharge. Capturing information on youth while they were in treatment at the RCCF was a common practice for RCCF staff. Capturing information post-discharge, however, was implemented with varying degrees of success among the providers and was complicated by (1) youth not being eligible for follow-up by the end of the study period, (2) a lack of contact information for and contact with the youth after discharge, (3) limited staff time and resources to follow up, and (4) possible non-cooperation from the youth, the youth's caretakers or the youth's new treatment

providers in completing the somewhat lengthy data collection. Hence, the relative paucity of information at both follow-up periods.

The study's data collection plan also included capturing historical data from Colorado's statewide automated child welfare information system, Trails, at two points in time: for the twelve months prior to the youth's admission to one of the study's participating RCCFs and twelve months after the youth's discharge from the RCCF. The purpose of the twelve-month, pre-admission data collection was to understand better the youth's prior placement experiences and the psychological disorders that led to their placement in a study RCCF. The purpose of collecting data post-discharge was to learn whether the treatment offered by the RCCF and the progress made by the youth in treatment had any lasting, positive effect on the youth through subsequent placements in lower levels of care and a higher level of global functioning.

The Trails data were collected retrospectively based on a match of the RCCF youth with valid identifying information and Colorado Trails. The match required that the youth have a Colorado Trails ID or a Medicaid ID. Those youth in the study who were placed privately or placed by out-of-state agencies had no Trails record and the analysis of their outcomes relies solely on the youth's treatment experiences at the RCCF and any post-discharge information the RCCF captured at the two follow-up periods, four and twelve months post-discharge. Also, Trails was not able to conduct a match for some eligible Colorado youth because the Trails and/or Medicaid IDs were missing or entered incorrectly by the RCCF. For example, although we have admission data for 1,207 youth, we have twelve-month pre-admission Trails information only for 734 of those youth, 59.9 percent of all youth in the study (Exhibit 12).

Exhibit 12: Summary of Data Availability by Data Collection Period and Data Source

Data Collection Period	Data Source	Number of Cases for Analysis ¹
12 months pre-admission	Colorado Trails	n=734
<u>Admission</u> Child demographics Non-CANS data Adequate CANS data	ROCRS	n=1,225 n=1,207 ² n=1,207
<u>Discharge</u> Non-CANS data Adequate CANS data	ROCRS	n=467 ² n=467
<u>Post-discharge</u> 4-month post-discharge follow-up 12-month post-discharge follow-up 12-months post-discharge	ROCRS ROCRS Colorado Trails	n=74 ³ n=11 ³ n=164

¹ For the purposes of the study, a case was defined as an episode of care at one of the participating RCCFs. A single youth could have multiple episodes of care in one or more of the RCCFs over the course of the two-year data collection period (1/1/2009 through 12/31/2010).

² At both admission and discharge the study had more non-CANS data than it did CANS data on study cases. The study evaluators made a conscious decision during the data merging and editing process to limit the analysis to those cases that had a complete set of CANS and no-CANS data.

³ RCCF staff were responsible for administering the follow-up surveys of youth after their discharge from the RCCF. This often was difficult and time consuming. Furthermore, since it was an additional responsibility and may have taken time away from service delivery to current residents, it was a lower priority function that frequently did not get completed. Hence the smaller number of cases for which follow-up data are available.

In the final analysis, the study collected data on youth for 1,225 episodes of care at the participating RCCFs. Of this number, there was complete admission data – both CANS and non-CANS data – for youth in 1,207 episodes of care. These are the data used to develop the profile of youth at admission (Chapter III), including information about their demographics (e.g., age at admission), their backgrounds (e.g., prior placement history), the nature of their disorders (e.g., Axis I and II disorders), their level of functioning (e.g., GAF scores), and the severity of their presenting problems (i.e., CANS variables).

There are many fewer cases (n=467 or 38.7% of the cases with admission data) with complete discharge data (i.e., completed CANS and non-CANS data). Most of the difference in these numbers is explained by the fact that many youth were not yet discharged from the RCCF and thus no discharge forms were completed at the time data collection ended (12/31/10). We did exclude ten cases with discharge information from our analysis either because the discharge information was not complete or there were no corresponding completed admission forms for the cases. A condition for the analysis of outcomes was that youth have both admission and discharge forms.

As Exhibit 12 shows, the study completed forms for 85 cases at the four-month follow-up period and for 11 cases at the twelve-month follow-up period. These are not cumulative, since we have follow-up information at both time periods for a few cases. Thus, on an unduplicated basis, we have follow-up information at one or both points in time for 92 cases, 19.7 percent of all the cases that were discharged during the data collection period. We have somewhat more information from Colorado Trails; 35.1 percent of youth had a match in Trails and had been discharged at least 12 months before the end of the data collection period. These data form the basis for the analyses in the subsequent chapters of this report.

CHAPTER III: PROFILE OF YOUTH AT ADMISSION

INTRODUCTION

This chapter presents information to profile the youth who were placed in participating RCCFs during the 24-month study period from January 1, 2009 through December 31, 2010. The data come from two sources. The first includes data RCCFs entered on the youth admitted to their facilities extracted from the Residential Outcomes Collection and Reporting System (ROCRS) website developed specifically for this study. The second includes historical data for the 12 months prior to that admission extracted from the Colorado's Trails database.¹⁹ To our knowledge, this is the first effort to develop a profile of youth in residential care that captures both a broad range of demographic and clinical information.

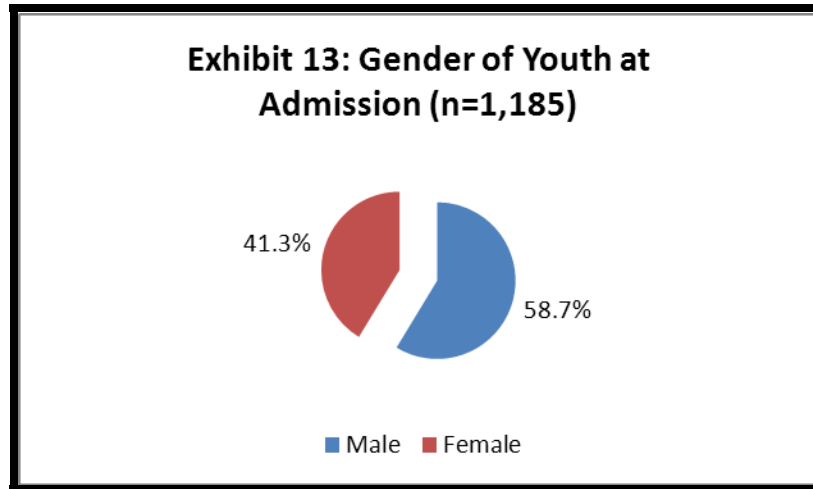
The ROCRS website is designed in modules. One module captures information about youth that will not change, such as the youth's gender, date of birth, race/ethnicity and Hispanic heritage. Other modules gather information that is less permanent, such as the source of funding for the placement, the expected length of stay in residential care, and the severity of the youth's medical and mental health issues at the time of admission. ROCRS contains a wealth of information, not all of which can be presented in this chapter. Thus, we have attached a more comprehensive set of data tables in Appendix D to this report. They present the data from four different perspectives; specifically by (1) gender, (2) age at admission, (3) status of parental rights at admission, and (4) the funding authority.

DEMOGRAPHIC INFORMATION

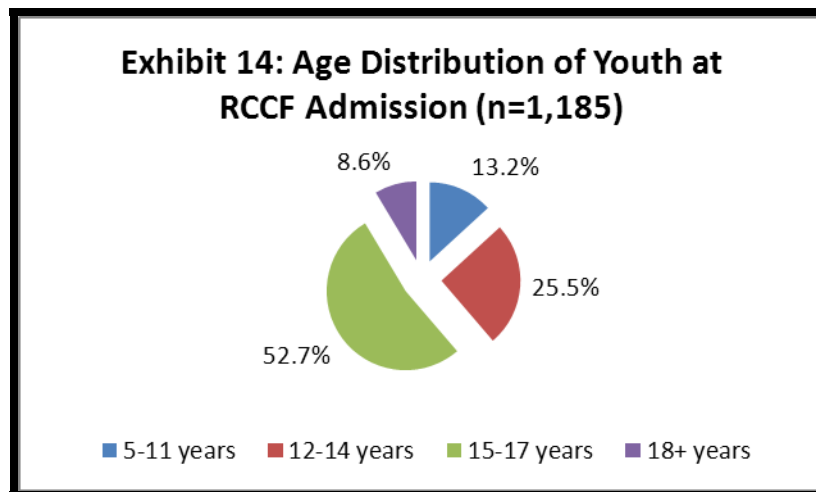
RCCF staff used the data collection instruments and system (ROCRS) to capture and key enter a small amount of basic demographic data on the youth in their care. This included the youth's gender, date of birth and ethnicity, and initial placement information, such as the source of funding, the immediate prior placement and the expected length of stay in residential care. The background information on the youth's gender, age and race/ethnicity in addition to the status of the biological parents' rights are displayed in Exhibits 13, 14, 15, and 16 respectively. The exhibits show that for the RCCFs and the time period of this study the youth placed in care were more likely to be:

- Male than female (Exhibit 13). Males represented 58.7 percent of the study admissions and females represented 41.3 percent. Females were somewhat more likely than males to be represented in the higher age ranges, particularly in the 15-17 year age group. There were no significant differences between the genders in their race/ethnic backgrounds or in the presence of a dependency/neglect charge at admission.

¹⁹Trails is Colorado's state automated child welfare information system (SACWIS). Using the youth's name, date of birth, and Medicaid and/or Trails ID numbers (if available), state programming staff matched RCCF youth in ROCRS with historical and follow-up data in the Trails system and sent a data extract with information on the matched cases.

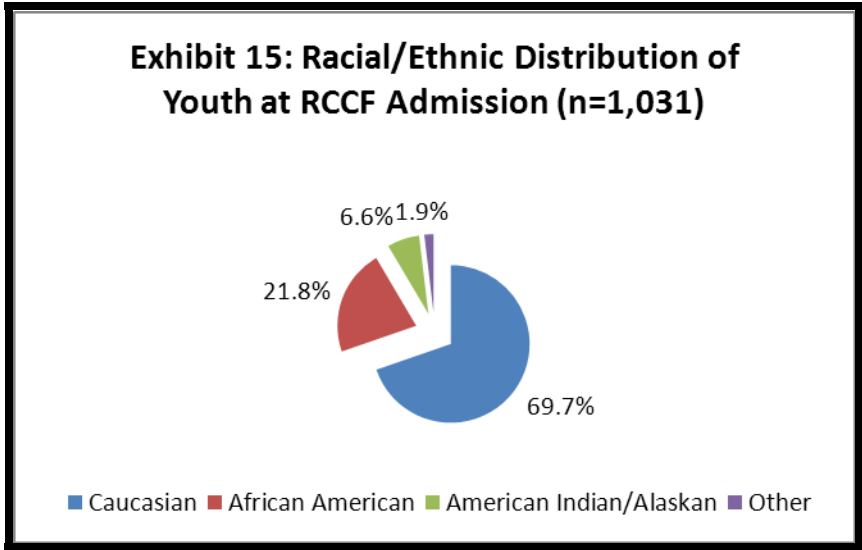


- Older than younger (Exhibit 14): the majority of youth were in the 15-17 year age group (52.7%), another quarter (25/5%) were between the ages of 12-14 years, 13.2 percent were between the ages of 5-11 years and there was a small group (8.6%) that were 18 years or age or older. The average age of all youth in the study was 15.3 years. The average age of males at admission was 15.6 years and the average age of females at admission was 14.7 years. There was not a statistically significant difference between the genders in their average age at admission.



- Caucasian than any other race/ethnicity (Exhibit 15): More than two-thirds of the admitted youth (69.7%) were Caucasian. The only other racial group prominently represented was African American at 21.8 percent of the admitted youth. Other groups (e.g., Asians, Native Americans) had very low representation in the study.

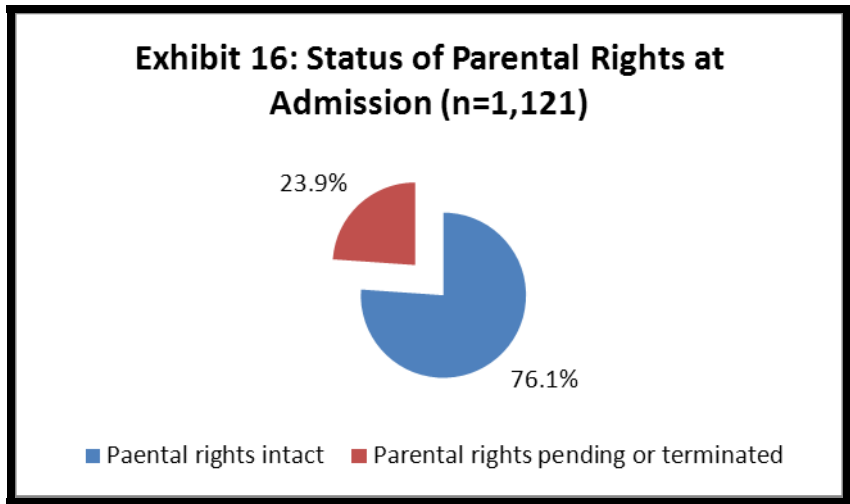
Exhibit 15: Racial/Ethnic Distribution of Youth at RCCF Admission (n=1,031)



In a separate question, the admission form gathered information about the youth’s Hispanic background since that status could apply to any racial or ethnic group. About a third of the admitted youth (32.8%) were of Hispanic origin. Of these Hispanics, 71.1 percent were recorded on ROCRS by the therapist as Caucasian, 12.9 percent were recorded as American Indian or Alaskan Natives, 12.0 percent were recorded as African American, and the remaining 4.0 percent were recorded as Asian or Pacific Islander.

- Parental rights (Exhibit 16):** Youth whose caretakers had intact parental rights represented more than three-fourths of the admissions (76.1%) while the remaining youth had caretakers whose parental rights were pending or terminated (23.9%).

Exhibit 16: Status of Parental Rights at Admission (n=1,121)



YOUTH PLACEMENT INFORMATION

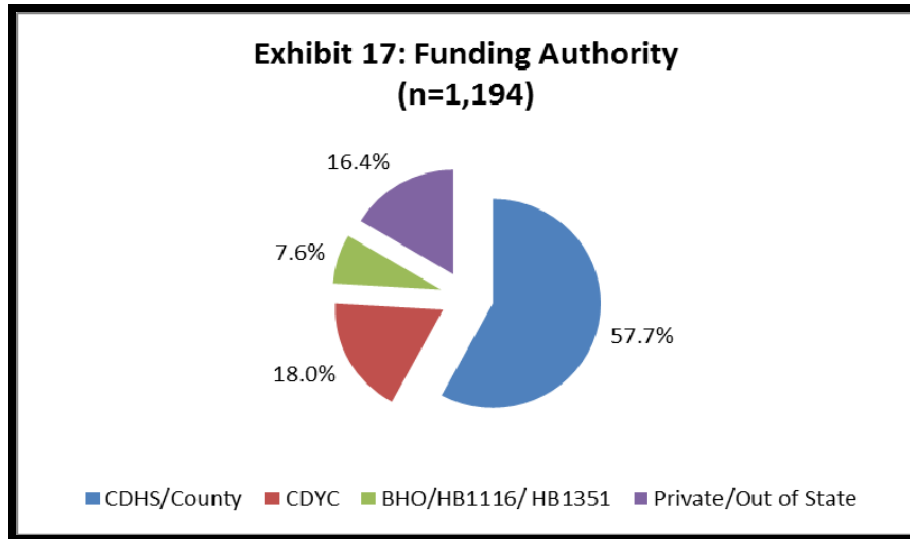
The RCCFs captured a range of placement and historical information for the youth they admitted. This information included prior placement history (e.g., whether and where the youth had been in out-of-home placement prior to admission to this RCCF and the number of those placements), the number of runs from home and from other facilities, the number of homicidal threats, and the number of past admissions to psychiatric hospitals. The facilities also recorded the funding authority (i.e., the source of funding for the placement), the referral source (e.g., Colorado county that referred the youth, out-of-state) and the youth's expected length of stay in the current placement.

Funding Authority and Source, and Length of Stay

As shown in Exhibit 17, the funding source for the placement of the majority of youth (57.7%) was the Colorado State Department of Human Services (CDHS) or individual counties' Departments of Human Services. The second most-frequently recorded funding authority was the Colorado Division of Youth Corrections (DYC), which was responsible for 18.0 percent of the placements. Private pay placements (i.e., those not funded by governmental agencies) and placements made by agencies/individuals from other states accounted for 16.4 percent of the admissions. Finally, 7.6 percent of placements were through other funding sources, primarily the Office of Behavioral Health within the Colorado Department of Human Services Behavioral Health Organizations (BHOs) and through The Child Mental Health Treatment Act.²⁰

Generally, the younger the youth's age at admission, the more likely that DHS was the funding authority. By contrast, DYC was the funding authority for more than three-fourths of youth in the oldest age group (i.e., 77.2% of those youth ages 18 years and older).

²⁰The Child Mental Health Treatment Act provides access to residential treatment for children with significant mental health needs, regardless of whether they are covered by Medicaid. Children can access residential care without the involvement of Social Services or the court system. Further information is available in the Handbook on HB1116 located at <http://aclboulder.org/cmsAdmin/uploads/Child-Mental-Health-Act.pdf>.



Of the 698 placements made by counties, 45 of Colorado’s 64 counties (70.3%) were represented in this study. The distribution of placements by county and the county’s relative rank in terms of its 2010 population are shown in Exhibit 18 below. As evident in the exhibit, the greatest number of placements also were from the most populous counties in the state, with one exception. The county with the eighth most study placements was only the 19th most populous Colorado county based on 2010 U.S. census figures. Taken together the ten counties with the most placements accounted for 82.1 percent of all study placements. This is comparable to the counties’ proportion of the total Colorado population (78.2%).

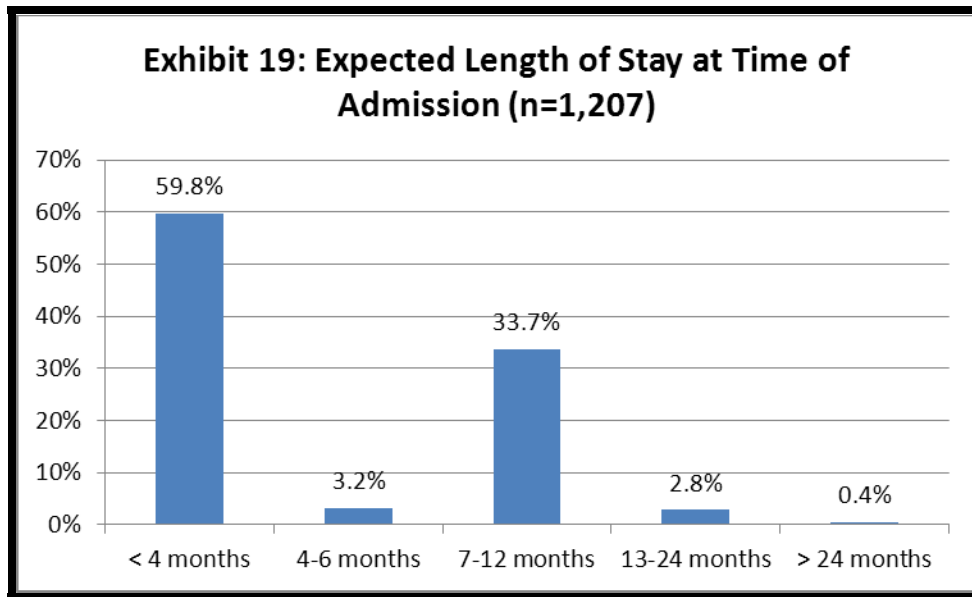
Exhibit 18: Top Ten Placing Colorado Counties (Number and % of Study Admissions to Participating RCCFs)			
County	Number of RCCF Study Admissions	Percent of all Admissions	County’s 2010 Population Rank
Denver County	n = 109	15.6%	2
Adams County	n = 105	15.0%	5
El Paso County	n = 89	12.8%	1
Arapahoe County	n = 75	10.7%	3
Jefferson County	n = 55	7.9%	4
Weld County	n = 41	5.9%	9
Douglas County	n = 36	5.2%	8

Exhibit 18: Top Ten Placing Colorado Counties (Number and % of Study Admissions to Participating RCCFs)			
County	Number of RCCF Study Admissions	Percent of all Admissions	County's 2010 Population Rank
Morgan County	n = 27	3.9%	19
Larimer County	n = 20	2.9%	6
Boulder County	n = 16	2.3%	7
TOTAL	n = 573	82.1%	—

A youth's expected length of stay at an RCCF is subject to many factors, some of which are related to the youth's need for care. Another important factor is the cost of care and what funds the funding authority has to support the placement. Nevertheless, the length of stay can be a useful indicator of the severity of the youth's problems and the time the RCCF estimates it will need to address those problems successfully. The length of stay is important from an outcomes measurement perspective for this study. That is, John Lyons, the author of the CANS tool, suggests that although the CANS can be used regardless of how long the youth has been in placement, outcomes are better measured if the time in placement is three months or more.

As shown in Exhibit 19 below, the majority of RCCF placements (59.8%) were expected to be relatively short (i.e. less than four months) and only 3.2 percent were expected to be longer than one year. The average expected length of stay for all placements was 213 days (about seven months). As the youth's age at admission increased, the expected length of stay at the RCCF also increased.

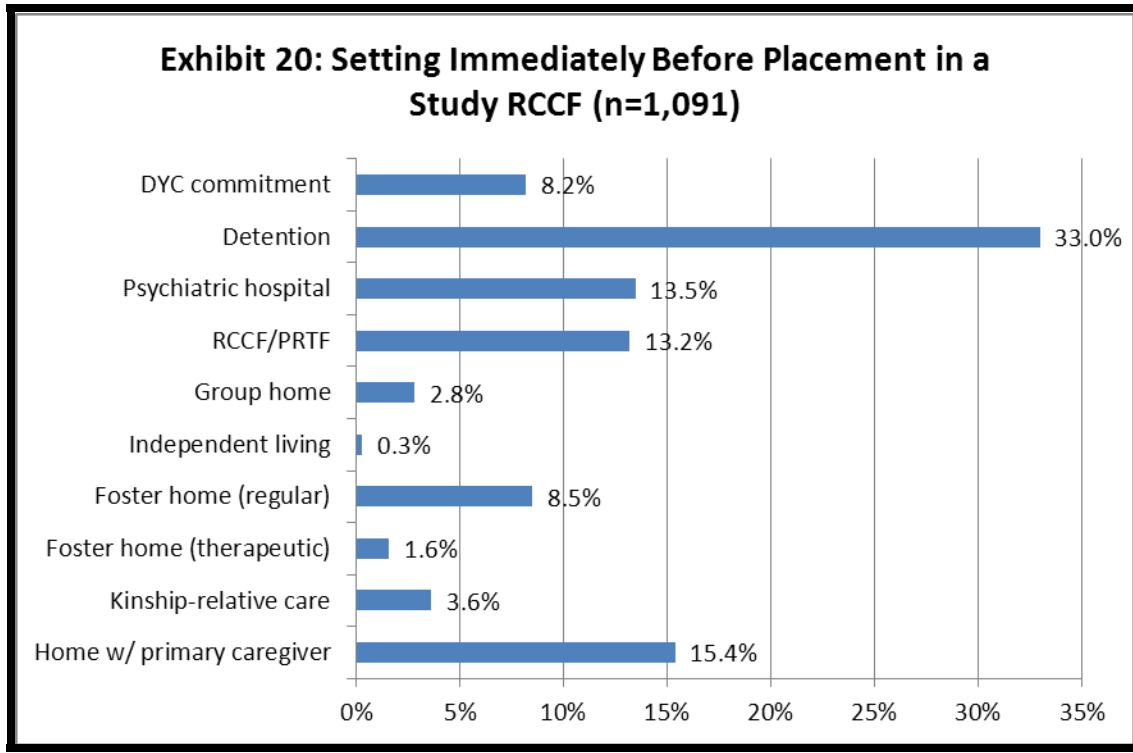
As discussed later in this report (Chapter IV), the length of stay for those youth with both admission and discharge dates was somewhat less than this average (5.8 months) and 27.8 percent of the discharged youth were in placement less than three months.



Placement History

At admission, close to three-fourths of youth (71.6%) had a prior history of out-of-home placements. Immediately prior to their admission to the RCCF participating in this study, the youth had been referred from a wide range of environments, both less and more restrictive than the RCCF that accepted them (Exhibit 20). Thus, for example, more than half the youth (54.7%) had been referred from a more restrictive placement (i.e., 33.0% from detention, 13.5% from a psychiatric hospital, and 8.2% from the Division of Youth Corrections). About 13.2 percent of the youth had been referred from another RCCF or a PRTF and the remaining third of youth (32.3%) had been referred either from less restrictive placements such as a group home or regular foster care (16.8%) or from the home of their primary caregiver (15.4%).

The youth's immediate prior placement was related to the youth's age at admission to the RCCF. The oldest group (i.e., those 18 years of age and older) were more likely than youth in other age groups to have been referred from a DYC commitment, detention or another RCCF. By contrast, youth in the youngest age group (i.e., 5-11 years) were more likely than youth in other age groups to have been referred from home with a primary caregiver, a regular foster home, or from a psychiatric hospital.

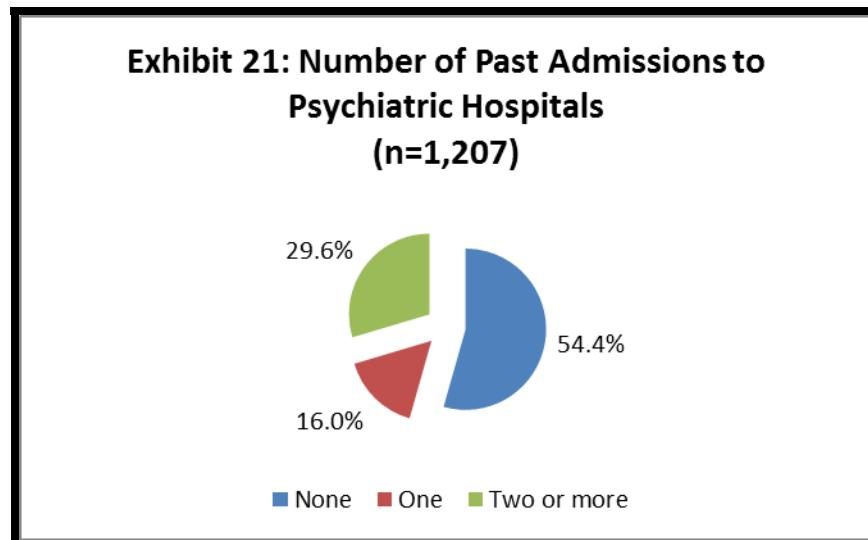


While the immediate prior placement – in terms of whether it was more or less restrictive than the study RCCF placement – had no correlation with the youth’s age at the time of admission, it was related to the number of the youth’s prior placements and to the expected length of stay at the RCCF. That is, youth who came from a less restrictive placement (e.g., home with a primary caretaker, group home) had significantly fewer prior out-of-home placements than did youth from more restrictive settings (e.g., DYC, psychiatric hospital). Similarly, youth from less restrictive settings had a significantly shorter expected length of stay at the RCCF than did youth from more restrictive settings. These relationships could result from a number of different factors, which while beyond the scope of this study could be explored as part of additional research.

Beyond the immediate prior placement, many of the youth had a history of out-of-home placements involving past runs (29.1% of youth had one or more runs from a facility and 37.6% had past runs from home) and/or past admissions to a psychiatric hospital (45.6% of youth had prior admissions to a psychiatric hospital). This history was significantly more frequent among females than among males and trended upward for both males and females as the youth’s age increased.

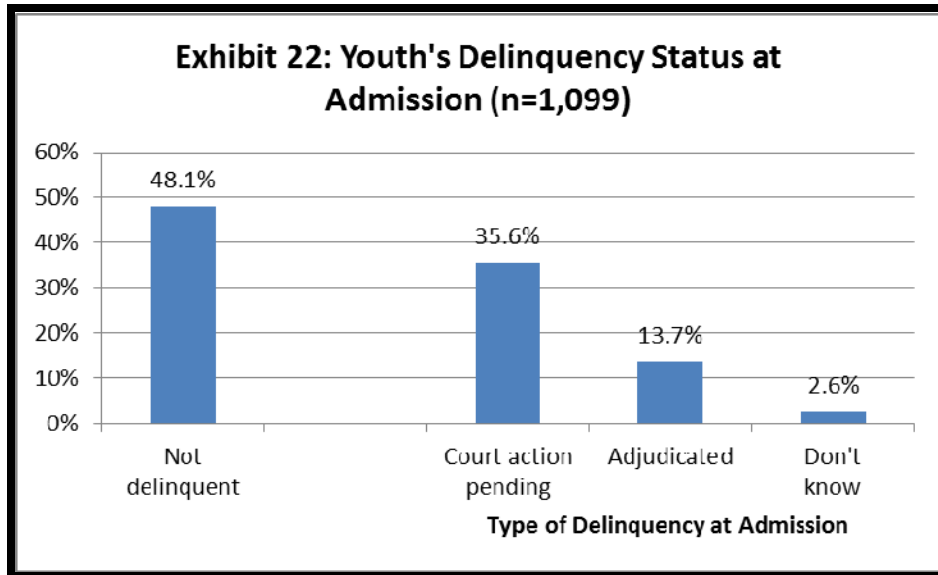
Psychiatric Hospitalization History

As with placement, prior psychiatric hospitalization history is an indicator of severity. Even within the current environment of reduced hospital beds for youth and stringent requirements for admission, 46 percent of youth were reported to have a history of inpatient psychiatric care. As shown in Exhibit 21, almost 30 percent of youth experience two or more psychiatric hospitalizations prior to their admission to the study RCCF and another 16 percent had one.

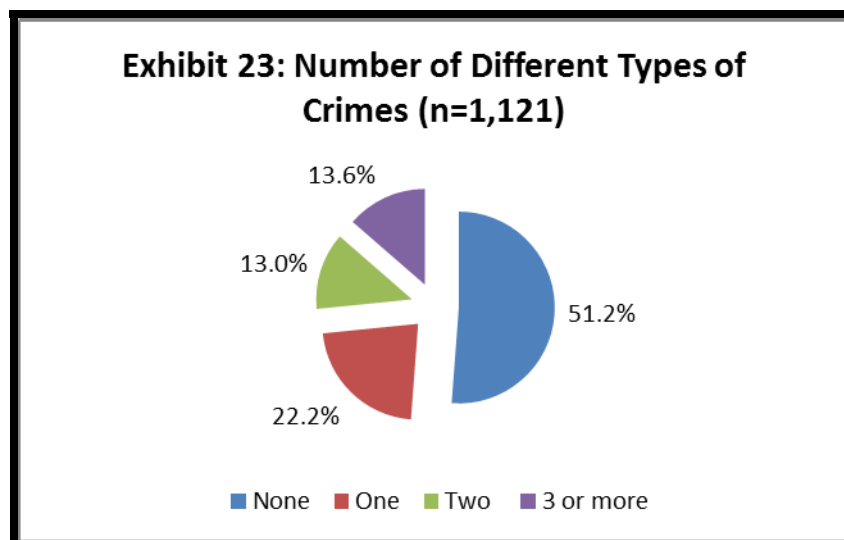


Juvenile Justice History

As shown earlier in Exhibit 17, 18.0 percent of youth were placed in the RCCF by the Colorado Division of Youth Corrections (DYC). We would expect these youth to have a history of delinquency. However, a much larger proportion of the study youth (51.2%) had a history of delinquency as shown in Exhibit 22 below. This proportion included youth whose cases had been adjudicated (13.7%) and youth with a court action pending (35.6%). For the remaining 2.6 percent of youth, there was no information captured at admission that described the youth's delinquency status.

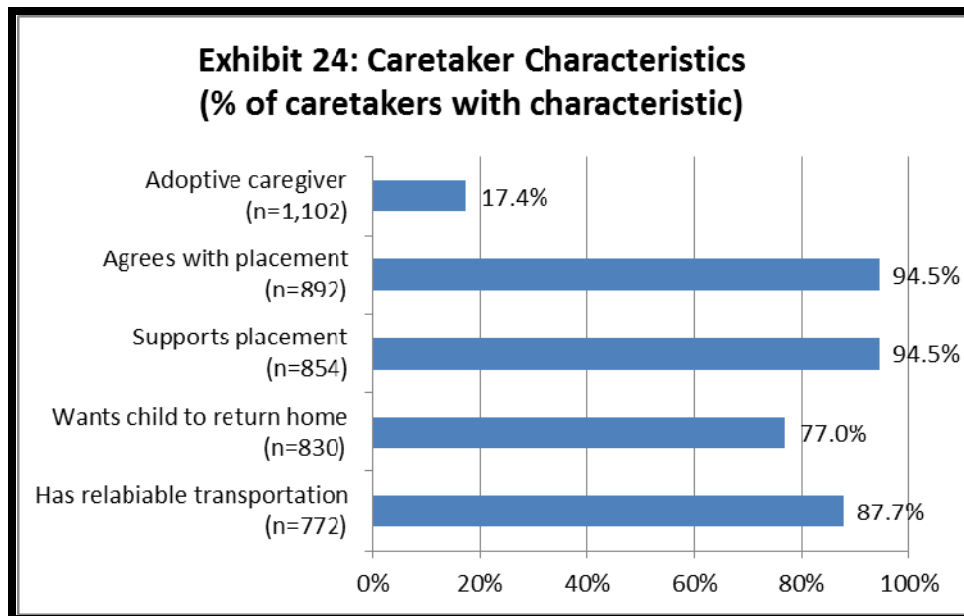


For those youth who had a history of some delinquency, the admission form captured information on the types of crimes committed, whether they were crimes against property or people, criminal substance abuse, and/or the use of weapons. That information, shown below in Exhibit 23, indicates that 51.2 percent of youth had not committed any of these types of crimes while the remaining 48.8 percent had committed a crime in at least one of these four areas. While somewhat more than a fifth of youth (22.2%) had committed only one of the different types of crimes, 13.6 percent had committed three or more of the types captured on the admission form.



CARETAKER INFORMATION AT ADMISSION

The caretaker's role is often critical in providing support and encouragement for a youth's progress in treatment. The admission form captured several pieces of information to document this support and to assess the difficulties of visiting the youth while in the RCCF placement. Exhibit 24 shows several measures of caretaker support in addition to documenting the caretaker's relationship to the child, whether a biological or adoptive parent.



As indicated in the exhibit, caretakers were very supportive of the youth's placement. There was almost unanimous agreement with the placement (94.5%) and support for the placement (94.5%). There was less support for the child's eventual return home from placement, however, with only 77.0 percent wanting the child back in the home. Caretakers were significantly less likely to support the youth's placement when their parental rights were pending or terminated and significantly less likely to want their child returned home. The highest proportion of caretakers who wanted the child returned home was among youth in the 12-14 year age group. Some 91.3 percent of these caretakers expressed a desire to have the child back in the home after placement.

Exhibit 25: Caretaker’s Access to RCCF



A large majority of the caretakers (87.7%) claimed they had reliable transportation needed to visit the youth at the RCCF. For a large proportion of caretakers, however, the RCCF was not nearby (Exhibit 25). About a third (33.6%) lived less than 20 miles from the facility and their travel time was 30 minutes or less. At the other extreme, however, 24.7 percent of caretakers lived more than 100 miles from the facility and access was more difficult. A quarter of all caretakers indicated that their travel time to the facility was more than two hours. A significantly larger proportion of males than females had caretakers who lived 50 miles or less from the RCCF (65.1% v. 51.0%, respectively). A third of females (33.0%) had caretakers who lived more than 100 miles from the RCCF, a factor most likely reflecting the fact that a significantly higher proportion of female placements were funded by private or out-of-state payers.

SEVERITY OF YOUTH ISSUES AT ADMISSION

RCCF therapists captured the severity of the youth’s issues at admission using the measures the State of Colorado uses as part of its diagnostic assessment: Axis I and Axis II disorders, and Axis V (Global Assessment of Functioning) scores. Our study also used the Child Adolescent Needs and Strength (CANS) inventory to assess severity.

Diagnostic Characteristics of Youth

Health care professionals have long used a taxonomy of mental health disorders to help them (1) categorize residents using diagnostic criteria, (2) determine clinical treatment options, and (3) communicate with other professionals about a resident’s condition. The taxonomy includes over one hundred diagnoses, none of which is discrete. Thus, the boundaries among disorders are often blurred and residents can have multiple disorders. The taxonomy is used internationally and in the U.S. it is often required by a wide range of

providers (e.g., clinicians, insurance companies) to classify symptoms. Individuals are typically classified across five Axes:²¹

- Axis I: clinical disorders and developmental and learning disorders,
- Axis II: personality disorders or mental retardation,
- Axis III: medical and/or physical conditions or disorders,
- Axis IV: factors associated with or contributing to psychiatric disorder and treatment outcomes, and
- Axis V: Global Assessment of Functioning (GAF), an interval scale to measure an individual’s overall level of performance in usual daily activities.

This study captured information on Axis I and Axis II disorders as well as GAF scores (Axis V). Exhibit 26 shows the total number of disorders each youth presented at admission. Only about a fifth (19.0%) of youth had only one diagnosis, while the plurality of youth (40.4%) had three diagnoses, reflective of the severity of the youth’s conditions at admission.

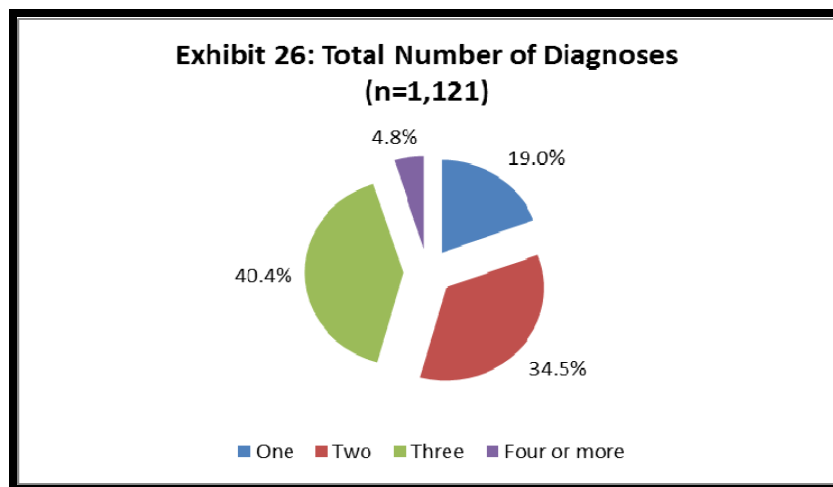
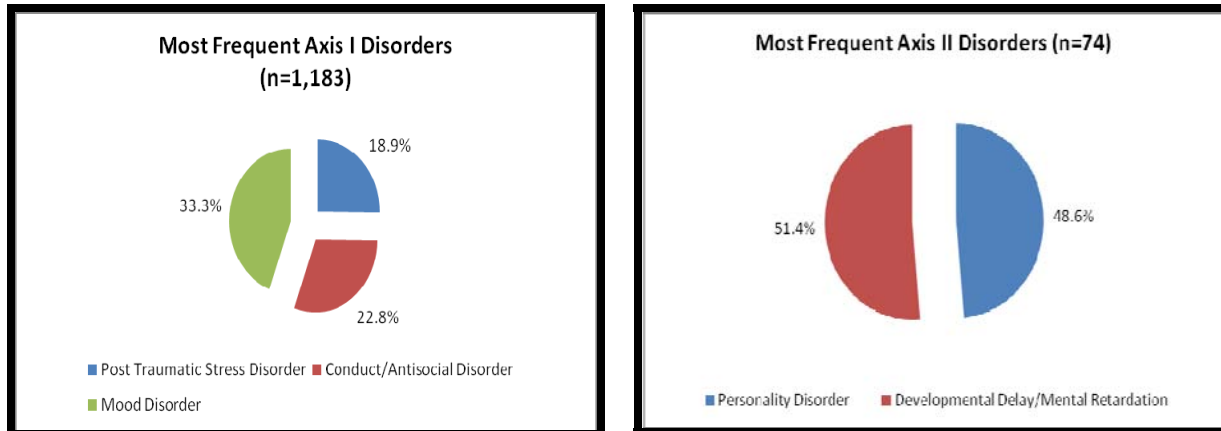


Exhibit 27 displays the Axis I and Axis two disorders that were the most common diagnoses for the youth who were admitted to the RCCFs that participated in this study. That evidence shows that the most common Axis I disorder was Mood disorder, prevalent in a third (33.3%) of all youth at admission. Somewhat more than a fifth (22.8%) of admitted youth displayed Conduct or Antisocial disorder and 18.9 percent of youth exhibited Post Traumatic Stress Disorder (PTSD). Axis II disorders were evident for a much smaller number of admitted youth. However, among the disorders that therapists most frequently classified were Developmental Delay/Mental Retardation (51.4%) and Personality disorder (48.6%).

²¹ American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders (4th edition). (Washington, D.C., APA).

Exhibit 27: Most Frequent Axis I and Axis II Diagnoses of Youth at Admission

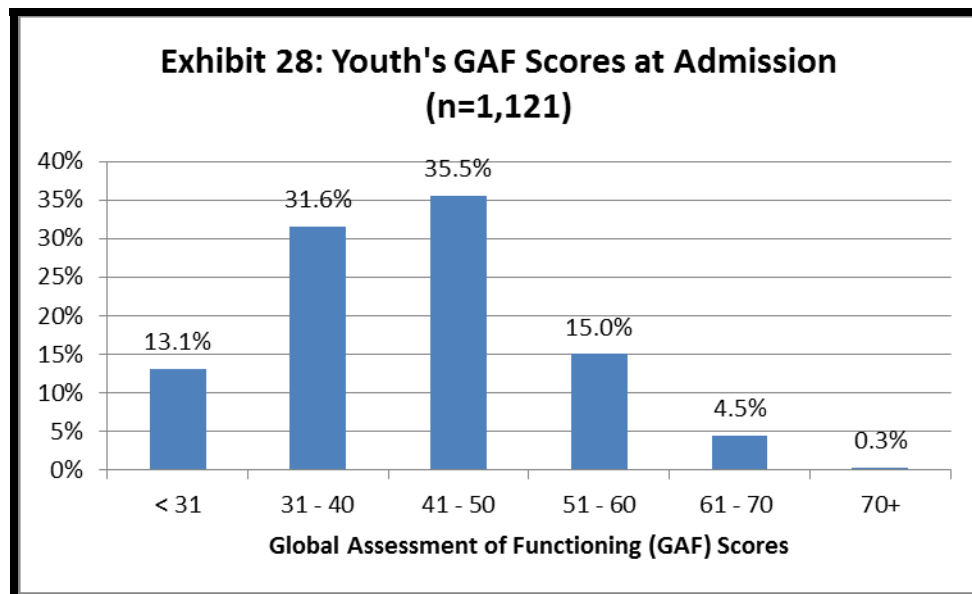


The prevalence of disorders varied by the youth's gender and age group and by the status of their caretaker's parental rights.

- Gender:** Although the most frequently mentioned Axis I disorder among males was Conduct/Antisocial Behavior disorder, the most frequently mentioned Axis I disorders among females were Mood disorder and PTSD. Similarly, males were statistically more likely to have Development Delay/Mental Retardation Axis II disorders than females (83.3% v. 36.0% for males and females, respectively), and females were statistically more likely to have an Axis II diagnosis for Personality Disorder than males (64.0% v. 16.7%, respectively).
- Age group:** The most frequently diagnosed Axis I disorders were the same for all age groups except for the youngest age group (5-11 years). Among that group, PTSD was the most frequently mentioned disorder (40.6% of admitted youth). By contrast, the three older age groups (12-14 years, 15-17 years and 18+ years) were most frequently diagnosed with Mood Disorder (33.2%, 36.7% and 32.7% for the three age groups, respectively). Axis II disorders also varied by age group with (1) 100 percent of youth in the 5-11 year age group exhibiting Developmental Delay/Mental Retardation, (2) youth in the 12-14 year age group showing significantly more Developmental Delay/Mental Retardation disorders than other disorders, and (3) youth in the 15-17 year age group having significantly more Personality Disorders than other disorders.
- Status of parental rights:** Youth with caretakers whose parental rights were intact had significantly more Mood Disorders (Axis I) than youth whose caretaker's parental rights were only pending or terminated (36.9% v. 24.9%, respectively). Conversely, the youth whose caretaker's parental rights were pending or terminated had significantly more PTSD symptoms than youth with caretakers whose parental rights were intact (31.3% v. 14.3%, respectively). Of those youth with an Axis II disorder, youth whose caregivers had pending/terminated parental rights were significantly more likely to be diagnosed with DD/MR (61.1%) than youth with caregivers whose parental rights were intact (47.1%).

Axis V, the Global Assessment of Functioning scale, is a therapist’s judgment about a resident’s overall level of functioning. Its principal advantage as a diagnostic tool is that it offers a single metric to track the progress a youth makes in treatment and to measure the outcomes and impact of that treatment over time. The scores are graded, with lower scores indicating greater symptoms and the need for a higher level of care and higher scores indicating minimal or an absence of symptoms and no impairment of functioning.

As shown in Exhibit 28, GAF scores for most youth at admission were rather low and averaged 46.6 for all youth. Some 13.1 percent of youth had scores of 30 or below indicating an inability to function in almost all areas. Furthermore, more than 80 percent of youth (80.2%) had scores of 50 or below. At that threshold, youth still have serious symptoms or serious impairment of functioning. It was only less than 1 percent of youth (0.3%) who had scores above 70, suggesting mild symptoms or mild impairment.

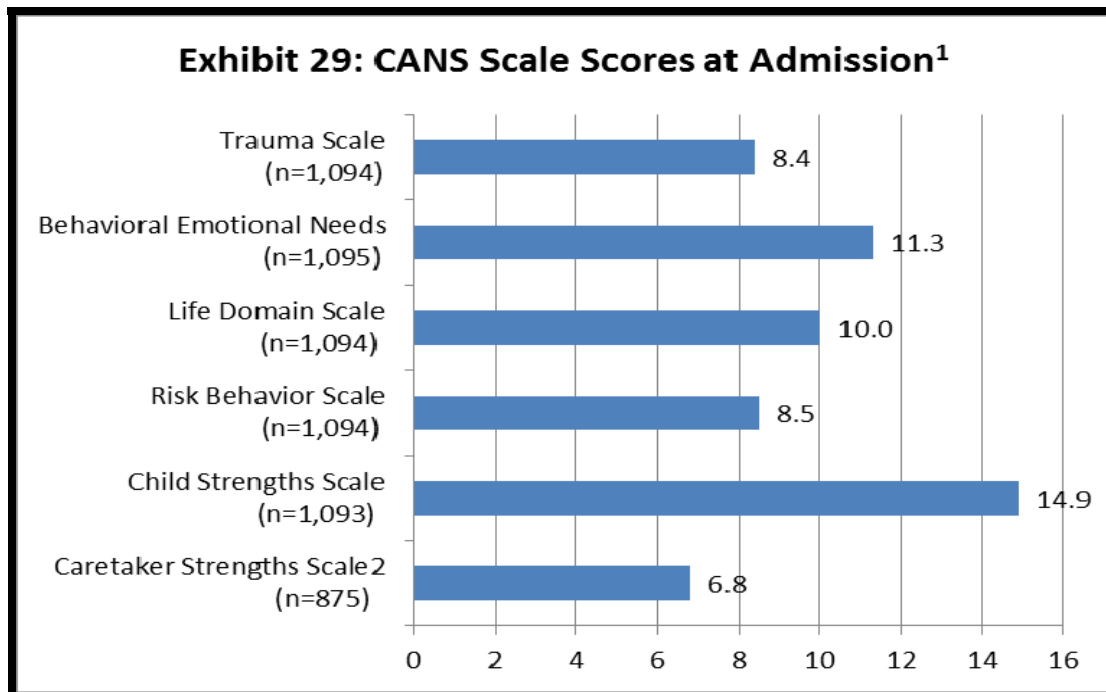


Child and Adolescent Needs and Strengths (CANS) Scales

As described in Chapter II, the CANS scales are calculations of scores on the individual items included in each scale. Scores on each item range from 0, indicating no evidence of need, to 3, indicating severe or profound need. The scales can be presented as a composite score using all the items within the scale or as a percent of actionable items, where “actionable” includes only the proportion of items within the scale that have scores of 2 or 3. The scales are calibrated so that the higher the scale score, whether it be a need or strength, indicates that the youth has more or less need in that area.

Exhibits 29 and 30 below present both of these perspectives on severity, respectively. Exhibit 29 shows the scale score using all the items in the scale. Given the way the scales are calculated, the highest possible score on each scale is 30. As the exhibit illustrates, all of the scale scores were less than half that maximum value.

The child strengths index had the highest value (14.9) for the residents included in this study, indicating fewer strengths. The caretaker strengths scale had the lowest value (6.8), indicating more strengths. The remaining scale scores measuring problem severity ranged from 8.4 (trauma scale) to 11.3 (behavioral emotional needs scale), well below the maximum threshold, but still indicative of need for attention.

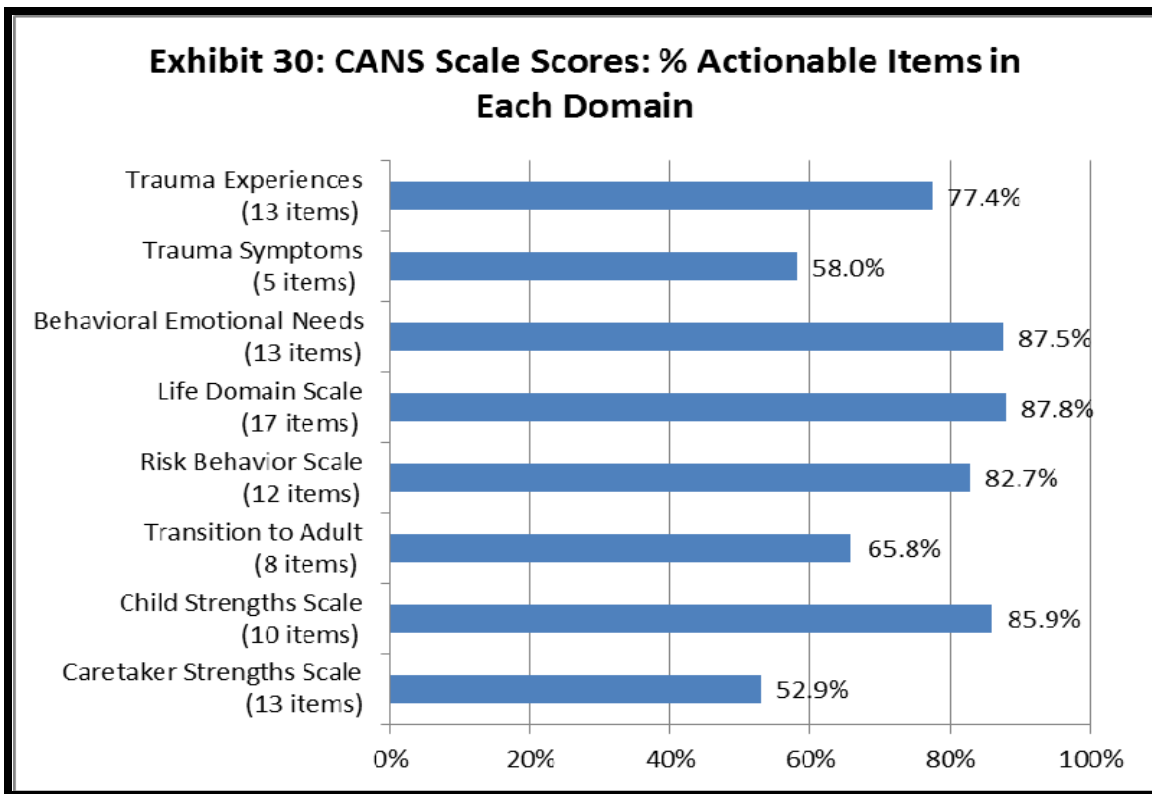


¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10, resulting in a scale that ranges from 0 (all 0s indicate no identified needs or all centerpiece strengths) to 30 (all 3s indicate all dangerous or disabling needs or no strengths identified). Dimensions scores are best thought of as complexity indicators. They reflect the number of actionable needs (2 or 3 on individual items) or useful strengths (0 or 1 on individual items). [Lyons, J.S. (2009) *Communimetrics: A Communication Theory of Measurement for Human Services* (New York; Spring Press).]

² The number of youth included in the Caretaker Strengths scale is lower than for other scales because youth who did not have caretakers at admission are excluded from the averages.

A statistical analysis of the composite scores shows few differences in the scale scores based on the residents' background characteristics. Thus, for example, there were no significant differences based on the youth's gender and although there were a few differences based on the youth's age (generally youth in the 12-14 year age group had the highest CANS scores), there was no general trend by age. There were, however, significant differences in the scores based on the status of parental rights for the caretakers of the residents. For example, youth whose caregiver's parental rights were pending or terminated had significantly higher scores on the CANS Trauma scale and the Child Strengths scale, while youth whose caregiver's parental rights were intact had significantly higher scores on the Risk Behavior scale.

Since the composite scores are an average of the values for all items within the scale, they include all youth who have scores of 0 (no evidence of need) or 1 (little evidence of need). The average thus masks or minimizes the severity of need for some youth and from a therapists' perspective presents a more positive picture of youth severity than may be present. Thus, a more accurate picture of severity may be the proportion of actionable items (i.e., items with scores of 2 or 3) within each scale. This measure of severity is illustrated in Exhibit 30. The exhibit disaggregates the composite trauma score in the previous exhibit into Trauma Experiences and Trauma Symptoms and adds a Transition to Adult scale.



The exhibit shows the complexity of the problems youth in residential care present and thus the challenge to therapists in addressing the range of those needs in the youth they treat. Thus, for example, 87.8 percent of the 15 items in the Life Domain scale (i.e., 15 of the 17 items) had youth with scores of 2 or 3. Only two items in this scale did not have any youth with scores of 2 or 3. A similarly high proportion of items were actionable in the Behavioral Emotional Needs scale and the Risk Behavior scale. The scale with the lowest proportion of actionable items was the Trauma Symptoms scale with 58.0 percent of actionable items.

The statistical comparison of the youth's background characteristics and the proportion of actionable items was more revealing about problem severity than the CANS scale scores in Exhibit 29.

- Gender: males had significantly higher proportions of actionable items on all the scales in Exhibit 29 than did females. The largest differences between the genders were in the (1) Trauma Experiences scale, (2) Behavioral Emotional Needs scale, (3) Life Domain scale, (4) Risk Behavior scale and (5) Child and Caretaker Strengths scale.
- Youth's age at admission: With respect to the youth's age at admission, each scale had significant differences among the age groups. The highest proportion of actionable items was among the 5-11 year age group followed by the 12-14 year age group. Further, in general, as the youth's age increased, the proportion of actionable items within each scale decreased. However, we also note that the younger the child in residential care, the more likely their parent's rights had been terminated.
- Caretakers' parental rights: The youth whose caretaker's parental rights were pending or terminated had significantly higher proportions of actionable items than youth whose caretaker's parental rights were intact on four of the eight scales in Exhibit 30. This included the proportions for the (1) Trauma Experiences scale, (2) Trauma Symptoms scale, (3) Life Domain scale, and (4) Risk Behavior scale.
- Funding Authority: The youth who were placed by the Division of Child Welfare (DCW) and Behavioral Health Organizations (BHOs) or through the CMHTA had significantly higher proportions of actionable items than youth who were placed by the Division of Youth Corrections (DYC) in six of the eight domains. This included the proportions for the (1) Trauma Symptoms Scale, (2) Behavioral Emotional Needs scale, (3) Life Domain scale, (4) Risk Behavior scale, (5) Child Strengths, and (6) Caregiver Strengths. The proportion of actionable items for Trauma Experiences Scale was about the same for the three service areas. Youth placed by the Division of Youth Corrections had the highest proportions of actionable items for Transition to Adult. Private Pay (PVT), including Out-of-State, youth had the lowest proportion of actionable items in all domains.

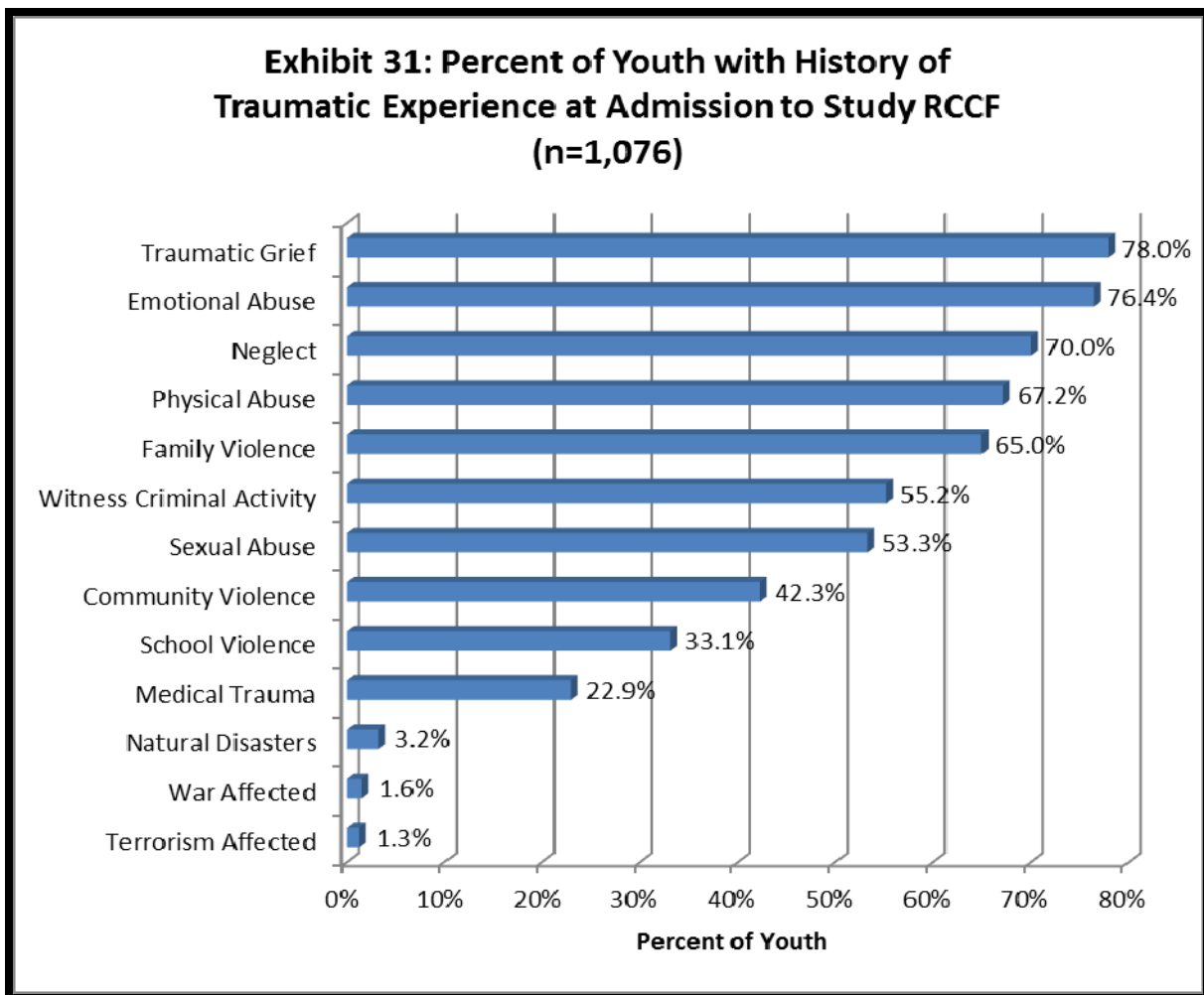
The trauma section of the CANS also asked therapists to document the various types of trauma youth had experienced prior to admission to the study RCCF. This is particularly relevant for Colorado, which launched a trauma informed system of care initiative in 2012.²² The initiative acknowledges research based on the Adverse Childhood Experiences Study (ACES), which showed the correlation between trauma exposure and a variety of health and mental health issues later in life. That is, the more trauma exposure, the more likely the person is to experience many negative life experiences (e.g., drug use, accidents, high risk behaviors, shortened life expectancy). In fact, trauma exposure is one of the most compelling reasons for the need for extensive treatment.²³

The CANS lists 13 different types of trauma: sexual abuse, physical abuse, school violence, and witness to criminal activity). Exhibit 31 displays the percent of youth for whom each type of trauma was identified at

²² Colorado Department of Human Services (2012) *Strong Minds, Strong Futures* (PowerPoint slides). Personal communication with Claudia Zundel, Director, Children, Adolescent and Family Services (September 13, 2012).

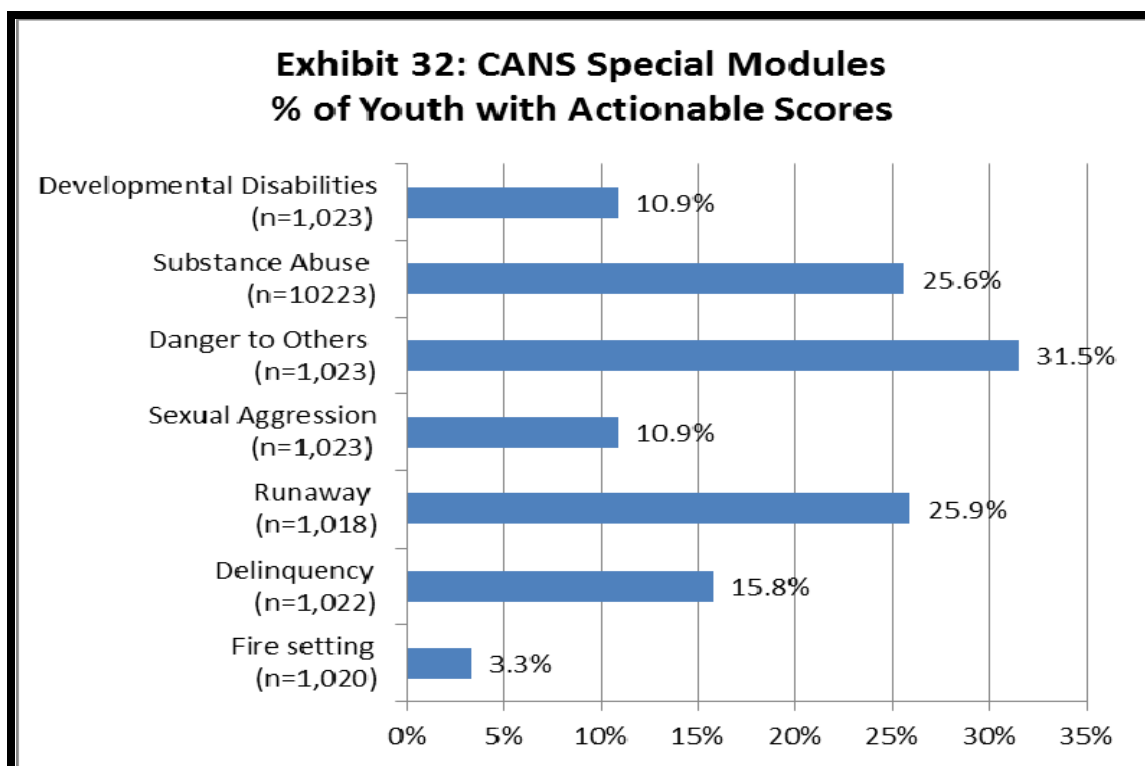
²³ For example, Felitti V.J., Anda R.F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P., et al. (1998) "The relationship of adult health status to childhood abuse and household dysfunction." *American Journal of Preventive Medicine*. 14:245-258.

admission to the study RCCF. Nine of the thirteen experiences were identified for 30 percent or more of the youth, the most common being Traumatic Grief, Emotional Abuse, and Neglect, Physical Abuse, and Family Violence.



We also looked at whether the number of past traumatic events to which youth had been exposed differed based on the background characteristics described above. Youth had been exposed to an average of 5.7 events. There were no significant differences across age groups or gender. Youth who had been placed by County Human Services or Youth Corrections had, on average, a significantly higher number of past traumatic events (6.1 and 5.9, respectively) than those placed by BHOs/CMHTA or Private/Out of State authorities (4.7 and 4.3, respectively) ($p = .000$). Youth whose Parental Rights were Terminated/Pending were also reported to have, on average, a significantly higher number of past traumatic events ($n=6.6$) than those with Intact Parental Rights ($n=5.4$).

One further piece of evidence about severity is available in the CANS data the admission form captured on seven special modules. For several CANS items, the admission form asked therapists to complete additional scoring if the youth had scores of 2 or 3. Exhibit 32 shows the proportion of youth who displayed problems in each of these special areas. Of these areas, almost a third of admitted youth (31.5%) showed evidence of being a danger to others and somewhat more than a quarter of youth had at least one runaway (25.9%) or substance abuse issues (25.6%). By contrast, only 3.3 percent of admitted youth had exhibited fire setting behaviors and only about 11 percent were developmentally disabled (10.9%) or had exhibited sexually aggressive behavior (10.9%). A somewhat higher proportion (15.8%) had been adjudicated as delinquent.



Statistical differences based on the youth's background characteristics were mixed.

- **Gender:** A significantly higher proportion of females than males had actionable scores in the Substance Abuse and Runaway modules. A significantly higher proportion of males than females had actionable scores in the Danger to Others, Sexual Aggression and Delinquency modules.
- **Age of resident at admission:** The proportion of youth with actionable scores in Substance Abuse and Delinquency increased as the youth's age increased, whereas the proportion with actionable scores for the Developmental Disabilities and Danger to Others modules were highest for the youngest age group (5-11 years).

- Caretakers' parental rights: Significantly higher proportions of youth from homes with intact parental rights than youth whose caretaker's rights were pending or terminated had actionable scores for the Substance Abuse, Runaway, and Delinquency modules.
- Funding Authority: Youth placed by DCW and the BHOs or through the CMHTA had the highest proportion of actionable items for Developmental Disabilities and Sexual Aggression. BHO-placed youth had the highest proportion of actionable items for Danger to others (43.5%), followed by PVT (36.6%) and DCW (32.4%) Youth. Those placed by DYC had the highest proportion of Substance Use, Delinquency, and Runaway behaviors. PVT-placed youth also had a high proportion of Substance Use problems. Fire Setting was a low incidence problem, reported for only 3-4 percent of youth overall, with no differences by Funding Authority.

Decision Support Models

John Lyons has used the information captured in the CANS to further his own research on youth care in alternative placement settings. His book *Communitometrics* discusses the development of two models (also referred to as algorithms) that use CANS data to determine the intensity of mental health care and placement type that youth need. These models are intended to be used prior to referral for services and have demonstrated improved outcomes for youth whose recommended and actual services matched. We used the algorithms developed for Indiana's Department of Child Services/Juvenile Justice to explore these related service intensity levels based on the admission CANS data that residential clinical staff captured as part of this study.

The models also reflect what is referred to as *complexity*, whereby CANS action levels in several domains are considered. This is in contrast to using a simple cutoff score, a more common method researchers use with assessment instruments. This research is very exploratory but illustrates further the utility of the CANS tools to serve the needs of youth. It also is important to note that the algorithms were developed using an in-depth process that reflected Indiana's placement standards and goals and, as such, are only presented to explore and demonstrate the potential value of a decision model in Colorado.

Level of Care: Placement Type/Setting

The CANS Level of Care algorithm results in a recommended placement for youth who have been removed from the home by a child welfare agency. Of the 1,084 youth with CANS admission data in our study, most (98.0%) had sufficient data to be classified. Exhibit 33 displays how youth were distributed across the four placement types. Using Indiana's model, about 40 percent of the youth in our study would have been recommended for Foster Care, mostly non-therapeutic. The remaining 60 percent would have been recommended for either Group or Residential Services.

Exhibit 33: CANS Indiana Decision Support Model for the Department of Child Services/Juvenile Justice (n=1,062)		
Placement Type	Number of Youth	Percent of Youth
<ul style="list-style-type: none"> • Foster Care with Services • Therapeutic Foster Care • Group Home • Residential 	412 33 208 409	38.8% 3.1% 19.6% 38.5%

¹ Used only for youth who have been removed from the home

Intensity of Mental Health Service Level Need

We also applied Indiana’s model for determining the level of mental health service need to the youth who were admitted to our study. Of those admitted, 1,075 (99.2%) had sufficient CANS data to be classified by the model. The result of applying Indiana’s definitions and standards to our study data are displayed in Exhibit 34. The exhibit shows that the model would recommend 26.0 percent of the youth in our study for inpatient mental health care and only 12.8 percent for residential care. Over half (61.3%) would have been recommended for various levels of in-home services, 40.3 percent with day treatment.

Exhibit 34: CANS Indiana Decision Support Model for Mental Health Service Level Need (n=1,075)		
Mental Health Service Level	Number of Youth	Percent of Youth
<ul style="list-style-type: none"> • Outpatient Clinic Services • Supportive Case Management • Intensive Case Management or Day Treatment • Home and Community Based (e.g., Wraparound) • Residential • Inpatient 	46 117 433 62 138 279	4.3% 10.9% 40.3% 5.8% 12.8% 26.0%

This exploration supports the idea that individual states or departments can work with stakeholders at all levels to develop standardized criteria based on standardized assessments for different levels of placement and service need. While, as in Indiana, recommendations could be overruled by individual circumstances, it provides a level of planning and accountability that reflects the range of need and resources available.

TRAILS DATA

Trails Data Available for Analysis

As described earlier, Colorado Trails is a state-wide multi-department information system into which county child welfare and state juvenile justice staff, among others, enter demographic, assessment, clinical, placement, criminal, financial, and other information about youth in their care. In order to add another perspective to the outcomes study, we worked with program and Information Technology (IT) business analysts from the Colorado Department of Human Services (CDHS), the Division of Child Welfare (DCW) and the Division of Youth Corrections (DYC) to develop an extract of Trails data for those youth in the RCCF Outcomes Study. The specifications for the extract focused on the 12 months prior to the youth's admission to the RCCF and 12 months after the youth's discharge from the study RCCF and included data from Child Welfare and Youth Corrections. We viewed this work as an exploratory opportunity to understand and possibly compare data from the state/county and residential treatment center perspectives. We also wanted to explore the resources needed to extract data as well as the face validity and utility of the Trails data within the context of an outcomes study conducted by an independent evaluator.

The evaluator submitted a file to Trails ITS for 1,056 youth who met the following criteria:

- Were admitted to one of the study RCCFs during the study period (January 2009 through December 2010),
- Had given consent to participate in the study, as recorded on the ROCRS database, and
- Had a Medicaid or Colorado Trails ID number recorded by the RCCF provider on ROCRS.

Of these youth, 734 (71.6%) were matched in the Trails Child Welfare database.²⁴

We were able to generate limited demographic and placement admission profile information and, more importantly, outcomes related to DCW's out-of-home placements for a small subsample of youth who had been discharged from the study RCCF for at least 12 months by December 2010.

Division of Child Welfare Trails Admission Profiles

Exhibits 35 through 38 display demographic, disability, placement, and permanency goal profiles of the 734 youth for whom DCW admission data were available from Colorado Trails.

Youth's demographic characteristics: The youth were:

- More than two-thirds male
- Distributed across all age groups, with almost half being 15-17 years old and about 20 percent ages 5-11 years
- About two-thirds non-Hispanic

²⁴Matches were also found in the DYC, but the number of youth who had been committed to DYC prior to the study placement was too low (n=12) for descriptive or outcome analysis.

- About two-thirds White/Caucasian
- Mostly in the custody of DHS, including DYC commitment; 20 percent were in parental custody

Exhibit 35: Selected Demographic Characteristics of Youth Pre-Study (Percent of youth)	
Characteristic	Percent of Youth (n=734) ¹
<u>Gender</u>	(n=734)
• Male	69.6%
• Female	30.4%
<u>Age at Admission</u>	(n=729)
• 5-11 Years	18.2%
• 12-14 Years	25.0%
• 15-17 Years	46.8%
• 18 or Older	10.0%
<u>Hispanic Ethnicity</u>	(n=723)
• Yes	34.0%
• No	66.0%
<u>Race/Ethnicity</u>	(n=627)
• Caucasian	69.2%
• African American	22.5%
• American Indian/Alaskan native	6.2%
<u>Custody of Youth²</u>	(n=734)
• DHS Legal Custody	29.6%
• Parental Custody	22.1%
• DYC Commitment	21.3%
• Emancipation	5.2%
• Other ³	1.4%
• Missing	20.6%
<u>Diagnosed Disabilities²</u>	(n=734)
• Yes	2.9%
<u>Disability Flags^{2,4}</u>	(n=139)
• Mental Health	15.1%
• Vision/Hearing	2.2%
• Emotional	95.7%

¹ Numbers in parentheses indicate the number of youth with valid data.

² Data element is not a required field in Trails, which may explain the large number of missing cases.

³ Other includes: Voluntary placement guardian approval, non-DHS custody/protective custody orders, custody with non-kin and county consent to adopt.

⁴ Multiple response variable (i.e., responses were allowed for more than one category of disability), thus percentages may exceed 100 percent. There were a total of 157 responses for 139 youth.

Youth disabilities: With regard to Disabilities, a non-required Trails data element, providers identified almost 20 percent (n=139) of youth as having a specific disability. Of these youth:

- 95 percent had emotional disabilities,
- 15 percent had mental health disabilities, and
- 2 percent had vision or hearing disabilities.

Placements

- 93 percent of youth had at least one placement prior to the RCCF placement in our study
- 80 percent of youth had at least one placement during the year prior to the RCCF placement in our study. Of these (note that Group/Group Center days were not available), duplicated because youth may have been placed on more than one setting,
 - ✓ 90 percent were in a TRCCF placement
 - ✓ 30 percent were in Regular Foster Care
 - ✓ 20 percent were in a different RCCF placement
 - ✓ 6 percent were in Kinship Care

Exhibit 36: DCW Placement History by Type of Placement Ever and During 12 Months Prior to Admission (Percent of youth) ¹		
Placement and Time Period	Placements Ever ² (n=734)	Placements in Period ³ (n=734)
<u>Any Placement Any Type</u>	(n=734)	(n=734)
• Yes	92.8%	80.4%
• No	7.2%	19.6%
<u>Number of TRCCF Placements</u>	(n=681)	(n=590)
• One	31.6%	59.3%
• Two	26.1%	29.9% ⁴
• Three	13.2%	—
• Four or more	24.0%	—
• None	5.1%	10.8%
<u>Number of RCCF Placements</u>	(n=681)	(n=590)
• One	18.6%	16.1%
• Two	6.2%	4.5% ⁴
• Three or more	7.5%	—
• None	67.7%	79.3%

Exhibit 36: DCW Placement History by Type of Placement Ever and During 12 Months Prior to Admission
(Percent of youth)¹

	(n=681)	(n=590)
<u>Number of Regular Foster Home Placements</u>		
• One	17.0%	18.1%
• Two	8.7%	11.6% ⁴
• Three	6.6%	—
• Four or more	16.5%	—
• None	51.1%	70.3%
<u>Number of Kinship Placements</u>	(n=681)	(n=590)
• 1 or more	14.4%	5.3%
• None	85.6%	94.1%

¹ Numbers in parentheses indicate the number of youth with valid data.

² “Ever” means through the day before the youth’s admission to the participating RCCF in our study.

³ “In period” means during the 12 months prior to the youth’s admission to the RCCF in our study.

⁴ Proportion includes two or more placements in this placement type.

Removal reasons: The most common reasons for removal were:

- Child behavior (80%),
- Caretaker’s inability to cope (23%),
- Sexual abuse (15%), and
- Neglect (12.5%).

Permanency goals:

- Remaining or returning home (56%) was the most common permanency goal,
- Emancipation (36%)

Exhibit 37: Most Recent Removal Reason Prior to Admission to the Study RCCF (Percent of youth)	
Removal Conditions	Percent of Youth (n=734) ¹
	(n=653)
• Physical Abuse	5.9%
• Sexual Abuse	15.0%
• Neglect	12.5%
• Alcohol Abuse (parent)	2.8%
• Drug Abuse (parent)	5.1%
• Child Disability	2.5%
• Child Behavior	79.6%
• Alcohol Abuse (child)	3.1%
• Drug Abuse (child)	9.2%
• Caretaker's Inability to cope	23.2%
• Abandonment	3.6%
• Other ²	3.8%

¹ Number in parentheses indicates the number of youth with valid data.

² Other includes inadequate housing, incarceration of parent(s), relinquishment.

Exhibit 38: Most Recent Permanency Goal Prior to Admission to the Study RCCF (Percent of youth)	
DCW Permanency Goal in Placement Period	Percent of Youth (n=734) ¹
	(n=669)
• Return or remain home	55.6%
• Emancipation	23.5%
• Adoption (non-relative)	8.5%
• Arrangement non-relative/long term foster care	7.8%
• Placement with relative/legal guardian with permanent custody	4.6%

¹ Number in parentheses indicates the number of youth with valid data.

CHAPTER IV: OUTCOMES

INTRODUCTION

As described in Chapter II, the Residential Outcomes Collection and Reporting System (ROCRS) we designed for the study collected a wide range of data elements that served multiple purposes. Participating agencies used the information for treatment planning and to monitor an individual youth's progress in placement. We used the information for different aggregate analyses of the youth at admission (e.g., a profile of youth in residential care) and discharge (e.g., the outcomes youth achieved while in placement). In considering the outcomes analyses, we focused on the youth for whom we had complete data at both admission and discharge. At a minimum, this included CANS and non-CANS data at both time periods and an expectation that the CANS data would be complete, with only a few missing variables. Finally, we also hoped that the agencies had been able to capture some post-discharge data at either the four- and or twelve-month follow-up periods included in the study protocol.

There were 467 youth who met the criterion for complete information at admission and discharge. Also, we had 85 youth at the four-month post-discharge follow up and 18 youth at the twelve-month follow up who had complete CANS information. Since some youth had post-discharge data at both follow-up periods, we had a total of 92 youth with CANS data from the four-month or twelve-month post-discharge follow-up survey as of December 31, 2010, the end of the study's data collection. This chapter discusses the analyses of outcomes we completed on the subset of youth for whom we have both admission and discharge data.

REPRESENTATIVENESS OF THE OUTCOMES SAMPLE

In order to determine whether the subsample of 467 youth was representative of all the youth who were admitted during the study period, we compared the two groups on key demographic and placement characteristics. Exhibit 39 shows that, demographically, youth with discharge data tended to be younger, proportionately more male, and slightly more Caucasian and of non-Hispanic ethnicity than all youth included in the study at admission. Exhibit 40 shows that the distribution of youth by Funding Authority (i.e., which agency funded the bed) and the status of Parental Rights also was only marginally different between the two time periods. Fewer youth with discharge data were placed by the Colorado Division of Youth Corrections (CDYC) than the larger group of youth at admission. Other payor sources, including the Colorado Division of Child Welfare (CDCW), a mental health agency, and private/out-of-state entities showed slightly higher proportional representation at discharge than admission. Finally, we looked at the distribution of youth by RCCF provider (not shown). Of the 11 providers represented in the discharge sample, 8 had the same or higher proportional representation in the discharge sample as they had in the admission sample. The remaining three providers were substantially less well represented in the discharge sample than they were in the admission sample.²⁵

²⁵ RCCFs Twelve RCCFs participated in the study and the youth they admitted to placement are included in our profile of youth at admission. One RCCF did not complete discharge information for its study youth, leaving 11 agencies represented in our discharge analyses.

Taken together, the subsample of youth with discharge data is largely representative of all the youth admitted to the study. However, it is important to note that we do not know why discharge forms were not entered for specific youth. Certainly one reason for a lack of discharge data is that some youth were not ready for discharge at the end of the study period; that is, they had not reached their planned discharge date. However, many youth who were not included in our outcomes analysis were excluded because their discharge data were not entered by the facility or the data were incomplete. As a result, we cannot make any assumptions about the youth for whom we do not have discharge data or generalize the findings from our analyses to the excluded youth.

Exhibit 39: Key Demographic Characteristics of Admitted Youth Compared to Youth with Discharge Data ¹ (Percent of youth)		
Characteristic	Youth with Admission Data/Forms (n=1,094)	Youth with Discharge Data/Forms (n=467)
<u>Age</u>		
• Mean Age at Admission	15.3 years	14.0 years
<u>Gender</u>	(n=1,094)	
• Male	61.5%	65.1%
<u>Race/Ethnicity</u>	(n=930)	(n=397)
• Caucasian	69.8%	71.3%
• African American	21.6%	20.9%
• Asian	1.2%	0.5%
• American Indian/Alaskan	6.6%	6.5%
• Hawaiian/Pacific Islander	0.9%	0.8%
<u>Hispanic Ethnicity</u>	(n=1,074)	(n=461)
• Yes	33.5%	31.5%

¹ If the number of youth available for analysis is less than the total number of youth in the sample, the number on which the analysis is based is specified.

**Exhibit 40: Selected Placement Characteristics of Admitted Youth
Compared to Youth with Discharge Data¹
(Percent of youth)**

Characteristic	Youth with Admission Data/Forms (n=1,094)	Youth with Discharge Data/Forms (n=467)
<u>Funding Authority (funding bed)</u>	(n=1,085)	
• CDHS/COUNTY	59.8%	63.4%
• CDYC	18.0%	15.6%
• BHO/CMHTA	7.8%	8.1%
• Private/Out of State	14.1%	14.1%
• Other	0.3%	0.4%
<u>Status of Parental Rights</u>	(n=1,023)	(n=433)
• Intact	75.2%	76.0%
• Pending or Terminated	24.8%	24.0%

¹ If the number of youth available for analysis is less than the total number of youth in the sample, the number on which the analysis is based is specified.

PROFILE OF YOUTH AT DISCHARGE

Youth present for residential placement and treatment at different stages in their treatment, with different needs, and with different post-placement needs. In an effort to understand the context and characteristics of the treatment episode, therapists completed a form that described the (1) treatment provided, (2) participation of the family and case manager in that treatment, (3) goals met, (4) discharge circumstances and (5) post-treatment episode placement and service recommendations. This section describes these data.

Characteristics of the Treatment Episode

Services Provided

The data collection at discharge asked therapists to estimate the frequency with which each of 18 services was provided during treatment by selecting a range of hours in a month that youth received services – from one hour (about 1 time per month) to 20-25 hours (about 5 times per week) and greater (about daily) – for each service. After analysis, we grouped the time periods into fewer ranges. Exhibit 41 displays each of the frequency time ranges and the services that were provided most often for each, including the services that were not provided at all.

Exhibit 41: Services Received During Treatment by Frequency ¹ Percent of Youth (N=467) ²	
Frequency of Service	Percent of Youth
<u>Daily or more often</u>	
• Milieu therapy	76%
• Recreational therapy	31%
• Evidence-based services ³	25%
<u>3-4 times per week</u>	
• Group therapy	50%
• Educational groups	18%
<u>1-2 times per week</u>	
• Individual therapy/counseling	89%
• Family therapy	62%
• Community activities	35%
• Faith/spirituality services	33%
<u>1-2 times per month</u>	
• Psychiatric services and medication management	85%
• Assessment, including psychological testing	55%
<u>None Provided</u>	
• Home-based	93%
• Special services (e.g., physical/occupational/speech therapy)	90%
• Mentoring	82%

¹ More complete data on the frequency that each of the services was provided are included in Table E-7 in Appendix E.

² The number of youth available for each analysis varied because of missing data.

³ Evidence-based is used broadly and does not refer to a specific service.

There are two major points to make about service provision. First, it is clear from the data that the participating RCCFs offered a wide range of services to their resident youth, a range that is influenced by the characteristics of the youth each agency accepts and the diversity of the needs those youth present at admission. All of the services were received by some proportion of youth in our study, even if the proportion was small. Second, it is also evident that only a few of the 18 services about which ROCRS captured data were provided frequently (i.e., more than once or twice a week) to the youth in placement. The services that youth received consistently included: (1) milieu therapy (76% received the service at least daily), (2) group therapy (received by 50% 3 or 4 times per week), (3) individual and family therapy/counseling (received by 89% and 62%, respectively, 1 or 2 times per week), and (4) psychiatric services and medication management (85% received 1 or 2 times per month). Youth received the remaining services listed with variable amount of frequency, determined by the availability of the service at the RCCF and the youth's need for the services as part of his/her treatment plan. Only a small percent of youth received home-based or special (e.g., physical therapy) services.

Psychotropic Medications

Although the data collection forms did not capture the specific medications that were prescribed for youth, they did ask therapists to indicate the number of medications that were prescribed for psychiatric problems (other than for attention), at admission and discharge.²⁶ Of the 467 youth discharged, 456 (97.6%) had medication data at admission. More than half (55.0%) of these youth had been prescribed one or more psychotropic medications at admission.

We used a paired-samples t-test to compare the total number of medications prescribed at admission and discharge for youth who had been prescribed one or more medications at admission. Although there was only a small change in the average number of medications prescribed at admission (mean=2.18, SD=1.176) and discharge (mean=2.0, SD=1.249); the difference was statistically significant [$t(253) = 2.759, p < .01$].

Conversely, we also looked at those youth who were admitted without prescriptions for psychotropic medications and for whom we had both admission and discharge data ($n=203$). Almost 70 percent of these youth remained without prescriptions during treatment. Among the remaining youth, about 18 percent were discharged on one medication and 14 percent on two or more medications.

Family Participation in Treatment

The importance of family participation in youth treatment is well-documented and the study captured the type (i.e., family therapy, telephone contact, on-site visits) and frequency (i.e., from none to weekly) of participation for each participation type. Weekly family participation varied from a high of almost 75 percent for telephone calls to almost 50 percent for visiting on site. Sixty-five percent of youths' families participated in weekly family therapy. The rates of total non-participation were very low: 4 percent for telephone calls, 11 percent for family therapy, and 14 percent for visiting on site.

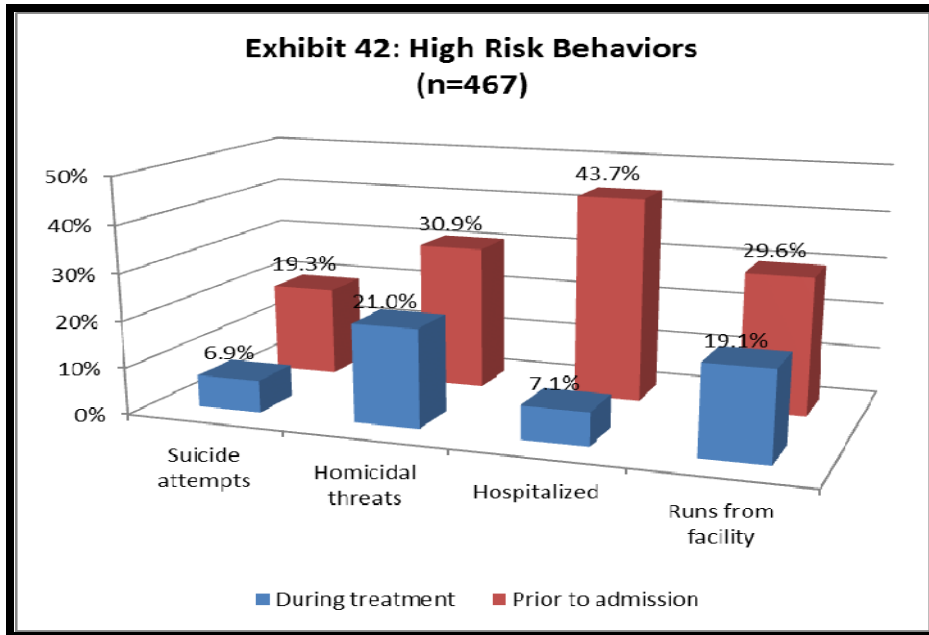
Visits by Case Workers/Managers

Therapists estimated that 80 percent of the youth received visits from their case workers/managers about two times per month, with only 5 percent having less than monthly visits.

High Risk Behaviors during Treatment

We were interested in whether youth demonstrated several high risk behaviors during treatment. Exhibit 42 shows the proportion of discharged youth who were reported to have made suicide attempts or homicidal threats, been hospitalized psychiatrically, or run from facilities before admission compared to during their episode of care at the RCCF. While it is beyond the scope of our analysis to understand how these behaviors may influence longer-term outcomes, there was a decrease in each behavior during the episode of care.

²⁶We should note that changes in the prescription of psychotropic medications are not necessarily a positive or negative outcome, since youth may need the medication as a critical component of treatment and recovery.



Criminal Activity during Treatment

Therapists indicated that 30 percent of the youth had engaged in some type of criminal activity during treatment. Nineteen percent had engaged in two or more types of crimes. As shown in Exhibit 43, crimes against persons, which included assault (including sexual), robbery, menacing, and reckless endangerment, were the most common activity, reported for 15 percent of the youth.

Exhibit 43: Criminal Activity During Treatment
Percent of Youth
(N=467)¹

Type of Criminal Activity	Percent of Youth
• Crimes against persons	15.2%
• Crimes against property	12.8%
• Violations of court proceedings	10.5%
• Status offenses	7.9%
• Other	6.8%

¹ Number of youth available for each analysis varied because of missing data.

New charges were filed against 18 percent of the youth during treatment (Exhibit 44). Almost half of those youth (44.5%) were charged or ticketed for assault or other crimes against persons.

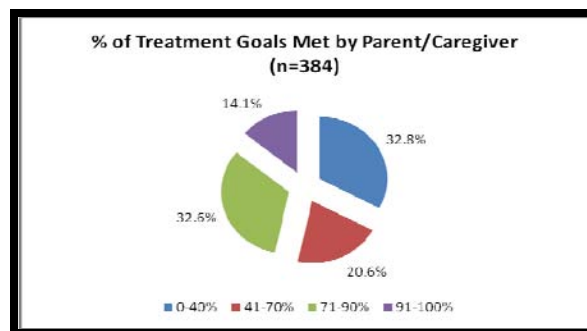
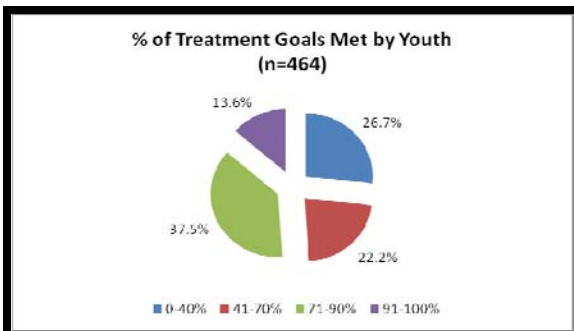
Exhibit 44: New Charges During Treatment Percent of Youth (N=83) ¹	
Type of Charges (including tickets)	Percent of Youth
• Crimes against persons	44.5%
• Crimes against property	12.8%
• Violations of court proceedings	15.7%
• Status offenses	15.7%
• Other	6.8%

¹ Number of youth available for each analysis varied because of missing data.

Treatment Goals Met

The data forms asked therapists to estimate the percentage of treatment goals met by the youth and the family during the youth’s episode of care. Response choices were presented in 10 percent increments and collapsed for analysis. Exhibit 45 displays numbers and percents for each group. Half of the youth and slightly less than half of families met more than 70 percent of their respective treatment goals.

Exhibit 45: Treatment Goals Met at Discharge¹



¹ Number of youth available for each analysis varied because of missing data

Reason for Discharge

Overall, youth who were discharged during the study period were in placement for an average of six months. The range of time was about one week to three years and the median length of stay was five months.

As shown in Exhibit 46, more than half of the youth (56.8%) were discharged after completing the residential program successfully and another 10 percent ran away, which triggered a discharge. Almost 9 percent of the discharges were DYC/detention related, including a small number whose commitment period ended during treatment and the youth was discharged before meeting treatment goals. About 7 percent were removed from placement, most often by parents or child welfare workers, against the advice of the residential provider.

Almost 13 percent of the youth were discharged for other reasons. Providers did explain this selection, but there were no specific trends or clusters. Answers included, for example, the need for medical placement, the loss of funding for placement, the youth reaching adulthood, and court-related actions.

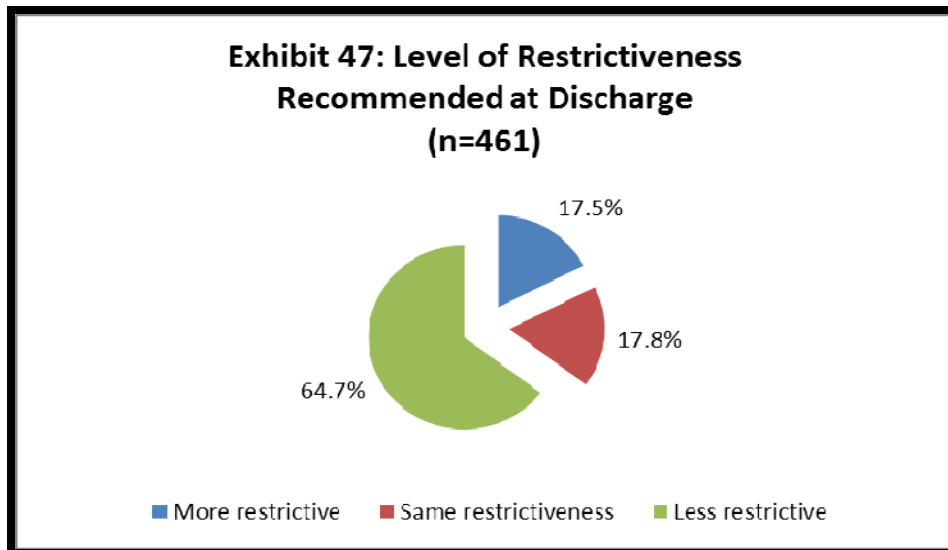
Finally, 7 percent of the youth were terminated against the advice of the residential provider.

Exhibit 46: Reason for Discharge		
Reason for Discharge	Total (n=462)	%
	(n=461)	(n=461)
• Completed program successfully – clinical goals were met	262	56.8%
• Ran away/ placement was terminated	50	10.8%
• DYC or Detention related	40	8.7%
• Placement was terminated against the advice of the provider	33	7.2%
• Behavior exceeded facility capacity/provider requested removal	17	3.7%
• Other (e.g., medical placement, youth reached adulthood, court-related actions)	59	12.8%

Placement/Setting Recommendations and Characteristics

Level of Restrictiveness Recommended

As shown in Exhibit 47, providers recommended almost two-thirds of the youth at discharge for a less restrictive placement (64.7%). The rest of the youth were divided evenly between needing the same level of restrictiveness (17.8%) or at a higher level (17.5%).



Therapists also indicated their recommended setting for less and more restrictive settings.

- Less Restrictive (n=296)
 - ✓ Home (61.0%)
 - ✓ Foster care, including Kinship Care (14.9%)
 - ✓ Group/CPA Home (14.5%)
 - ✓ Therapeutic Foster Care (9.5%)

- More Restrictive (n=83)
 - ✓ A secure, locked facility, including detention (56.6%)
 - ✓ DYC Commitment (21.7%)
 - ✓ PRTF (10.8%)
 - ✓ Psychiatric Inpatient (10.8%)

Recommended Services

Therapists recorded their recommendations for the type and amount of services youth needed after discharge. This list was more limited than the one used to identify services received and included: (1) Assessment, various types of Outpatient, Family Preservation (office- or home-based); (2) Day Treatment; (3) Substance Abuse; (4) Sex Offender; (5) Chafee Foster Care Independence Program (CFCIP); (6) Independent

Living; (7) Psychiatric/Medication Monitoring Treatment; and (8) Other. Day Treatment, a relatively intensive treatment, was recommended for 18 percent of the youth (Exhibit 48). Either individual or group treatment was recommended for the majority of youth (60%); almost 1-2 times per week. Psychiatric services, including medication management, was recommended for two-thirds (67%) of the youth on a monthly basis.

Exhibit 48: Services Recommended after Residential Treatment by Frequency (Percent of youth) ¹	
Frequency of Service	Percent of Youth ² (n=477)
<u>Daily or more often</u>	
• Day treatment	18%
<u>1-2 times per week</u>	
• Individual therapy/counseling	60%
• Outpatient family therapy	43%
• Home-based family preservation	24%
• Substance abuse treatment	21%
• Outpatient group therapy	82%
<u>1-2 times per month</u>	
• Psychiatric services and medication management	67%
• Assessment, including psychological testing	55%

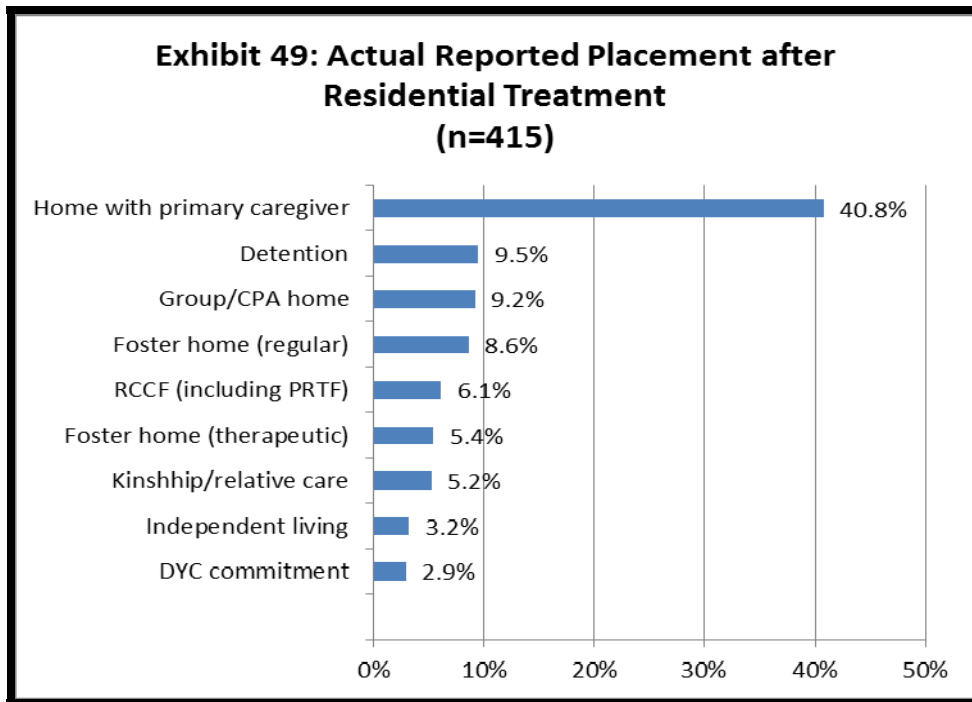
¹ Number of youth available for each analysis varied because of missing data

² Percentages exceed 100% because therapists recommended youth for multiple services post-discharge.

Actual Post-Discharge Placement or Setting

Providers reported that their recommendations for placement settings and service needs were followed by the referring agency 89 percent of the time. This high proportion was somewhat surprising to us since anecdotal information from this and prior studies suggested that that the proportion would be lower even though we had no concrete evidence to support that assumption. Some of our assumptions for this and other issues in our study that were exploratory may have been based on conventional wisdom in the field rather than data. Future studies may want to explore this outcome more thoroughly.

Providers also indicated what they thought was the actual placement after residential treatment. As shown in Exhibit 49, the plurality of youth – over 40 percent of youth – returned home to live with the primary caretaker. Since a return home is most often the preferred placement option by referring agencies, the high proportion in this placement category is not surprising. Yet, it is encouraging to know that RCCF treatment helped stabilize the youth sufficiently that he/she could return home. Post-discharge placements for the remaining youth were distributed over a large number of settings including (1) 15 percent went to a Group or RCCF facility, (2) 14 percent were placed in Therapeutic or Regular Foster Care, and (3) 12 percent went to youth detention or commitment. A small percentage went into Kinship Care (5.2%) or Independent Living (3.2%).



THE CANS: CHANGES FROM ADMISSION TO DISCHARGE

There are two principle approaches that can be used to measure change with the CANS. The first is based on changes in the Actionable level of individual items and the second is based on changes in aggregate scale scores by domain. This section presents the results of both approaches.

Change in Actionable Items

As described earlier in this report, each CANS item is scored from 0-3, with higher numbers indicating more problems and fewer strengths. Each score is also associated with an Action Level that should be reflected in the service plan. Exhibit 50, which also appeared in Chapter II, describes the CANS scores in detail to understand the comparisons in this chapter.

Exhibit 50: CANS Ratings and Actions for Needs and Strengths

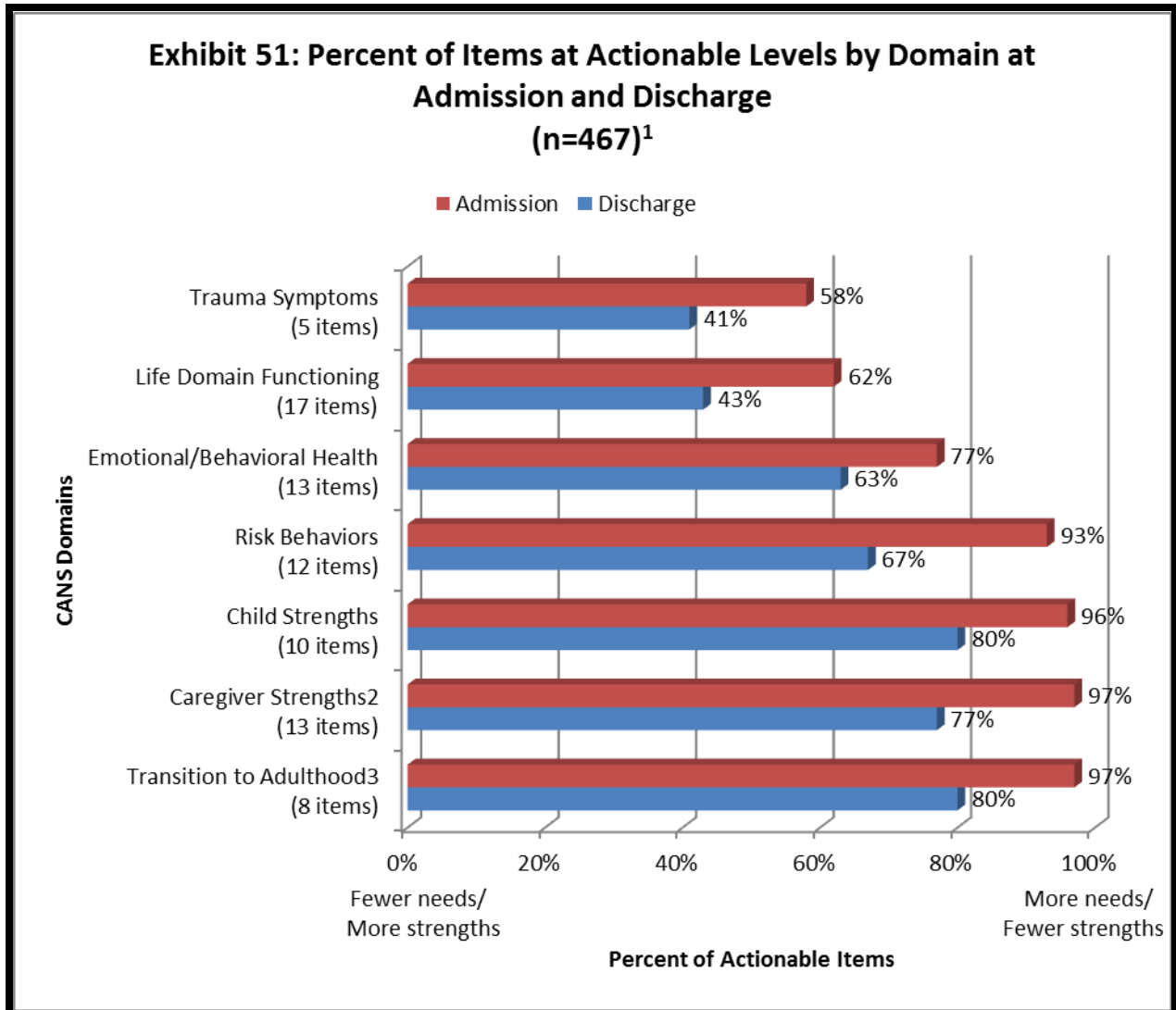
Score	Ratings for Needs	Ratings for Strengths	Action
0	No Evidence	Centerpiece strength	<i>no need for action/ support strength</i>
1	Mild degree	Strength can be use in planning/treatment	<i>need for watchful waiting to see whether action is needed (i.e., flag it for later review to see if any circumstances change) or prevention planning/support and build strength</i>
2	Moderate degree ¹	Strength identified - potentially useful-must be built	<i>need for action/ build strength</i>
3	Severe or profound ¹	No strength identified	<i>need for either immediate or intensive action/ build strength</i>

¹ Items that are scored as a “2” or “3” are referred to as *Actionable*. Items that are scores as a “0” or “1” are *non-Actionable* with regard to current treatment planning and intervention, even though they may be important.

CANS Domains: Percent of Actionable Items at Admission and Discharge

For the first analysis, we calculated a new variable for each item. If the item was scored 0 or 1, we scored it a 0 (i.e., Not Actionable) and if the item was scored 2 or 3, we scored it a 1 (i.e., Actionable). We counted the number of Actionable items in each of seven domains and divided that number by the total number of items in each domain. The result was a Percent Actionable Score for each domain. This is a very broad analysis; that is, one youth with an Actionable score on an item would cause that item to be Actionable for the sample in the domain. However, it does provide a big picture of which domains exhibited the highest density of problems.

Exhibit 51 displays the results of these calculations for the 467 youth with data at admission and discharge. As the data in the exhibit show, almost all the items in four domains were scored Actionable and one-half to two-thirds of the items were Actionable in the remaining three domains. We measured change in this simple score from admission to discharge with the McNemar test, a non-parametric statistical test that can be used to compare pre- and post- circumstances with two levels. The change was significant for all domains. Thus, although it is easy for an item to be scored Actionable, two items – Trauma and Caregiver Strengths (only scored for youth with Caregivers at admission) – fell to just above 40 percent of Actionable Items at discharge. Two other items – Risk Behaviors and Transition to Adulthood (only scored for youth who were 17 years of age or older at admission) – fell to the two-thirds range.



¹ Change from Admission to Discharge is statistically significant ($p < .01$) for all domains.

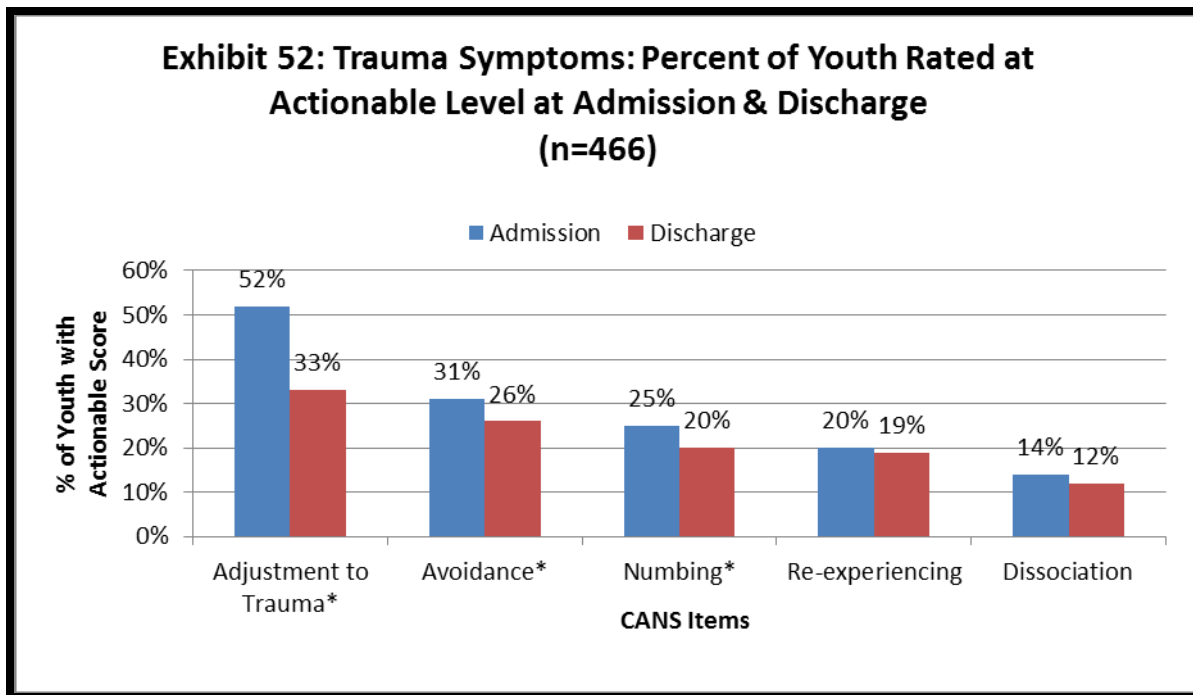
² Caregiver strengths is only calculated on youth with caregivers ($n = 379$).

³ Transition to adulthood is only calculated on youth who were 17 years of age or older at admission ($n = 123$).

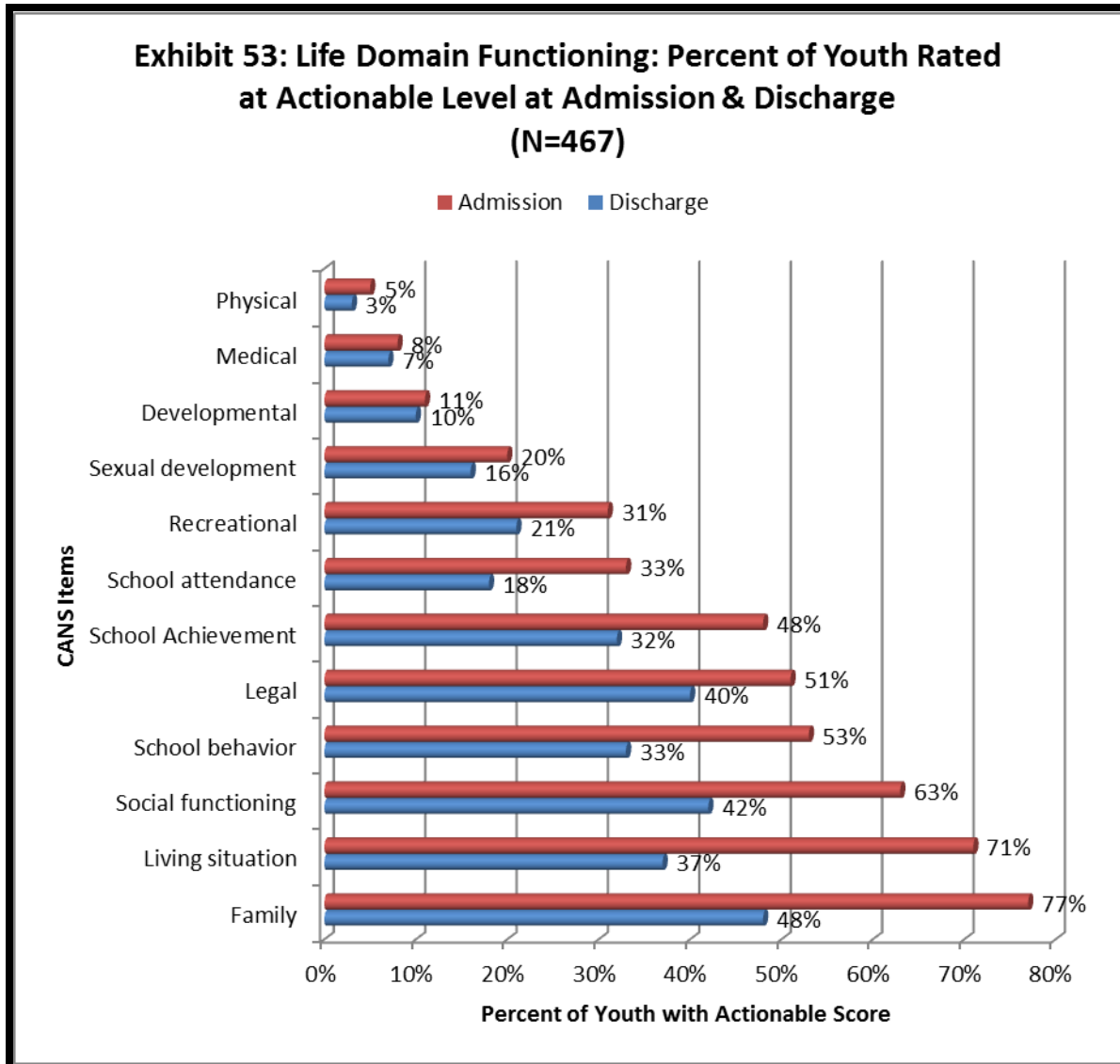
CANS Items: Percentage of Youth with Actionable Scores at Admission and Discharge

While the broad look in Exhibit 51 provides a quick overview, it is logical that we would want to know answers to the following questions: (1) which items within each CANS domain had the highest rate of Actionable scores at admission? and (2) was change in these items observed at discharge? For this analysis, we used the same approach to score the items within each domain that we used to score the domain as a whole. That is, if the item was scored 0 or 1, we scored it a 0 (i.e., Not Actionable) and if the item was scored 2 or 3, we scored it a 1 (i.e., Actionable). We again used the McNemar test to determine whether the change in the percentage of youth with Actionable scores at admission and discharge was statistically significant.

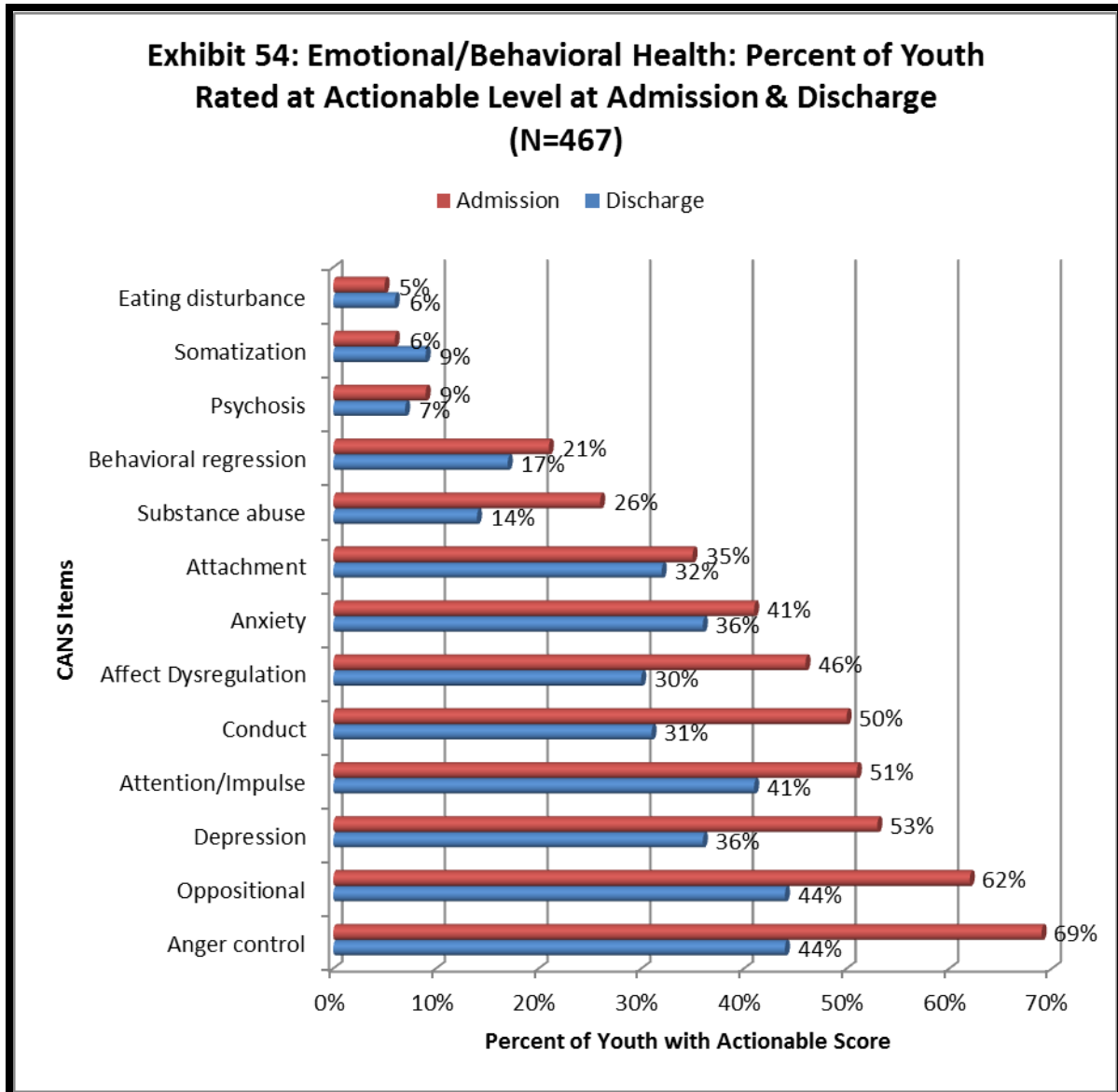
Exhibits 52 through 58 show the percentage of youth with Actionable scores for each item within each of the seven domains. Although the items are presented by domain for convenience, each item percentage and significance level was calculated separately. All of the individual items in the Risk Behavior and Child Strengths domains showed significant change from admission to discharge. Items in Trauma Symptoms and Transition to Adulthood showed the fewest significant changes.



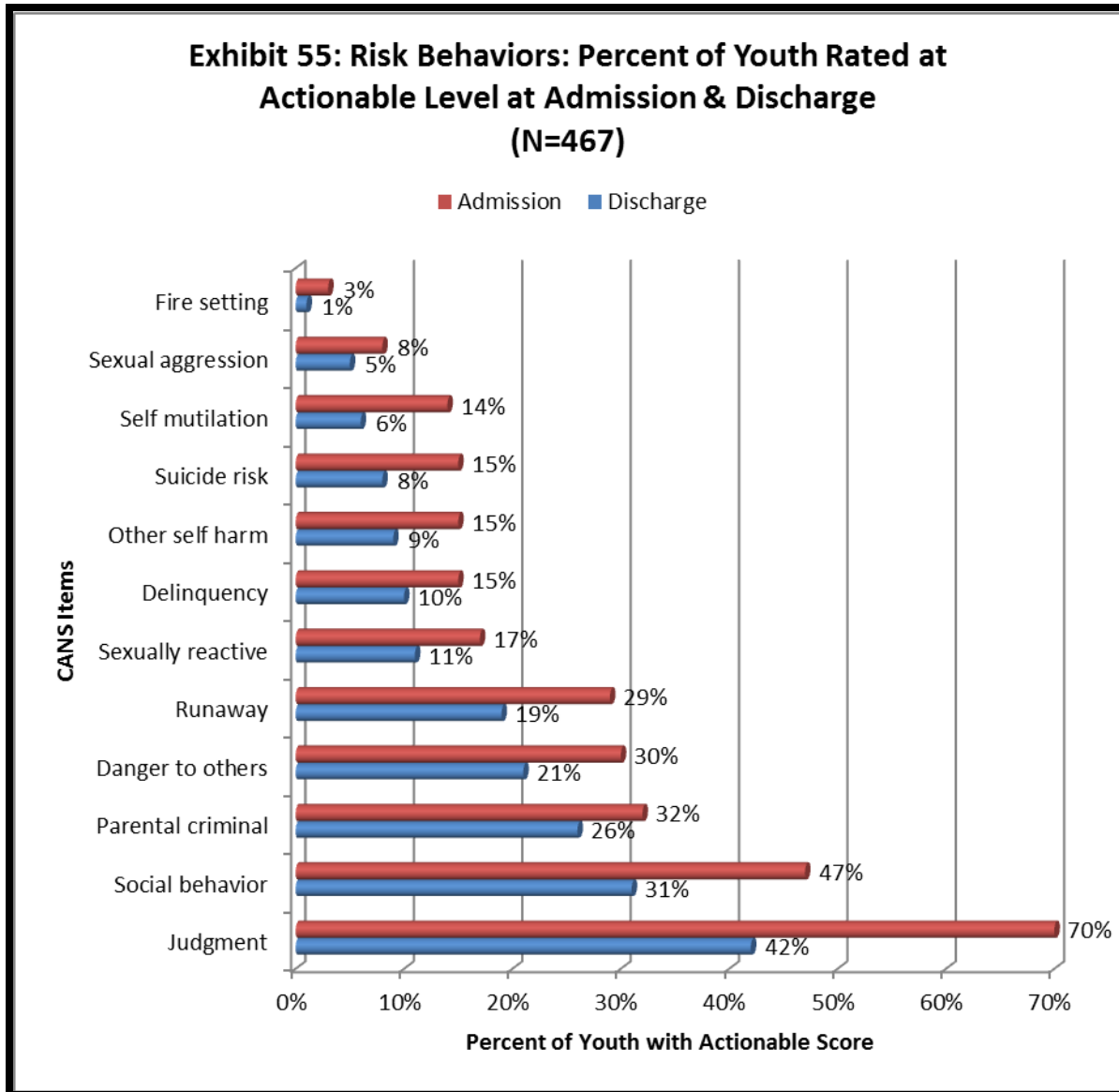
* P<.05 McNemar test



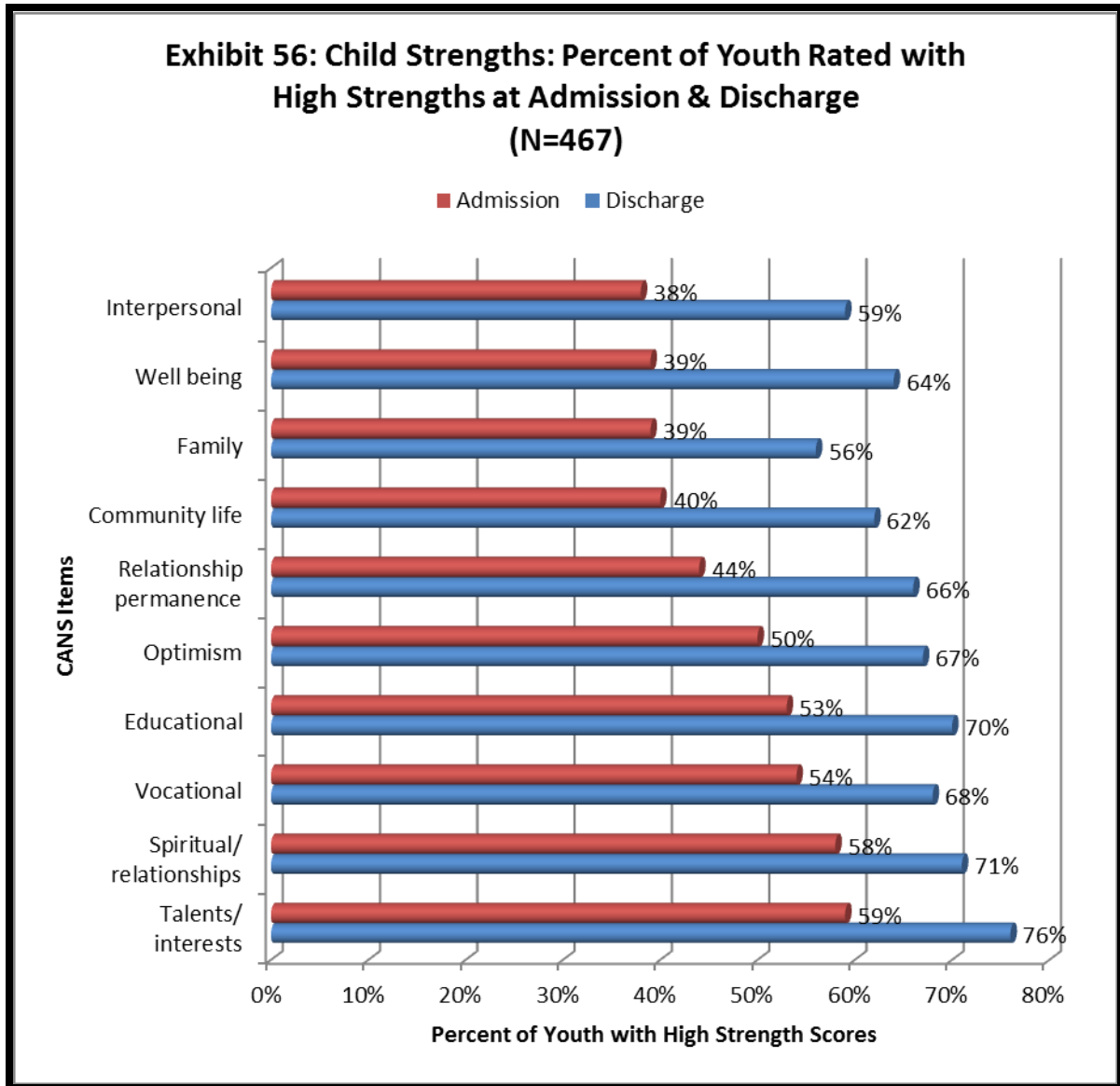
* P<.05 McNemar test



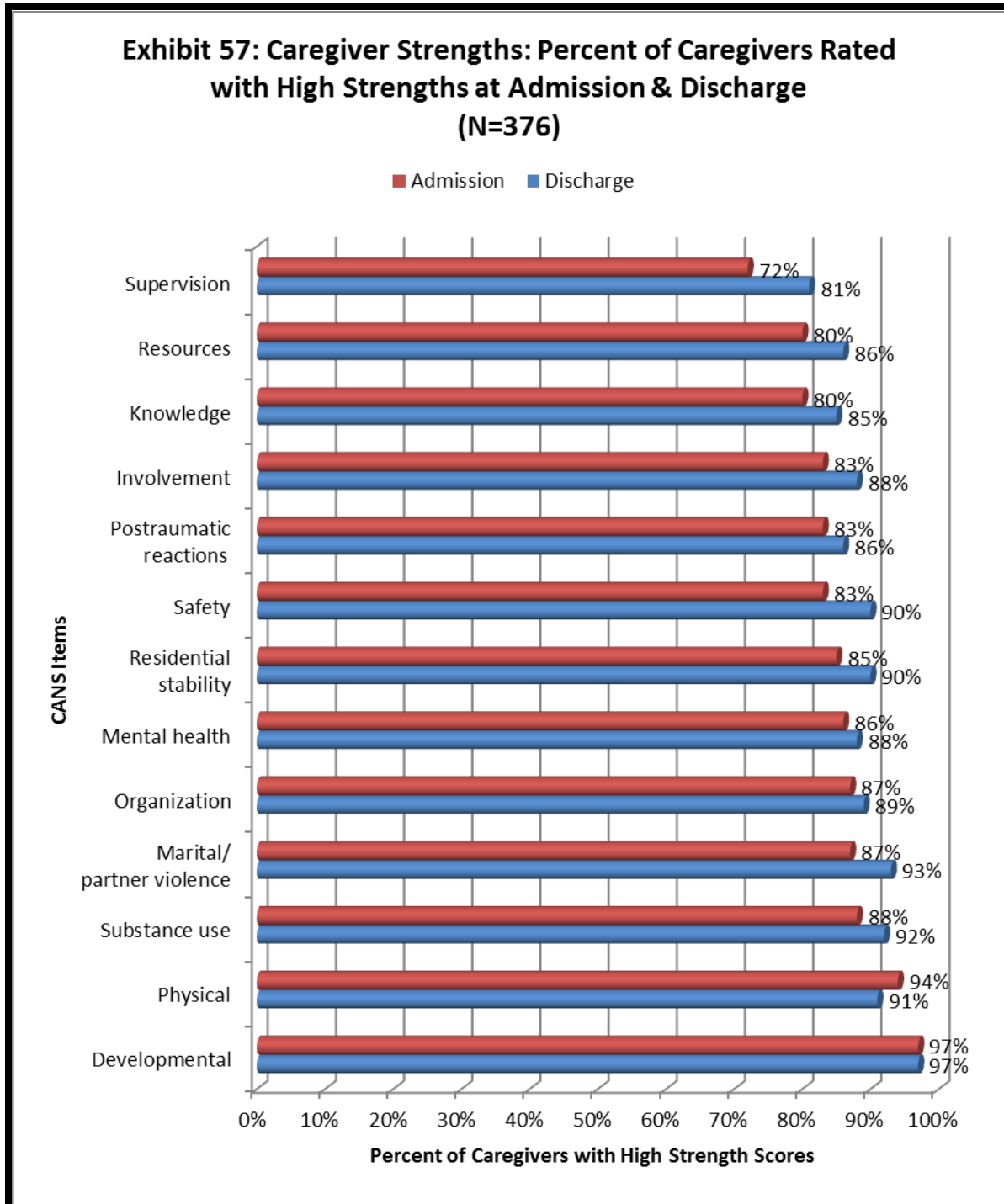
* P<.05 McNemar test



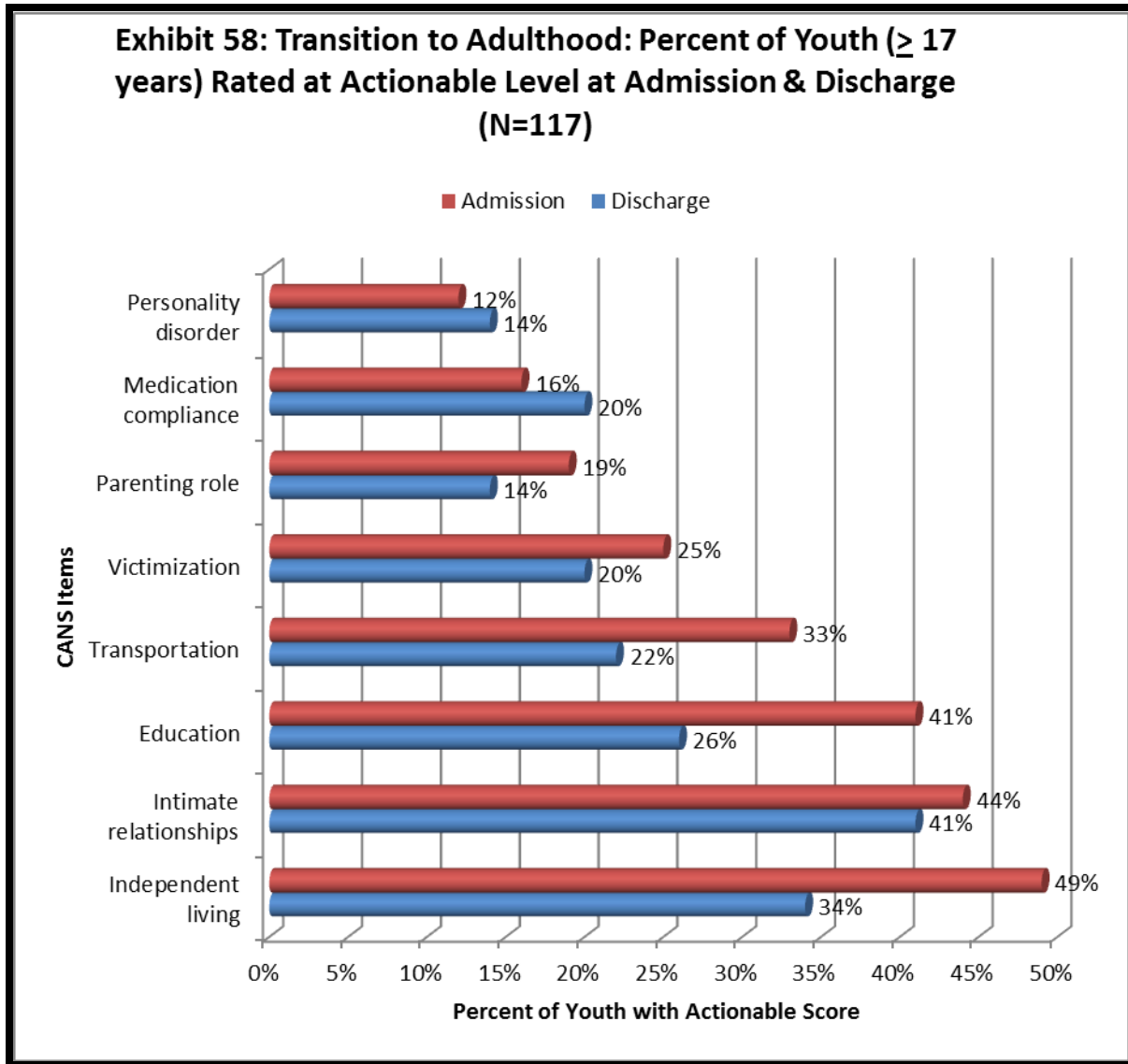
* P<.05 McNemar test



* P<.05 McNemar test



* P<.05 McNemar test



* P<.05 McNemar test

Exhibit 59 summarizes the CANS items with the highest Actionable-level endorsement at admission, the percent Actionable at discharge, and whether the change was statistically significant. The CANS manual in Appendix C contains full descriptions of each item and its associated ratings.

Youth demonstrated significant improvement in almost all of their most serious problems and lowest strengths. The exceptions were two items in Transition to Adulthood, for the subset of youth who were 17 years of age or older at admission: Intimate Relationships and Transportation. Caregiver Strengths were rated very high at admission, with 70 percent to over 80 percent of caregivers showing strengths in their lowest strengths areas. Moreover, therapists reported that caregivers increased their strengths from admission to discharge. It is important to note that Caregiver Strengths reflect the clinician’s assessment of the primary

caregiver at admission and the person who will be responsible for the child at the time of discharge; this may or may not be a parent. The items that identified the primary caregiver by role (e.g., biological mother, adoptive father, foster parent, other relative) was not required and significant amounts of data were missing. We are, therefore, unable to provide more detail or interpretation.

Exhibit 59: CANS Items with Highest Actionable-Level Endorsement at Admission and Change from Admission to Discharge, by Domain (N=467)			
Domain and Highest Actionable-Level Items at Admission	Admission % Actionable	Discharge % Actionable	Significant Change (✓)*
<u>Traumatic Stress Symptoms – 5 items (n=466)</u>			
• Adjustment to trauma	52.0%	32.8%	✓
• Avoidance	31.0%	26.2%	✓
• Numbing	24.6%	19.9%	✓
<u>Life Domain Functioning – 16 items (n=467)</u>			
• Family	77.3%	48.3%	✓
• Living situation	70.9%	36.9%	✓
• Social functioning	63.2%	42.0%	✓
• School behavior	52.7%	32.5%	
<u>Child Behavior/Emotional Needs – 16 items (n=467)</u>			
• Anger control	69.0%	43.9%	✓
• Oppositional	61.9%	43.5%	✓
• Depression	53.3%	35.6%	✓
• Attention/impulse	51.5%	40.9%	✓
<u>Child Risk Behaviors – 12 items (n=467)</u>			
• Judgment	69.6%	42.0%	✓
• Social behavior	47.1%	30.8%	✓
• Parental criminal	31.7%	25.6%	✓
• Danger to others	30.2%	21.0%	✓
<u>Transition to Adulthood – 8 items (n=117)³</u>			
• Independent living	48.8%	34.7%	✓
• Intimate relationships	43.8%	41.1%	
• Education	40.5%	25.8%	✓
• Transportation	33.1%	21.8%	

Exhibit 59: CANS Items with Highest Actionable-Level Endorsement at Admission
and Change from Admission to Discharge, by Domain
(N=467)

Exhibit 59: CANS Items with Highest Actionable-Level Endorsement at Admission and Change from Admission to Discharge, by Domain (N=467)			
<u>Child Strengths – 10 items (n=466)¹</u>			
• Interpersonal	37.8%	58.9%	✓
• Well being	39.1%	64.0%	✓
• Family	39.3%	56.1%	✓
• Community life	39.5%	61.7%	✓
<u>Caregiver Strengths – 10 items (n=376)^{1,2}</u>			
• Supervision	71.8%	80.8%	✓
• Resources	79.7%	86.4%	✓
• Knowledge	79.7%	85.4%	✓
• Involvement	82.8%	87.8%	

* P < .05.

¹ Items displayed for Child and Caregiver Strengths are those with the lowest strengths at admission.

² Caregiver Strengths for those with Caregivers at admission.

³ Transition to Adult is only calculated for those youth 17 years of age or older at admission.

CANS Items: Clinically Meaningful Improvement

Since CANS ratings are tied to different action levels on the part of the clinician, moving from one level to the next may be considered meaningful from a therapeutic point of view. For example, a youth moving from a rating of 3 (needing immediate/intensive action) to a rating of 2 (requires action), changes the treatment approach and service plan, although both are actionable levels.

Using Adjustment to Trauma as an example, Exhibit 60 shows that:

- 69 youth were rated as needing immediate/intensive action at admission (i.e., CANS rating = 3). Of these, 68 percent improved by one or more action levels at discharge.
- 174 youth were rated as needing action (i.e., CANS rating = 2) at admission. Of these, 58.9 percent improved by one or more action levels.
- 141 youth were rated as needing monitoring (CANS rating = 1) at admission. Of these, 20.6 percent were rated as having no evidence of need.

While it was not possible to examine all the CANS variables at this level of detail, the example in Exhibit 58 illustrates how much clinically meaningful change had occurred among the study youth and how the changes for those youth can be documented for all the CANS items.

Exhibit 60: CANS Item with Highest Actionable-Level Endorsement for Traumatic Stress Symptoms at Admission and Change by Action Level from Admission to Discharge (N=467)

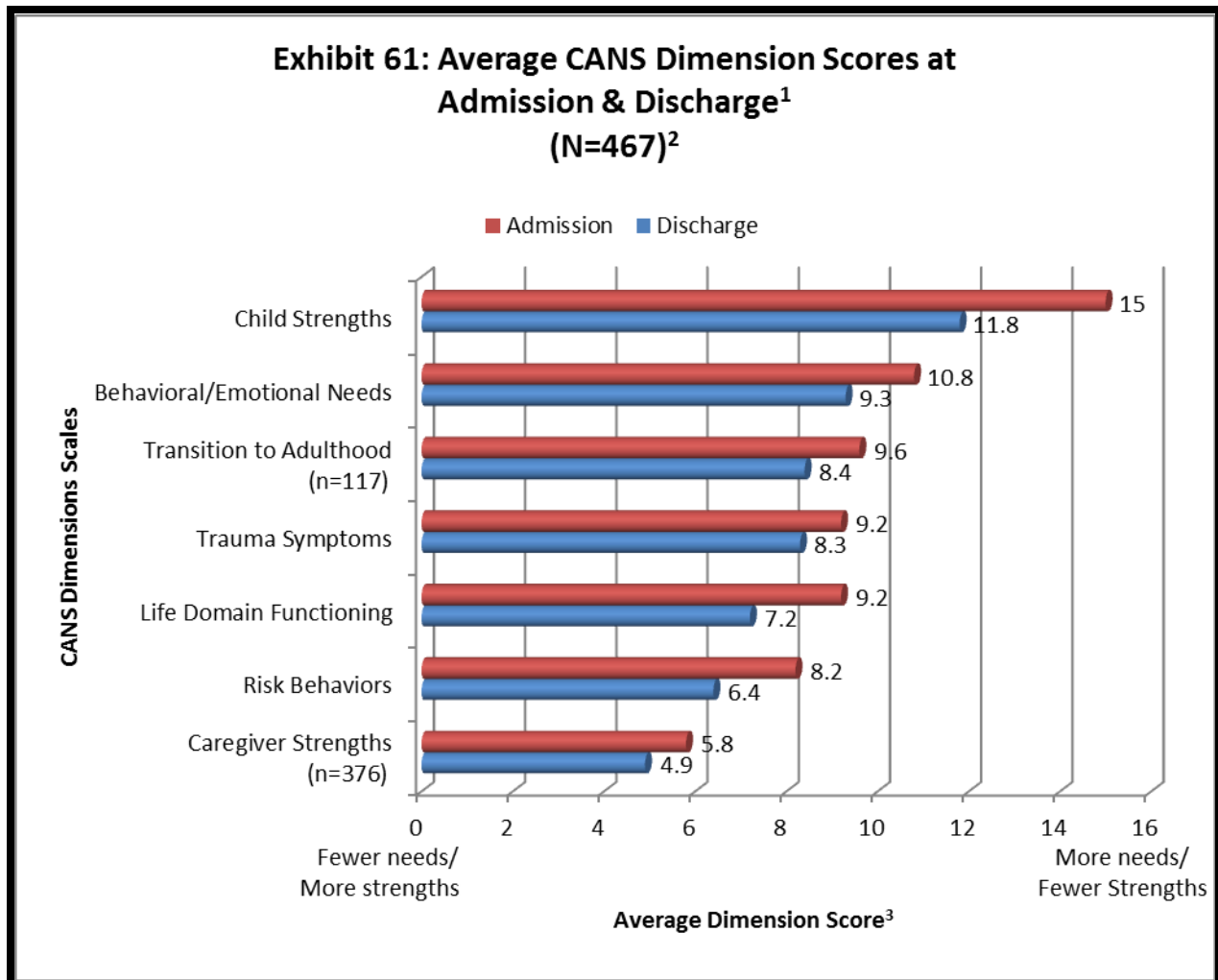
Dimension and Highest Actionable-Level Item at Admission	Number at Admission (% of Total)	% with Improved Rating
<u>Traumatic Stress Symptoms</u>		
• Adjustment to Trauma		
✓ Number of youth rated Level 3 at Admission	69 (14.8%)	
▪ % rated Level 2 or lower at Discharge		68.0%
✓ Number of youth rated Level 2 at Admission	174 (37.3%)	
▪ % rated Level 1 or lower at Discharge		58.9%
✓ Number of youth rated Level 1 at Admission	141 (30.2%)	
▪ % rated Level 0 at Discharge		20.6%

Change in Domain Scale Scores

As indicated earlier, we also calculated CANS dimension scores at admission and discharge, using the formula indicated by John Lyons.²⁷ The result is a standardized scale score that ranges from 0 – 30, with higher numbers indicating more problems and fewer strengths and lower numbers indicating fewer problems and more strengths. Exhibit 61 displays the average scores at admission and discharge for each of seven CANS dimensions. All of the dimension scores improved, with lower scores at discharge compared to admission and the differences in scores were all statistically significant. Though less specific than the item-level analysis, this approach provides an overview of the dimensions that are more and less severe with regard to overall functioning and needs.

The dimension with the highest score at admission was Child Strengths, indicating that the youths entered treatment with very low strengths. While Child Strengths improved the most during treatment, it is still the most challenging area rated. The dimensions with the next highest average admission scores were Behavioral/Emotional Needs (10.8), Transition to Adulthood (9.6, but only for youth who were 17 years of age or older at admission) and Trauma Symptoms (9.2). Of particular interest in the exhibit is the low Caregiver Strengths score. As the dimension is scored, this indicates that caregivers had high strengths at admission (average dimension score of 5.8) and even higher strengths at discharge (4.9).

²⁷ Lyons, J.S. (2010) *Communimetrics: A Communication Theory of Measurement in Human Service Settings* (Springer Verlag), p.104.



¹ CANS dimension scores are calculated by averaging items within a dimension and multiplying those averages by 10. The result is a scale that ranges from 0 (all “0”s reflect no identified needs or all centerpiece strengths) to 30 (all “30”s indicate dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items) or useful strengths (0 or 1 on individual items).

² The number of youth varied slightly from n=467 for each dimension because of some missing data. The analysis for Transition to Adulthood and Caregiver Strengths only included youth who were 17 years or age or older at admission and youth with caregivers, respectively. The number of youth included in those analyses are shown in parenthesis in the exhibit.

³ All admission and discharge comparisons are statistically significant ($p < .02$ using paired t-tests).

Reliable Change

Significant change measures whether a cohort or group has experienced sufficient change from one point in time to another that the change is unlikely due to chance alone. We can also measure whether the change reported for an individual is sufficient to overcome any unreliability or internal inconsistency within the

measure (i.e., scale). *Reliable change* is a more rigorous indicator of change than statistical significance because it requires that the difference between the two scores for an individual youth in treatment – in this case the youth’s admission and discharge scores – exceeds the Reliable Change Index.²⁸ (This Index is calculated based on the reliability and distribution of the measure.)

We calculated the Reliable Change Index (RCI) and the proportion of youth who achieved reliable change for each dimension. Dr. Lyons suggests that 60 percent to 80 percent of youth are expected to improve in at least one of the dimensions and 20 percent to 40 percent of youth will improve in a specific dimension.²⁹ As shown in Exhibit 62, 55 percent of the youth achieved reliable improvement in at least one dimension, slightly below the 60-80 percent threshold. The percent of youth with reliable change varied considerably among CANS dimensions, ranging from 15 percent to 28 percent, with 20 percent or more of the youth showing reliable improvement in four of the six CANS dimensions. Fifteen percent of youth demonstrated reliable change in Trauma Symptoms and 18 percent showed reliable change in Caregiver Strengths, both below the 20 percent threshold suggested by Dr. Lyons. While the Caregiver Strengths dimension was rated very high at admission, leaving less room for improvement, Trauma Symptoms had more opportunity for improvement.

An ongoing evaluation of wraparound services in Indiana using the CANS,^{30,31} gave us an opportunity to compare the results from over 2,000 Indiana youth who completed an episode of care in Indiana’s usual public mental health system, including a broad range of needs and services. Exhibit 61 shows that the percentage of youth with reliable change varied considerably among CANS dimensions, ranging from 15 percent to 28 percent for the Colorado RCCF Outcomes Study and from 20 percent to 33 percent for the Indiana study.³²

We also calculated overall reliable change (i.e., the percentage of youth who achieved reliable change on at least one measure). Although the dimensions included in this calculation differed between the two studies, the overall measures of reliable change were identical for the two studies, 54 percent, with the Indiana rate representing over 11,000 youth who received “usual public behavioral health services.”³³

²⁸ Jacobson, N.S. and P. Traux (1991): “Clinical Significance, A Statistical Approach to Defining Meaningful Change in Psychotherapy Research,” *Journal of Consulting and Clinical Psychology* 59: 12-19.

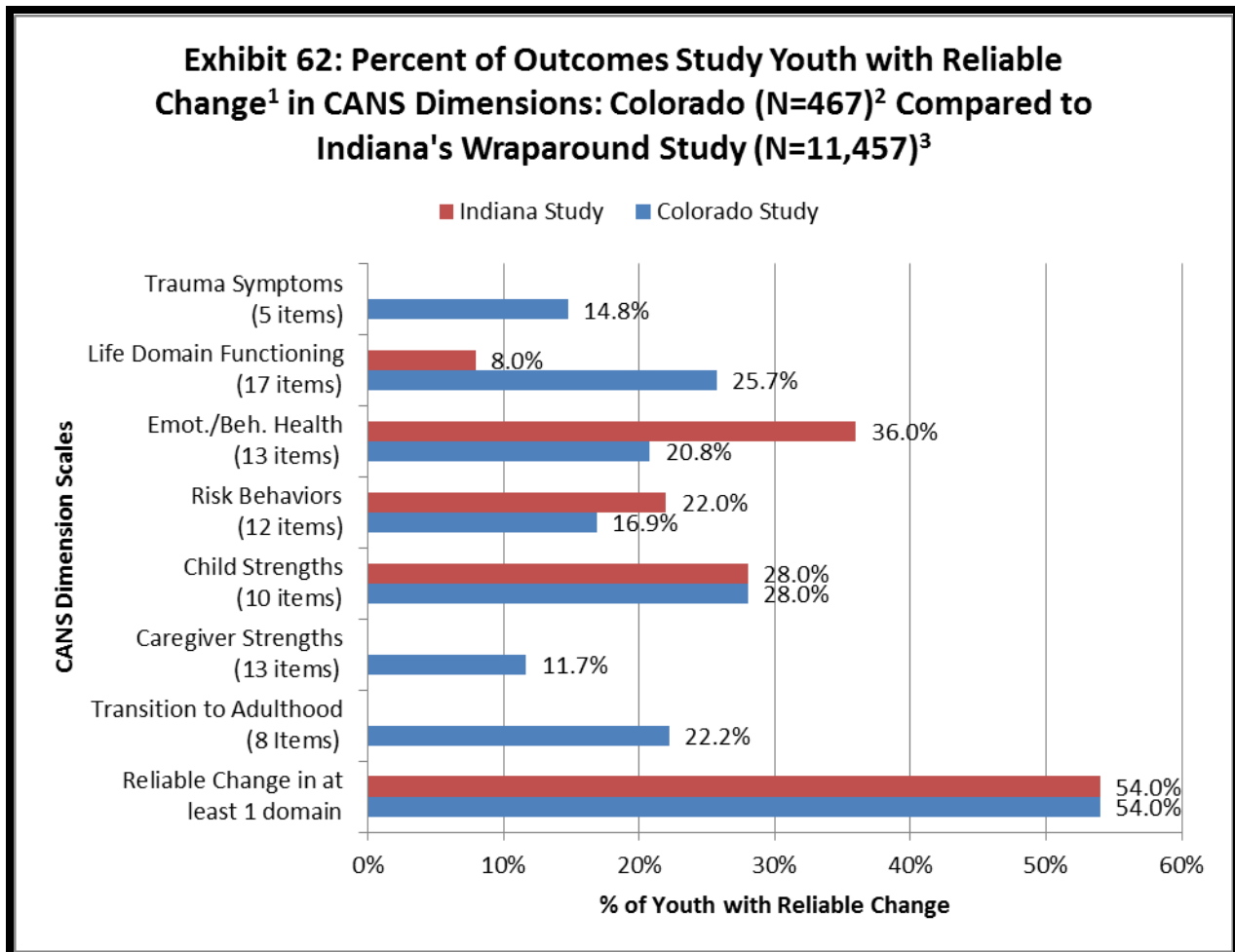
²⁹ Walton B., L. Stanisc and M. Moore (2011) Indiana CA-PRTF Grant Evaluation Update (Indiana Division of Mental Health & Addiction).

³⁰ Ibid, slide 3.

³¹ Effland, V.S., B.A. Walton and J.S. McIntyre (2011) “Connecting the Dots: Stages of Implementation, Wraparound Fidelity and Youth Outcomes,” *Journal of Child and Family Studies*, 20: 736-746.

³² Trauma Symptoms and Transition to Adulthood were not available for Indiana.

³³ Walton B. (2010). Reliable Improvement Information – SuperUser Booster. (Indiana Family & Social Services Administration, Division of Mental Health & Addiction).



¹ Comparable data for the Colorado and Indiana studies were not available for all dimensions.

² The Colorado N size for each dimension varied because of missing data.

³ Walton B. (2010) Reliable Improvement Information – SuperUser Booster (Indiana Division of Mental Health & Addiction).

Differences in Outcomes by Age, Gender, Funding Authority, and Parental Rights

Chapter III presented profiles of all youth at admission, regardless of whether a discharge was completed. This overview included: demographic; placement, juvenile justice, mental health and substance abuse status and history; caregiver information; and CANS dimension scale scores for the overall sample, with comparisons for four characteristics (also referred to as break variables): age group; gender; funding authority (i.e., funder) for the current placement; and parental rights (i.e., custody). These four characteristics were selected by the Steering Committee based on their experience and interest as it regards planning for residential services.

We also were interested in whether the changes we saw from admission to discharge for the overall sample differed according to the same set of characteristics. We used repeated measures analysis of variance with

each CANS dimension scale for each break (i.e., independent variable). Overall, there were only a few significant differences in outcomes that were related to the break variables and all were related to Child Strengths. We followed-up significant results with oneway analysis of variance to explore the differences within the Child Strengths domain.

- Age: Our initial analysis showed a small but significant effect in Child Strengths outcomes by age. The youngest age group, 5–11 year old youth, tended to show the most improvement in Child Strengths – almost significantly more so ($p=.053$) than the 12-14 year old youth.
- Gender: No significant differences in outcomes by gender.
- Funding Authority: Initial analysis showed a small but significant effect in Child Strengths outcomes based on the funding authority. Youth who were placed by private or out-of-state authorities tended to show significantly more improvement in Child Strengths than youth placed by Colorado public agencies (i.e., Child Welfare, Mental Health, DYC).
- Parental rights: Initial analysis showed a small but significant effect in Child Strengths outcomes by parental custody/rights. Youth with pending or terminated parental rights tended to show significantly more improvement in Child Strengths.

SUSTAINABILITY OF OUTCOMES

An important part of assessing outcomes is to determine whether improvements have been sustained over time. This presents unique challenges for assessing residential placements, which occur for different reasons, within different contexts, lengths of time, payor sources, and with no post-discharge intervention or control of service delivery by treatment centers. There are no clear expectations as to what outcomes are reasonable to sustain for how long and for which youth.

The participating RCCFs attempted to collect data on the youth they served at four and twelve months after the youth was discharged. Providers were responsible for using ROCRS reports to track the timing of follow-up and collecting the data. This was challenging and resulted in relatively low rates of follow-up data. In addition to burden and procedural issues, 20 percent of the 467 youth with discharge data were not eligible for follow-up before the end of the study period. As described in Chapter II, there were 74 youth with four-month and 11 youth with twelve-month post-discharge data, 15.8 percent and 2.4 percent, respectively, of the discharge sample. Given the low numbers of youth with twelve-month data, we focused our analysis on the four-month post-discharge period.

Profiles and Representativeness of Youth at Follow-up

In order to determine whether the subsample of 74 youth was representative of all the youth who were admitted during the study period, we compared the two groups on key demographic and placement characteristics. Exhibits 63 and 64 show that youth with discharge data tended to be younger, more male, and slightly more Caucasian and of Hispanic ethnicity than youth without follow-up data. Exhibit 64 shows a greater percentage of youth with follow-up data were placed by CDHS and fewer were placed by CDYC than the larger group of admissions. Youth with follow-up data also had higher rates pending or terminated parental rights. Finally, we looked at the distribution of youth by RCCF Provider (not shown). Of the 11

providers represented in the discharge sample, seven were represented in the four-month follow-up sample. Two providers, however, accounted for almost two-thirds of the follow-up cases. Therefore, the follow-up sample is clearly not representative of all the youth discharged during the study.

As with the discharge sample, but even more emphatically for the small follow-up sample, we do not know why follow-up data collection was not completed for specific youth. Given the low numbers, we assume the majority of providers were not able to implement the follow-up procedures routinely and with consistency, were not able to locate the youth post-discharge, or were not able to get permission to administer the follow-up survey. Therefore, we cannot make any assumptions about or interpret any differences noted.

Exhibit 63: Key Demographic Characteristics of All Youth Compared to Youth with Data 4 Months Post Discharge ¹		
Characteristic ²	All Youth with Admission Data/Forms (n=1,094)	Youth with Follow-Up Data/Forms (n=74)
<u>Age</u>		
• Mean Age at Admission	15.3 years	12.5 years
<u>Gender</u>		
• Male	61.5%	77.0%
<u>Race/Ethnicity</u>	(n=930)	(n=62)
• Caucasian	69.8%	79.0%
• African American	21.6%	8.1%
• Asian	1.2%	—
• American Indian/Alaskan	6.6%	9.7%
• Hawaiian/Pacific Islander	0.9%	3.2%
<u>Hispanic Ethnicity</u>	(n=1,074)	(n=71)
• Yes	33.5%	43.7%

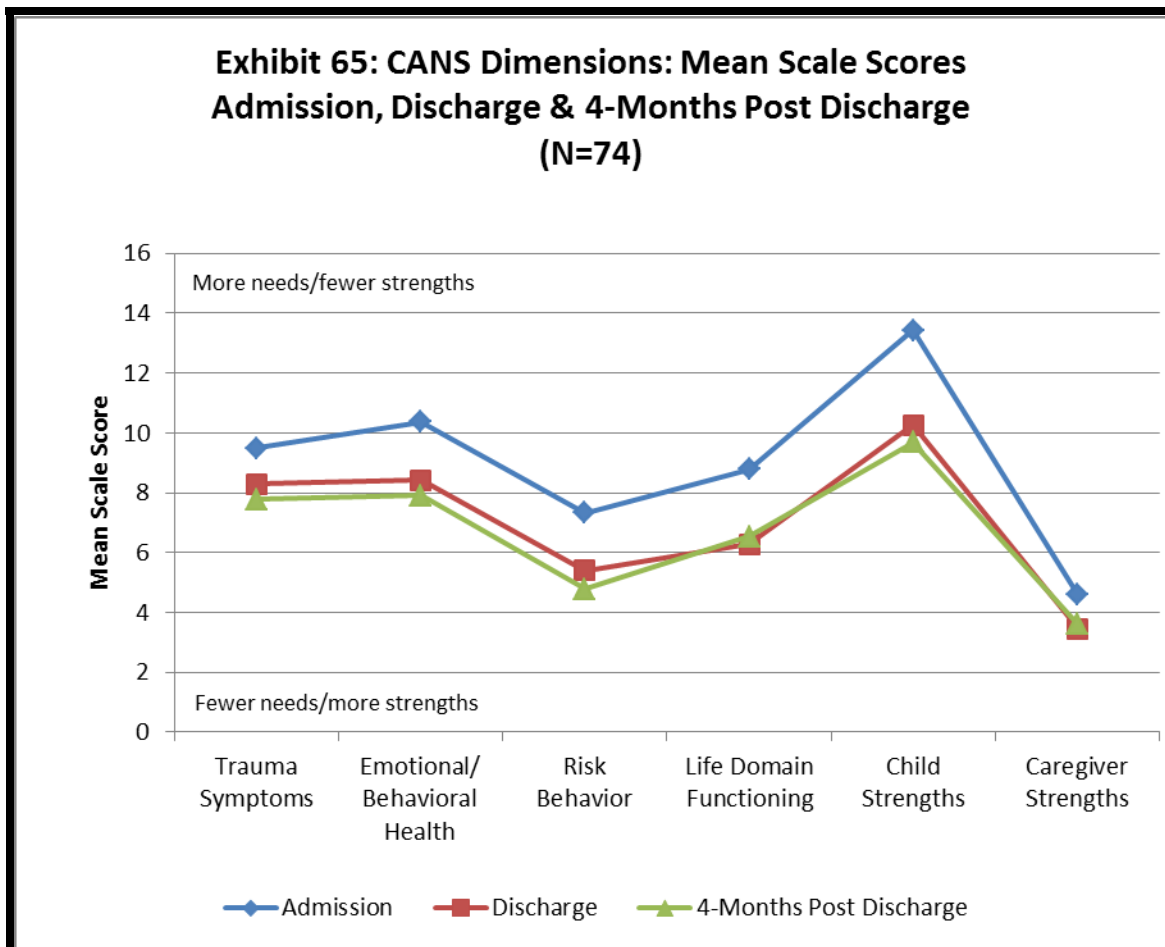
¹ If the number of youth available for analysis is less than the total number of youth in the sample, the number on which the analysis is based is specified by characteristic.

Exhibit 64: Selected Placement Characteristics of All Youth Compared to Youth with Discharge Data ¹		
Characteristic ²	All Youth with Admission Data/Forms (n=1,094)	Youth with Follow-Up Data/Forms (n=74)
<u>Funding Authority</u>	(n=1,085)	
• CDHS/County	59.8%	71.6%
• CDYC	18.0%	5.4%
• BHO/CMHTA	7.8%	6.8%
• Private/Out of State	14.1%	14.9%
• Other	0.3%	0.4%
<u>Status of Parental Rights</u>	(n=1,023)	(n=68)
• Intact	75.2%	61.8%
• Pending or Terminated	24.8%	38.2%

¹ If the number of youth available for analysis is less than the total number of youth in the sample, the number on which the analysis is based is specified by characteristic.

The CANS: Changes Over Time: Admission, Discharge and Post Discharge Follow-up

In order to explore longer-term outcomes, we conducted repeated measures analysis of variance for the subsample of youth for whom we had admission, discharge and four-month post-discharge data. There were insufficient youth with data at twelve months to conduct similar analyses. Exhibit 65 displays the average CANS Dimension Scores for these 74 youth. As shown, all effects by time were significant, except Caregiver Strengths. There were too few youth who were 17 years of age or older in this sub-sample to measure Transition to Adulthood. While this is a small, non-representative sample, it shows distinct trends toward continued improvement after discharge. There were insufficient youth with data at 12 months post-discharge to conduct similar analyses.



SUPPLEMENTAL TRAILS ANALYSIS

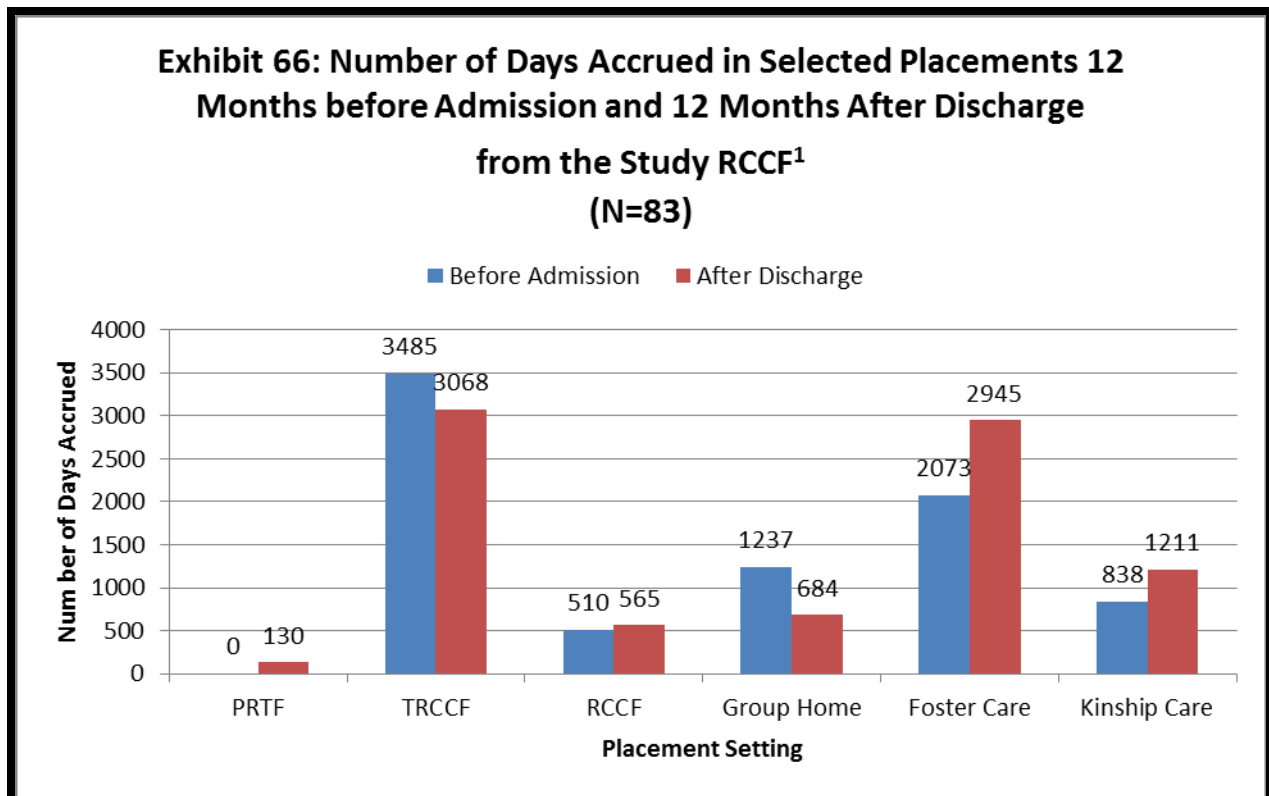
Trails Data Available for Outcome Analysis

There were 164 youth for whom we had admission and discharge data from the Child Welfare Trails database. We focused our analysis on 83 youth (50.6%) who had been discharged from the study RCCF for at least twelve months, providing equal pre- and post-placement periods.

Division of Child Welfare (DCW)

Outcomes: Change in Out of Home Placement Days

Trails DCW information technology staff provided us with hand-verified counts of out-of-home placement days accrued during the twelve months before youth were admitted to the study RCCF and in the twelve months after the youth was discharged from the study RCCF for 83 youth. This information is displayed in Exhibit 66. Combined, there was an overall reduction of 22 percent in out-of-home days, from 9,388 to 7,358 days, with notable decreases occurring in all but the RCCF and Psychiatric Residential Treatment Facility (PRTF) placement days, which increased slightly.



¹ Source: Colorado Trails, 2012

CHAPTER V: CONCLUSIONS

INTRODUCTION

Colorado's Department of Human Services has a long-standing interest in outcomes measurement for youth in out-of-home placements. This has been demonstrated by its continued efforts to encourage, facilitate, and support studies and convene committees to discuss and propose recommendations for appropriate outcomes measurement tools and a process to implement those tools for agencies providing out-of-home placement services. Despite these efforts, other priorities and constraints (e.g., budget, staffing, federal requirements, state policies, differing interests across State divisions and counties, and oversight) have limited progress at the state level toward reaching consensus about and hence in developing a consistent approach to assessment and outcomes measurement.

In late 2006, the Colorado Association of Families and Children's Agencies (CAFCA), in collaboration with and funding from the Colorado Health Foundation (CHF), began a multi-year study of outcomes for youth in out-of-home residential placements. Grounded in system-wide aims to improve services to those youth and their families and inform public policy at the state level to effect positive, systemic change in service delivery to all youth in out-of-home care, the purpose of the study was to examine the effectiveness of behavioral health services for children in residential placement. Primary among the study goals was to develop and use tools that would provide a more in-depth description of the population of youth in residential care (e.g., their characteristics, placement history, problem severity) and outcomes than were available with current statewide databases. (The study followed on the heels of reductions in Medicaid reimbursement for residential care services. Both CAFCA and CHF viewed these reductions as an opportunity to learn better the merits and limitations of residential services as they affected outcomes for vulnerable youth.)

The scope of the study included overall design and planning (e.g., developing instruments, collecting data, managing project implementation and ongoing operations, compiling and analyzing data); executing the plan and the tasks in that plan, and reporting the study results. The study's architects assembled a steering committee to provide guidance, complete study tasks, and oversee study implementation. This chapter highlights the process and outcomes findings from the RCCF Outcome Measures Study.

SUMMARY AND CONCLUSIONS

Developing an outcomes measurement system from scratch was an enormous undertaking. CAFCA's members, all Residential Child Care Facilities (RCCFs), had only a basic foundation upon which to build a system and no blueprint for action. The study required considerable time to build support for and consensus among CAFCA's RCCF members that this study would be worth their time and effort to participate. Now, five years after the study was conceived, a collaborative framework has been created and CAFCA has a set of tools and a web-based system, the Residential Outcomes Collection and Reporting System (ROCRS), with which to capture a wide range of data on the youth in out-of-home care. The materials developed through this study are in the public domain and thus could easily be adapted by Colorado as its standard approach to outcomes measurement for all out-of-home placements.

Given this background, an analysis of the study's outcomes requires an assessment of the process the study used to develop the outcome measurement tools and capture and report data. It also requires an examination of the outcomes youth achieved from their placement in residential care.

The Process

The RCCF Outcome Measures Study had several accomplishments, some of them involving the process of designing and developing an outcomes measurement system. A few critical elements in that process were (1) assembling a group of service providers willing to collaborate to develop a system and take a risk in supporting a lengthy study of outcomes for the youth they served; (2) designing and implementing a web-based data collection and reporting system that could be flexible, extensible, and manageable for the purpose of fulfilling the study objectives and serving as a platform for ongoing measurement beyond the study period; and (3) deciding what data should be captured in the system by all service providers and then developing a set of instruments those providers could use appropriately for data capture.

RCCF Collaboration

This study represented a first-ever effort by a group of residential providers to collaborate in developing and implementing an outcomes measurement system for the youth they served. As the facility information in Chapter I illustrates, the RCCFs that participated in this study had somewhat different characteristics in terms of their size, the populations they served (e.g., ages, types and severity of needs, admission criteria), and the expected length of stay in placement. Nevertheless, the participating RCCFs, operating under the umbrella of the Colorado Association of Family and Children's Agencies, agreed to subsidize a study financially and cooperate with its implementation. CAFCA established a steering committee to oversee the study through all its various stages. This collaboration ultimately was critical to the success of the study.

ROCRS Website

A fundamental and essential feature of this study was our development of a website to (1) capture and store data on each youth at different stages of their treatment, (2) manage the data collection effort (e.g., monitor the completeness and quality of data collection), and (3) report findings for individual youth and for all youth within and across agencies. This proved to be a Herculean task given the complexity of the instruments, the data collection process and the requirements for security and data confidentiality. Yet, the website was successful in collecting and assembling data and in creating reports for data management and outcomes. While the website needs further refinements, it is a stand-alone system that RCCFs have continued to use beyond the duration of the study.

CANS Tool

The Steering Committee deliberated extensively in deciding which, among several outcomes measurement tools, it wanted to use for this study. It chose the CANS for multiple reasons. Among others, these reasons included the tool's applicability as an instrument for treatment planning and for outcomes measurement. In practice, the tool worked well for both purposes.

- **Treatment Planning:** the CANS is designed to facilitate treatment planning at admission and at discharge. The dimensions of need are easily scored to determine severity and establish priorities for treatment at admission. Also, the scoring can be color-coded – as was done in this study – to highlight the needs that should be included in the treatment plan. The multiple dimensions of the CANS also allow the clinician to identify areas of strength on which treatment services are able to build.

At discharge, reapplication of the CANS can identify the dimensions that still need attention and help the clinician to recommend post-residential treatment options and services.

- **Outcomes Measurement:** Outcomes measurement using the CANS proved to be very straightforward. Initially, there was skepticism among RCCFs about the ability of the CANS to detect change over time reliably during their relatively short average lengths of stay. Ultimately, this study was able to use the CANS successfully to assess outcomes by measuring change from admission to discharge and even beyond discharge from the RCCF when clinicians were able to complete four and twelve month follow-up interviews and re-administer the CANS. This provides important local support for the utility of the CANS, which is being used by jurisdictions in 38 states nationally.³⁴

As a tool for both treatment planning and outcomes measurement, the CANS proved to be flexible by providing different ways to describe severity and assess change. This study looked at change from multiple perspectives, including:

- Change in overall scale scores for each domain.
- Change in the proportion of items in each domain that were actionable and change in the proportion of youth with actionable items in each domain.
- Clinically meaningful change; that is, since scores are related to actions, this study was able to examine change from one action level to another.

All the measures are interval level variables that allow for standard statistical testing approaches (e.g., paired t-tests, reliable change) that can look at change at the individual and group level. The statistical tests indicated considerable improvement in the youths' level of functioning over the course of their treatment at the participating RCCFs.

³⁴ The CANS is being used statewide in 16 states and in one or more jurisdictions in an additional 22 states.

Follow-up Post Discharge

Most studies that require voluntary – as opposed to mandatory – cooperation with an evaluation protocol face tremendous challenges in following up with participants once they complete services or leave a program before service completion. This study's experience with follow up was similar and, as a result, we had relatively few follow-up interviews completed with youth once they were discharged from the RCCF. Clinicians were able to complete interviews with 74 youth at four months post discharge and 11 youth at 12 months post discharge. The four-month number represented 15.8 percent of all youth discharged over the study's two-year data collection period (1/1/2009 through 12/31/2010). Moreover, the youth with follow-up data were statistically not representative of all youth discharged which made it difficult to discuss the sustainability of treatment outcomes over time.

Although clinicians are the appropriate individuals to conduct the follow-up interviews and administer the surveys, the additional work this required proved time-consuming and thus difficult for clinicians to accommodate within their busy work schedules. In future studies of this population, we therefore recommend that funds be allocated to the evaluation contractor to conduct the follow-up data collection.

The Outcomes

The RCCF Outcome Measures Study did not begin in a vacuum. Colorado had encouraged and supported outcomes measurement research and studies in the past, and other states and other investigators had conducted studies of outcomes for youth in out-of-home care. These studies provided a foundation for our study in terms of what research questions to ask. A basic issue our study needed to address was describing the youth in residential care. What are their social and demographic characteristics and what are their treatment needs from residential placement? Beyond that issue, the study's main goal was to evaluate the progress youth made during their stay in residential placement (i.e. treatment outcomes) and the durability of those gains over time, which is one reason the study included an effort to follow-up with youth after their discharge from treatment and capture information from Colorado Trails.

Profile of Youth at RCCF Admission

A chief goal of the study was to develop a profile of youth at admission to residential placement, both in terms of their demographic (e.g., age, race/ethnicity) and social (e.g., placement history, delinquency status, diagnoses) backgrounds, and their service needs. In addition to the CANS, which therapists used to assess the youth's needs and strengths, the study developed instruments to gather information about the number and types of diagnoses, and systematically capture some of the information RCCFs were already gathering but not necessarily recording on every youth admitted to their facilities.

The analysis had mostly complete information for 1,207 youth at admission. In terms of background characteristics, the profile yielded the following general findings:

- A higher proportion of admitted youth were males (58.7%) than females. They were predominantly Caucasian (69.7%), and teenagers (i.e., the average age for the youth was 15.6 years; slightly higher for males and slightly lower for females). A slight majority (51.9%) had been adjudicated delinquent at the time of their RCCF admission.

- The parental rights of most of the youths' biological parents were still intact (76.1%) and the majority of those parents were supportive of the residential placement and wanted the child eventually to return home. Yet, at the time of RCCF admission, most of the youth had not come from living with their primary caretakers, but from another out-of-home placement. (Only 15.4 percent of youth had been living at home with their primary caregiver prior to their RCCF placement.)
- Almost all youth (97.7%) had a history of some trauma experiences. Of the 13 trauma items listed on the CANS, more than 50 percent of youth had experienced trauma in seven of the items from sexual abuse (53.3%) to traumatic grief (78.0%). Almost a third of youth (31.3%) had a history of four or more types of trauma experiences. There were no statistically significant differences in the prevalence of traumatic experiences based on the youth's age or gender, although youth from homes where the parental rights were terminated/pending had experienced significantly more traumatic events than youth from homes where the parental rights were intact.
- The diagnostic profile showed that most youth (81.0%) had more than one diagnosis at admission. The prevalence of Axis I and Axis II disorders was markedly different for males and females, with males statistically more likely than females to have conduct/antisocial behavior disorder and development delay/mental retardation and females statistically more likely than males to have mood and personality disorders. The majority of youth (80.0%) had GAF scores of 50 or less, indicating they had serious symptoms or serious impairment of functioning.

The CANS was used to develop a clinical profile of youth at admission. Clinicians use a four-point scale (0 to 3) to score each CANS item, with "0" indicating no evidence of need and "3" indicating a dangerous or disabling level of need. There is more than one approach to assessing a youth's severity of need using these scores. The most basic approach is to calculate an overall score for each domain using all the individual item scores within that domain. Using that approach, the highest possible score is 30 indicating that a youth had a dangerous level of need on each of the items within a domain. The analysis of CANS data showed the following:

- On average, all the CANS domains indicated a need for attention. However, the overall scores were well below the maximum threshold. The behavioral-emotional needs scale showed the highest level of severity with an overall score of 11.3 (out of 30) and the trauma scale showed the lowest level of severity with an overall score of 8.4.
- In terms of child and caregiver strengths; the CANS overall score for caregivers was substantially higher than the score for child strengths.

In some regards, the overall average scores understate the severity of need youth present at admission because they include the scores for those youth and those items where there is no evidence of need. As a result, the study also looked at the severity of need in terms of the proportion of actionable items (i.e., items with scores of 2 or 3) within each scale. That perspective helped underscore the complexity of the problems youth in residential care present and thus the challenge to therapists in addressing the range of youth needs. Thus, for example:

- 87.8 percent of the 15 items in the Life Domain scale had youth with actionable scores of 2 or 3.
- 87.5 percent of the 13 items in the Behavior Emotional Needs Domain scale had youth with actionable scores of 2 or 3.
- More than half of the items in each of the eight domains had actionable items. The proportions ranged from 52.9 percent for the Caretakers Strength Scale to 87.8 percent for the Life Domain Scale.
- Nine of thirteen prior trauma experiences were identified for 30 percent or more of the youth, the most common being Traumatic Grief, Emotional Abuse, and Neglect, Physical Abuse, and Family Violence.

This approach to assessment would enable us to control for severity at the outset of treatment in future outcomes measurements, a difficult but important component of analyzing outcomes within an array of youth who have differential risks and strengths.

CANS Outcomes at Discharge

One of the major benefits of using the CANS tool for this study was its ability to reliably measure changes in youth functioning from admission to discharge even for relatively short lengths of stay in residential care. (The CANS developer suggests that the tool is best applied after a three-month length of stay, but that it can be used satisfactorily with shorter lengths of stay.) Most of the youth in this study were in residential care for more than three months; the average length of stay was six months and the median length of stay was five months.

Our analysis of data for discharged youth included the following key facts:

- Half of the discharged youth (51.1%) met at least 70 percent of their treatment goals and slightly less than half of caretakers (46.7%) met at least 70 percent of their goals.
- More than half (56.8%) of the discharged youth completed the residential treatment program successfully. Only a small proportion (7.2%) were removed from placement against the advice of the RCCF provider.
- At discharge, the RCCF provider recommended almost two-thirds of the youth (64.7%) for a less restrictive placement. Return home to live with the primary caretaker was the most frequent recommendation for youth in this group and 40.8 percent of youth reportedly did return home after their discharge.

- RCCF providers also recommended a lower frequency of treatment services for youth post-discharge; only 18 percent were recommended for day treatment. The majority of youth were recommended for services to occur 1-2 days per week, such as individual therapy/counseling and outpatient family therapy.

Providers reported that their recommendations for placement settings and service needs were followed by the referring agency 89 percent of the time.

Arguably, the more important findings at discharge were related to changes in the youth's needs and strengths at discharge compared to their needs and strengths at admission. We measured these changes by comparing CANS scores at both time periods. We had complete CANS data at admission and discharge for 467 youth.

Our first comparison examined the proportion of actionable needs and strengths within each of seven domains: Trauma Symptoms, Life Functioning, Emotional/Behavioral Health, Risk Behaviors, Child Strengths, Caregiver Strengths, and Transition to Adulthood. This very broad analysis provides a picture of which domains exhibited the greatest density of need. The analysis showed that at admission, almost all the items in four domains had scores that were actionable (i.e., more than 90% of the items were actionable) and more than half of the items in the other three domains were actionable (the range was 58% of items in the Trauma Symptoms domain to 77% of items in the Life Functioning domain). At discharge, the proportion of actionable items had decreased significantly from admission in all seven domains.

We also calculated the proportion of youth with actionable item scores at admission and discharge for each item in the seven domains. For two domains – Risk Behaviors and Child Strengths – the proportion of youth with actionable items decreased significantly from admission to discharge for all items within the domain. The other five domains showed decreases in the proportion of youth with actionable items from admission to discharge in all or most of the items within them, but not all the changes were significant. The Trauma Symptoms and Transition to Adulthood domains showed the fewest significant changes between the two assessment periods.

The most rigorous approach we used to evaluate changes from admission to discharge was calculating a Reliable Change Index and the proportion of youth who achieved reliable change for each domain.³⁵ The percentage of youth with reliable change varied considerably among the CANS domains ranging from a low of 15 percent for Trauma Symptoms to a high of 28 percent for Child Strengths. Overall, 20 percent of the youth in this study showed reliable change from admission to discharge in four of the seven CANS domains; 20 percent being the threshold Dr. Lyons suggests should be expected as an outcome from treatment. The proportions of youth with reliable change in the other three domains were close to this threshold (15%, 17% and 18%).

As a final benchmark, we calculated the percentage of youth who had reliable change on at least one measure in this study and compared it to the reliable change findings from a study of wraparound services Dr. Lyons

³⁵ Reliable change is a more rigorous indicator of change than statistical significance because it requires that the difference between the two scores for an individual youth in treatment – in this case the youth's admission and discharge scores – exceeds the Reliable Change Index.

completed in Indiana. Although the dimensions included in this calculation differed slightly between the two studies, the overall measures of reliable change were almost identical, 54 percent for our Colorado study and 56 percent for the Indiana study.

Trails Data for Outcomes Analysis

Trails is the state's management information system for youth in out-of-home placements who are receiving state-funded services. This study worked with staff from the Divisions of Child Welfare and Youth Corrections, and with a team of Trails programmers to develop the parameters for an extract of Trails data about the study youth 12 months prior to their admission to and 12 months after their discharge from the RCCFs. Among the lessons we learned in this study is that as an outcomes measurement tool, the Trails database has limitations. Some of these limitations are in the completeness and quality of data Trails captures and other limitations are in the timing of data collection. Specifically, although Trails includes the data elements that could be used for outcomes measurement, many elements are not required to be completed and/or they are not completed before various interventions begin and after they end. This makes the measurement of treatment specific outcomes unreliable.

For the youth involved in this study, we extracted data at the individual clinical level from the Colorado Client Assessment Record and the Colorado Juvenile Risk Assessment. However, we found discrepancies in the completion dates of those instruments that did not allow us to document pre- and post-placement changes.

Regardless of these limitations, this study made a concerted effort to identify the most important variables to capture from Trails. This primarily included variables that state researchers rely upon for their outcomes analyses and that they recommended we capture. The most compelling finding from this database was the significant reduction in residential treatment days in the one-year following discharge from the RCCF compared to the twelve-month period prior to admission to the RCCF. We were disappointed, however, in the completeness and quality of the other information we received about the study youth from the Trails data extract. As a result, the Trails data did not inform our study outcomes substantively.

Beyond Outcomes

John Lyons has continued his research using the CANS on youth care in alternative placement settings. That research has involved using the CANS data to determine the intensity of mental health care and placement type that youth need. He has developed models that are intended to be used prior to referral for services in deciding the most appropriate placement type. Early evidence from the models' application in Indiana has demonstrated improved outcomes for youth whose recommended and actual services matched. Our application of the model to the youth in our study indicate that about 40 percent of the youth would have been recommended for foster care, mostly non-therapeutic, while the remaining 60 percent would have been recommended for either group, residential, or inpatient care. The ability to use CANS as a tool to make decisions about placement and the positive findings from the tool's application in Indiana hold the promise of finding better placement fits for youth with severe mental health and behavior problems.

Finally, our study suggests that the CANS can be a powerful tool to assess the level of service need across many levels of functioning, assist in developing approaches to treat those needs, and measure the outcomes

that result from treatment. We encourage Colorado to look more closely at the CANS tool and consider implementing the tool statewide to assess the level of treatment needs for the youth it places in out-of-home care. Given the challenges of implementing and sustaining special studies, we also strongly recommend that such an implementation be integrated into required elements of the statewide database to ensure timely and complete data.

**Appendix A:
RCCF Organization Survey**

ROCRS Residential Child Care Facility (RCCF) Survey

INTRODUCTION

Your answers to the background questions below will be key-entered into the Residential Outcomes Collection and Reporting System (ROCRS) by the web developers. The information will be available only to your agency and to the study evaluators.

PLEASE RETURN THIS SURVEY BY FRIDAY, MARCH 20, 2009. We know that several of you provide services at more than one location. Please consider all your locations in answering the questions. For example, if you provide a service at one location but not another, please respond that you DO provide the service. Where a question asks for counts (e.g., total residents in the most recently completed fiscal year), please aggregate the information across all your locations.

You may complete and submit your survey using one of the following options:

- **Mail:** send your completed survey by mail to David Price; Policy Studies Inc.; 1899 Wynkoop St., Suite 300; Denver, Colorado 80202
- **Fax:** submit your completed survey by fax to 303-295-0244; attn: David Price
- **E-mail:** send your completed survey to dprice@policy-studies.com

Thank you for your cooperation in this data collection effort.

INFORMATION SUPPLIED BY (only for follow up if we have questions)		
Name: Shayna Miller		
Telephone	Area code	Number
E-mail address:		

BACKGROUND INFORMATION

1. Agency name _____
2. Form of business organization
1 – Public (government) 2 – Private, for profit 3 – Private, not-for-profit
3. In what year did your agency begin RCCF operations? _____
4. How many staff secure beds does your agency have? _____
5. Does your agency use locked seclusion? *(Please check one)*
1 – Yes 2 – No
6. Does your agency use physical crisis restraint of clients? *(Please check one)*
1 – Yes 2 – No

7. With which of the following organizations is your agency accredited? (Check all that apply)

- 1 – None, our RCCF is not accredited
- 2 – None, but our RCCF is in the process of becoming accredited
- 3 – COA
- 4 – JCAHO
- 5 – CARF
- 6 – Other (please describe): _____
- 9 – Unable to determine

8. Please complete the following information about the residents in your facility for your most recently completed fiscal year. (Unduplicated counts only, please.)

- Total residents in the most recently completed fiscal year _____
- Total residents from Colorado: Division of Youth Corrections _____
- Total residents from Colorado: County Child Welfare _____
- Total residents from Colorado: Mental Health (HB 1116, HB 1351, MHASA) _____
- Total residents from Colorado: Other public, non-Medicaid (e.g., CHAMPUS) _____
- Total residents from Colorado (private pay) _____
- Total residents from outside Colorado _____

9. In the list below, please check those cases that as a general rule your agency DOES NOT ACCEPT into its program. (Check all that apply)

- | | |
|--|--|
| 1 – <input type="checkbox"/> Adjudicated sex offenders | 15 – <input type="checkbox"/> Pregnant |
| 2 – <input type="checkbox"/> Non adjudicated sex offenders | 16 – <input type="checkbox"/> Psychotic or thought disorders |
| 3 – <input type="checkbox"/> Fire starters | 17 – <input type="checkbox"/> Actively suicidal |
| 4 – <input type="checkbox"/> Previous gang activity | 18 – <input type="checkbox"/> Residents needing routine psychiatric monitoring for psychoactive medication |
| 5 – <input type="checkbox"/> Previous DYC commitment | 19 – <input type="checkbox"/> Risk of running |
| 6 – <input type="checkbox"/> Alcohol abuse | 20 – <input type="checkbox"/> Residents without family involvement |
| 7 – <input type="checkbox"/> Drug abuse | 21 – <input type="checkbox"/> Assaultive/combatative |
| 8 – <input type="checkbox"/> Residents needing medically supervised detoxification | 22 – <input type="checkbox"/> Emancipated minors |
| 9 – <input type="checkbox"/> IQ less than _____
(please fill in the IQ threshold) | 23 – <input type="checkbox"/> Self-paying residents |
| 10 – <input type="checkbox"/> Pervasive Development Disorder | 24 – <input type="checkbox"/> HB 1116/HB 1351 residents |
| 11 – <input type="checkbox"/> Fetal Alcohol effects/syndrome | 25 – <input type="checkbox"/> Residents with private insurance |
| 12 – <input type="checkbox"/> Residents NOT designated as SIED/IEP | 26 – <input type="checkbox"/> Medicaid residents (i.e., DYC, Child Welfare, MHASA) |
| 13 – <input type="checkbox"/> Medically fragile | 27 – <input type="checkbox"/> Out of state referrals |
| 14 – <input type="checkbox"/> Non-ambulatory | 28 – <input type="checkbox"/> Other (please describe below) |

Other: _____

10. Please answer the following about the length of stay of residents in your RCCF for your most recently completed fiscal year.

Data not available

1 – range (in days) from (low) _____ to (high) _____

2 – average number of days _____

3 – median number of days _____

11. For each of the following treatment modalities/services, please indicate whether they are provided using RCCF staff, contractor staff, both RCCF and contractor staff, or are not provided.

Service	RTC staff	Contractors	RTC staff & Contractors	Volunteers	Do not provide
a. Assessment, including Psychological Testing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
b. Individual therapy/counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
c. Group therapy (e.g., offense-specific therapy, substance abuse, sexual safety, grief and loss, problem solving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
<u>Other options (Check if appropriate):</u>					
<input type="checkbox"/> SOMB certified therapist					
<input type="checkbox"/> ADA approved provider					
d. Family therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
e. Educational groups (e.g., teen parenting, early childhood development, smoking cessation, independent living skills)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
f. Psychiatric services and medication management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
g. Expressive therapy (art, music, dance, theater)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
h. Special services (physical, occupational, speech)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
i. Recreational therapy (sports, yoga)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
j. Vocational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
k. Mentoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Community services/restorative justice services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
m. Faith/spirituality services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Mileau therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
o. Services delivered in the client's home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
p. Community activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
q. Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

12. Which of the following evidence-based services does your agency provide? *(Check all that apply)*

- | | |
|--|--|
| 1 – <input type="checkbox"/> ABA (Applied Behavior Analysis) | 5 – <input type="checkbox"/> MST (Multisystemic Therapy) |
| 2 – <input type="checkbox"/> ART (Aggression Replacement Training) | 6 – <input type="checkbox"/> PBS (Positive Behavior Support) |
| 3 – <input type="checkbox"/> DBT (Dialectical Behavioral Therapy) | 8 – <input type="checkbox"/> Other evidence-based services (specify below) |
| 4 – <input type="checkbox"/> FFT (Functional Family Therapy) | 9 – <input type="checkbox"/> Do not provide any evidence-based services |

Other: _____

13. Which of the following other specialized services does your agency provide? *(Check all that apply)*

- | | |
|--|---|
| 1 – <input type="checkbox"/> Equine | 5 – <input type="checkbox"/> EMDR |
| 2 – <input type="checkbox"/> Wilderness/adventure | 8 – <input type="checkbox"/> Other (please specify below) |
| 3 – <input type="checkbox"/> Ropes course/experiential | 9 – <input type="checkbox"/> Do not provide |
| 4 – <input type="checkbox"/> Animal assisted Pet Therapy | |

Other: _____

14. What types of school facilities are available in your agency? *(Check all that apply)*

- 1 – On site
- 2 – Off site (public school)
- 3 – Off site (facility/agency other than public school)
- 4 – Evidence-based curriculum
- 5 – North central accreditation

15. After a resident is discharged, which of the following services does your agency provide? *(Check all that apply)*

- | | |
|--|--|
| 1 – <input type="checkbox"/> After school/evening program | 6 – <input type="checkbox"/> Respite care |
| 2 – <input type="checkbox"/> Foster care/therapeutic foster care | 7 – <input type="checkbox"/> Outpatient therapy |
| 3 – <input type="checkbox"/> Transitional programs | 8 – <input type="checkbox"/> Home-based after care |
| 4 – <input type="checkbox"/> Community-based family services | 9 – <input type="checkbox"/> Tracking for DYC youth (e.g., verification of location, GPS, electronic monitoring) |
| 5 – <input type="checkbox"/> Day treatment | 10 – <input type="checkbox"/> Other (please describe below) |

Other: _____

**Appendix B:
Residential Outcome Collection and
Reporting System (ROCRS)**



Welcome to ROCRS!

RCCF OUTCOMES STUDY: OVERVIEW

The Colorado Association of Family and Children's Agencies (CAFCA) with funding from the Colorado Health Foundation (CHF) is conducting a three-year study to assess the effectiveness of services youth receive while in residential care.

Background

Residential treatment is one of the most intensive interventions provided by the child welfare, youth corrections, and mental health systems. Yet, the outcomes youth achieve from residential treatment have not been systematically measured, partly for the lack of consensus about what outcomes to measure and the lack of a comprehensive assessment tool to capture those outcomes. This study will address some of these gaps and examine fundamental issues about the reasons for admission to residential care, the profiles of youth placed in residential treatment and the outcomes of treatment services.

The Study

CAFCA and CHF have partnered with PSI, an independent contractor, to design and implement a web-based data collection and reporting system and analyze the data. We expect the analysis to:

- Provide feedback to participating agencies that will help them improve their residential programs,
- Identify strengths and weaknesses of residential services, and
- Inform policies and funding priorities statewide.

The study is guided by a steering committee that selected and adapted the CANS (Child and Adolescent Needs and Strength Assessment) as the instrument the study will use to measure functional outcomes. We will supplement the CANS data with other information, including youth demographics, clinical history, family functioning, treatment process variables, and Trails data. As the study unfolds, the steering committee will monitor and make recommendations for mid-course corrections, as needed, to ensure that the study is adequately capturing the information needed to examine trends and identify areas for improvement in child welfare.

Each agency participating in the study (16 RCCFs currently) has sent representatives to be trained on the CANS and on the Residential Outcomes Collection and Reporting System (ROCRS), the web-based system designed for the study. The agencies' ongoing responsibilities will be to train new staff hires in the assessment protocols, ensure the timely submission of data, monitor and correct gaps in the data, provide access/clearance to agency personnel and incorporate the outcomes data into their quality assurance programs.

The PSI evaluators will analyze and compile data and prepare annual, aggregate reports of findings. Each agency will be able to download and analyze its own data on a more frequent basis.

For more information contact Skip Barber, Executive Director -- Email: skipbarber@earthlink.net



[Alternative Homes for Youth](#) [Beacon Center](#) [Childrens Ark](#) [Denver Childrens Home](#) [Devereux Cleo Wallace](#) [Excelsior Youth Center](#) [Griffith Centers for Children](#) [Jefferson Hills Kidz Ark](#) [Lost and Found](#) [Mount Saint Vincent Home](#) [Namaqua Center](#) [North Range Behavioral Center](#) [Shiloh Home](#) [Synergy Adolescent Treatment Services](#) [Tennyson Center for Children](#) [Third Way Center](#)

Comments, questions, or problems? Contact Support [here](#)



Introduction Main Management Reports Data Export Administration Support

Search for a Child

Click on the **Search** button to search the database for an existing Child record. When records are found, click on the **Episode Period(s)** button to display all the Episode Periods for the child.

Click on the **New Child** button to create a new child record. Please make sure that the child does not already exist in the system by doing a search on known information.

- ROCRS Child ID
- Child Last Name
- Provider Assigned Child ID
- Trails ID (e.g., 1234567)
- Medicaid ID (e.g., A123456)

Search for a RCCF Episode Period

Episode Period is used to describe a youth's admission to/stay at an RCCF and includes the following data collection forms:

- Consent (for each admission to the RCCF)
- Admission Assessment
- Discharge Assessment
- 4-Month Assessment
- 12-Month Assessment

If this is an active/current Episode Period and you know the ROCRS Episode Period ID, or if the RCCF assigned the Episode Period a unique ID, you may click on the **Search** button to search the database for an existing Episode Period. When the correct Episode Period is found, click on the status link (Incomplete/Complete) to **view**, **add** or **modify** (if applicable) the Consent or Assessment (Admission, Discharge, 4 or 12 Month) information.

To create a **New Episode Period**, click on the Episode Period(s) button of an existing Child record to associate the Episode Period with that child or you may click on the New Child button to begin the assessment creation process with a new client. Then click on the New Episode Period button below to create a new episode period record and be taken to the Consent information form. Please make sure that the Episode Period does not already exist in the system by doing a search on known information before creating a new Episode Period.

IMPORTANT: A youth may have multiple Episode Periods within one RCCF (i.e., youth is readmitted to the same RCCF), but a new Episode Period should only be created if the Discharge Form for the previous Episode Period has been submitted as Complete.

- ROCRS Episode Period ID
- Provider Assigned Episode Period ID

General Announcements

Welcome to the Central hub of the ROCRS application!

Important Note: [New Release](#) as of 7/6/2009 at 8 AM MST. Several issues that have come up during training and testing have been addressed. Please continue to provide feedback to Monica! Thanks! - Shoptiq Support.

Important Note: If you are using IE8, please toggle the "compatibility view" to use this site.

My Provider Announcements

Comments, questions, or problems? Contact Support [here](#).

ROCRSONline.com developed by [Shoptiq, LLC](#).

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Introduction Main Management Reports Data Export Administration Support

Child Information Record

ROCRS Child Id: _____

Provider Id and Name: _____

Is Active?

Name: First / Middle / Last *

Date of Birth: (MM/DD/YYYY) *

Youth's ID Number at this facility (No hyphens)

Medicaid ID (e.g., A123456):

Trails ID (e.g., 1234567):

Gender: *

Hispanic Ethnicity: (please select Unknown if you are unable to determine/don't know) *

Race/Ethnicity (please check all that apply)

- American Indian or Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Declined to disclose
- Unknown



Introduction Main ▶ Management Reports ▶ Data Export ▶ Administration ▶ Support

FieldMdd

Export Data For Analysis

Please select a data set to download and click the download button. You will be prompted to save the file. Save the file to your computer. The data is best viewed with MS Excel.

Select Data For Download:

Comments, questions, or problems? Contact Support [here](#).
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Provider:

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ROCRS Support

To better support change requests, please follow these steps.

Step 1 - Please talk with an Administrator and see if they can help you BEFORE sending an email to support or submitting this form. Often times your Administrator will be able to answer your question quickly so you can continue using the site.

Step 2 - If you still have an issue after talking with an Administrator, submit this form. Please fill it out as completely as possible. The more detail, the easier it will be to answer your question promptly. All support requests are sent to Monica Mendoza at CAFCA (monicasmendoza@gmail.com).

Your Name:

Provider and Site Name:

Phone:

ROCRS User ID / E-mail Address:

Date and Time the issue occurred:

Child ID and Name:

Episode Period ID you were working on at the time of the issue:

Other Details:

Comments, questions, or problems? Contact Support [here](#).

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RCCF Outcomes Study

Process, Quality Assurance & Management Review (PQMR 1)

[Print this page](#)

Provider/Agency	TEST	
Site Name	ALL	
Report Reference Period Start Date (MM/DD/YYYY)	1/1/2009	(required)
Report Reference Period End Date (MM/DD/YYYY)	3/1/2010	(required)
<input type="button" value="Run Report"/>		

RCCF Outcomes Study

Management Report - Case List (PQMR-2)

[Print this page](#)

Provider/Agency	TEST
Site Name	ALL
Report Reference Period Start Date (MM/DD/YYYY)	mm/dd/yyyy (not required)
Report Reference Period End Date (MM/DD/YYYY)	mm/dd/yyyy (not required)
<input type="button" value="Run Report"/>	

RCCF Outcomes Study

Type of Report: Aggregate Outcomes Report

[Print this page](#)

Provider/Agency	TEST	
Site Name	ALL	
Report Reference Period Start Date (MM/DD/YYYY)	1/1/2009	(required)
Report Reference Period End Date (MM/DD/YYYY)	3/1/2010	(required)
		<input type="button" value="Run Report"/>

Appendix C: Child And Adolescent Needs And Strengths (CANS)

- **CANS Admission**
- **CANS Discharge**
- **CANS Follow up**
- **CANS User Manual**

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

9. Race (Please check all that apply)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Declined to disclose <input type="checkbox"/> Unable to determine/Don't Know
10. Funding Source for Bed/Slot	<input type="checkbox"/> Colorado Division of Child Welfare (CDHS)/County initiated placement (see 10.a. below) <input type="checkbox"/> Colorado Division of Youth Corrections (CDYC) <input type="checkbox"/> Behavioral Health Organization (BHO)/Community Mental Health Center (CMHC) <input type="checkbox"/> HB 1116 /HB1351 <input type="checkbox"/> Private in-State (e.g., Ins., self-pay, scholarship) <input type="checkbox"/> Out-of-State (e.g., State, ins., self-pay, scholarship) <input type="checkbox"/> Other (Specify below)
10.a. If County initiated, Indicate Placing County	_____
10.b. If Other, please specify	_____
11. What is this youth's expected length of stay in this facility? (Please estimate)	Years _____ Months _____ Days _____ <input type="checkbox"/> Don't know
12. Indicate status of parental rights	<input type="checkbox"/> Intact <input type="checkbox"/> Pending (under review) <input type="checkbox"/> Terminated <input type="checkbox"/> Other: Specify <input type="checkbox"/> Don't know
12.a. If Other, please specify	_____
13. Delinquency involvement at admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
13.a. If Yes, specify type	<input type="checkbox"/> Adjudicated <input type="checkbox"/> Court action Pending <input type="checkbox"/> Don't know
14. Dependency & Neglect involvement at admission?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
14.a. If Yes, specify type	<input type="checkbox"/> Involuntary placement <input type="checkbox"/> Court action pending <input type="checkbox"/> Voluntary placement <input type="checkbox"/> Don't know

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

15. Please identify the youth's primary caregiver(s): <i>(Please check <u>all that apply</u>)</i>	<input type="checkbox"/> Two (2) biological parents living together <input type="checkbox"/> Two (2) biological parents living separately <input type="checkbox"/> Biological Mother <input type="checkbox"/> Biological Father <input type="checkbox"/> Adoptive Mother <input type="checkbox"/> Adoptive Father <input type="checkbox"/> Step-mother <input type="checkbox"/> Step-father <input type="checkbox"/> Parent's Significant Other <input type="checkbox"/> Foster parent(s) <input type="checkbox"/> Independent Living, Alone <input type="checkbox"/> Other Relatives (e.g., siblings, grandparents, aunts/uncles) <input type="checkbox"/> Friend(s), Friend(s) of the family <input type="checkbox"/> Unrelated Guardian <input type="checkbox"/> None (i.e., youth has no primary caregiver) <input type="checkbox"/> Other (Specify below): <input type="checkbox"/> Don't know																																				
15.a. If Other, please specify	_____																																				
16. Is the youth currently adopted?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know																																				
17. Has the youth experienced any relinquished adoptions?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know																																				
17.a. If Yes, how many?	_____																																				
18. Does primary caregiver/family agree with current placement decision?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver																																				
19. Is the primary caregiver supportive of/invested in the current treatment plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver																																				
20. Does primary caregiver/family want the youth to return home?	<input type="checkbox"/> Yes <input type="checkbox"/> No (specify reason below) <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver																																				
20.a. If No, please indicate reason	<input type="checkbox"/> Ready for emancipation <input type="checkbox"/> Housing/other resource issues <input type="checkbox"/> Feels unable to care for youth <input type="checkbox"/> Other																																				
20.b. If Other, please specify	_____																																				
21. Please indicate the amount of contact to which the family has committed for each of the following types of contact	<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Daily</th> <th style="width: 10%; text-align: center;">Weekly or more often</th> <th style="width: 10%; text-align: center;">2 X/Month</th> <th style="width: 10%; text-align: center;">Monthly</th> <th style="width: 10%; text-align: center;">Less than Monthly</th> <th style="width: 10%; text-align: center;">Placing Agency Req. No Contact</th> <th style="width: 10%; text-align: center;">NA</th> <th style="width: 10%; text-align: center;">DK</th> </tr> </thead> <tbody> <tr> <td>Family Therapy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Telephone Calls</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Visiting on site</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Daily	Weekly or more often	2 X/Month	Monthly	Less than Monthly	Placing Agency Req. No Contact	NA	DK	Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Telephone Calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Visiting on site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Daily	Weekly or more often	2 X/Month	Monthly	Less than Monthly	Placing Agency Req. No Contact	NA	DK																													
Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																													
Telephone Calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																													
Visiting on site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																													

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

22. Does primary caregiver have access to reliable transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver
23. Approximate distance from facility to primary caregiver's home	<input type="checkbox"/> 0-20 miles <input type="checkbox"/> 21-50 miles <input type="checkbox"/> 51-99 miles <input type="checkbox"/> 100 miles or more <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver
24. Approximately how long does it take for the primary caregiver to get to your facility	<input type="checkbox"/> 30 minutes or less <input type="checkbox"/> 31 minutes to 1 hour <input type="checkbox"/> More than 1 hour, less than 2 hours <input type="checkbox"/> 2 hours or more <input type="checkbox"/> Don't know <input type="checkbox"/> NA – no primary caregiver
25. In what type of setting did youth live immediately before enrollment?	<input type="checkbox"/> Home with Primary Caregiver <input type="checkbox"/> Kinship / Relative Home <input type="checkbox"/> Foster Home - Therapeutic <input type="checkbox"/> Foster Home - Regular <input type="checkbox"/> Independent Living <input type="checkbox"/> Group Home/Child Placement Agency (CPA) <input type="checkbox"/> RCCF (includes, TRCCF, PRTF) <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Detention <input type="checkbox"/> DYC (Division of Youth Corrections) Commitment <input type="checkbox"/> Don't know <input type="checkbox"/> Other (specify below)
25.a. If Other, please specify	_____
26. For about how long was the youth in this setting?	Years: _____ Months: _____ Days: _____ <input type="checkbox"/> Don't know
27. Total number of previous out of home placements reported at intake (Please estimate number and do not enter a range; does not include informal family arrangements or hospitalizations)	_____ <input type="checkbox"/> Don't know
28. Total number of past runs/AWOLs (overnight without permission) from facilities reported (Please estimate number and do not enter a range)	_____ <input type="checkbox"/> Don't know
29. Number of past (overnight) runs from home (Please estimate number and do not enter a range)	_____ <input type="checkbox"/> Don't know
30. Number of past (overnight) psychiatric hospitalizations (Please estimate number and do not enter a range)	_____ <input type="checkbox"/> Don't know
31. Number of past suicide attempts resulting in injuries, poisoning or overdose requiring hospitalization (Please estimate number and do not enter a range)	_____ <input type="checkbox"/> Don't know
32. Does youth have a history of making homicidal threats?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

33. Primary Axis I Diagnosis	Code / Description: _____	<input type="checkbox"/> Don't know
34. Secondary Axis I Diagnosis	Code / Description: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> None
35. Third Axis I Diagnosis	Code / Description: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> None
36. Primary Axis II Diagnosis	Code / Description: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> None
37. Secondary Axis II Diagnosis	Code / Description: _____	<input type="checkbox"/> Don't know <input type="checkbox"/> None
38. Axis V / GAF	GAF Score: _____ (1-100)	<input type="checkbox"/> Don't know <input type="checkbox"/> None
39. Indicate the total number of <u>psychotropic</u> medications in use at the time of intake other than those prescribed for Attention Deficit or Hyperactivity. (Please Check all that apply)	_____	<input type="checkbox"/> Don't know
40. Is the youth approved as a Special Education Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
41. Has youth ever been adjudicated?	<input type="checkbox"/> Yes (please indicate crimes/violations below) <input type="checkbox"/> No <input type="checkbox"/> Don't know	
41.a. If yes, please check all the categories that describe the crimes/violations	<input type="checkbox"/> Crimes against persons (e.g., sexual or other assault, robbery, menacing, reckless endangerment) <input type="checkbox"/> Crimes against property (e.g., trespassing, stolen property, shoplifting, burglary, arson, theft, destruction of property, fraud, motor vehicle theft) <input type="checkbox"/> Substance use-related violation/crimes (e.g., DUI/DWI, possession, distribution, public intoxication, positive drug screen) <input type="checkbox"/> Crimes against public order (e.g., weapons offenses, non-violent sex offenses, disorderly conduct, abuse of animals, traffic violations [not DUI/DWI]) <input type="checkbox"/> Violations of court proceedings (e.g., not complying with terms of probation, parole) <input type="checkbox"/> Status offenses (e.g., curfew violation, truancy, runaway) <input type="checkbox"/> Other, please describe the charges	
41.b. If Other, please specify	_____	

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

Please refer to the CANS coding definitions while completing this section.

TRAUMA EXPERIENCES	0	1	2	3	NA
1. Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. School Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Natural or manmade disasters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Traumatic Grief/Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. War Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Witness to Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TRAUMATIC STRESS SYMPTOMS	0	1	2	3	
14. Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Re-experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD STRENGTHS	0	1	2	3	
19. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Interpersonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Optimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Talents/Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Spiritual/Religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Community Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LIFE DOMAIN FUNCTIONING	0	1	2	3	
29. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Developmental (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.1. Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.2. Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.3. Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.4. Self Care/Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.5. Specify I.Q.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	YES				NO
32.6. Does the child require any special assistive devices?					
32.6.a. If YES, please specify (Optional)					
32.7. Does the child require any special accommodations for home or school?					
32.7.a. If YES, please specify (Optional)					

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

LIFE DOMAIN FUNCTIONING (cont.)	0	1	2	3	NA
33. Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Job Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Sexual Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. School Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. School Achievement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. School Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ACCULTURATION	0	1	2	3	
42. Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43. Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44. Ritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD BEHAVIOR / EMOTIONAL NEEDS	0	1	2	3	
46. Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47. Attention/Impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50. Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51. Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52. Substance Abuse (if score is 2 or 3 on this question score the following 6 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.1. Severity of Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.2. Duration of Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.3. Stage of Recovery</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.4. Peer Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.5. Parental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.6. Environment Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
53. Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54. Eating Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55. Affect Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
56. Behavioral Regression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
57. Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58. Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

CHILD RISK BEHAVIORS	0	1	2	3
59. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Self Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
61. Other Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Danger to Others (if score is 2 or 3 on this question score the following 14 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.1. History of Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.2. History of Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.3. Witness to Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.4. Witness to Environmental Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.5. Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.6. Frustration Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.7. Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.8. Paranoid Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.9. Secondary gains from anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.10. Violent Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.11. Awareness of Violence Potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.12. Response to Consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.13. Commitment to Self-Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.14. Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Sexual Aggression (if score is 2 or 3 complete the following 10 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.1 Date of most recent sexually abusive behavior? (MM/DD/YYYY)				
	YES	NO		
63.2 Was sexual act against a family member? (Identity)				
63.3 Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.4 Physical Force/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.5 Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.6 Age Differential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.7 Type of Sex Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.8 Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.9 Temporal Consistency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.10 History of Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.11 Severity of Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.12 Prior Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO		
63.13 Is the youth currently required to be on Colorado's Sex Offender Registry?				
64. Runaway (if score is 2 or 3 complete the following 8 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.1. Frequency of Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.2. Consistency of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.3. Safety of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.4. Involvement in Illegal Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.5. Likelihood of Return on Own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.6. Involvement of Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.7. Realistic Expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.8. Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **ADMISSION ASSESSMENT**

64. Runaway (Continued)				
<i>64.9. To what locations has the child run in the past</i>	1. Friends 2. Family 3. Street 8. Other 9. Unknown			
<i>64.9a If Other, Specify</i>				
<i>64.10. What reasons has the youth given for running in the past?</i>	1. Missing family 2. Feeling unsafe 3. Reaction to treatment 4. Avoid consequences 5. For fun 8. Other 9. Unknown			
<i>64.10.a. If Other, Specify</i>				
<i>64.11. In the past, what does the youth do while on run?</i>	1. Drugs 2. Other illegal activity 3. Stays with family 8. Other 9. Unknown			
<i>64.11.a. If Other, Specify</i>				
CHILD RISK BEHAVIORS (cont.)				
	0	1	2	3
65. Delinquency (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.1 Date of most recent delinquent behavior</i>				
<i>65.2 Seriousness</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.3 History</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.4 Planning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.5 Community Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.6 Peer Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.7 Parental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.8 Environmental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	No	Don't Know	
<i>65.9 During the past year has the youth committed acts of delinquency against property?</i>				
<i>65.10 During the past year has the youth committed acts of delinquency against people?</i>				
<i>65.11 Has the youth used a weapon in the commission of an act of delinquency?</i>				
<i>65.12 Has the youth committed any acts of delinquency involving illegal substances?</i>				

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66. Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Fire Setting (if score is 2 or 3 complete the following 9 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.1 Date of the most recent fire-setting behavior? (MM/DD/YYYY)				
	YES	No	Don't Know	
67.2 Was the child alone at the time of the incident or were there any other children involved?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.3 Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.4 History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.5 Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.6 Use of accelerants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.7 Intention to harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.8 Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.9 Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.10 Remorse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.11 Likelihood of future fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Social Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Sexually Reactive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. Parental Criminal Behavior (biological parents(s))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71. Transition to Adulthood (The following items are required for youth 17 and older at the time the form is completed). However, any of these items can be rated regardless of age if they represent a need for a specific youth. A check indicates that the youth is under age 17 and the Transition to Adulthood Section will NOT be completed.	<input type="checkbox"/>			
	0	1	2	3
71.1. Independent Living Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.2. Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.3. Parenting Roles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.4. Personality Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.5. Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.6. Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.7. Educational Attainment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
71.8. Victimization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Continued on next page

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<p>The next section, Caregiver Strengths concerns the youth's community-based caregiver(s).</p> <p>72. If the youth does NOT have one or more individuals who can reasonably be expected to function in this role, e.g., biological or adoptive parents, family, long-term foster parents, when the youth is out of residential care, please check here.</p> <p>A check indicates that the Caregiver Strengths Section will NOT be completed.</p>	<input type="checkbox"/>																																																																						
Caregiver Needs & Strengths (parents, relatives and prospective adoptive parents):	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;"></th> <th style="width: 12.5%;">0</th> <th style="width: 12.5%;">1</th> <th style="width: 12.5%;">2</th> <th style="width: 12.5%;">3</th> </tr> </thead> <tbody> <tr> <td><i>72.1. Physical</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.2. Mental Health</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.3. Substance Use</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.4. Developmental</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.5. Supervision</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.6. Involvement</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.7. Knowledge</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.8. Organization</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.9 Resources</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.10. Residential Stability</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.11. Safety</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.12. Marital/Partner Violence</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><i>72.13. Posttraumatic Reactions</i></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		0	1	2	3	<i>72.1. Physical</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.2. Mental Health</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.3. Substance Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.4. Developmental</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.5. Supervision</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.6. Involvement</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.7. Knowledge</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.8. Organization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.9 Resources</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.10. Residential Stability</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.11. Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.12. Marital/Partner Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>72.13. Posttraumatic Reactions</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

4. If the child was removed against the recommendation of the residential provider, who made the decision?	<input type="checkbox"/> Child Welfare Case Worker <input type="checkbox"/> DYC Youth Manager <input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Court <input type="checkbox"/> Guardian Ad Litem (GAL) <input type="checkbox"/> Other (Specify below)																
4.a. If Other, please specify																	
5. What percentage of the treatment goals were met by the <u>youth</u> at the time of discharge?	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 0%</td> <td><input type="checkbox"/> 21-30 %</td> <td><input type="checkbox"/> 51-60%</td> <td><input type="checkbox"/> 81-90 %</td> </tr> <tr> <td><input type="checkbox"/> 1-10%</td> <td><input type="checkbox"/> 31-40%</td> <td><input type="checkbox"/> 61-70%</td> <td><input type="checkbox"/> 100%</td> </tr> <tr> <td><input type="checkbox"/> 11-20%</td> <td><input type="checkbox"/> 41-50%</td> <td><input type="checkbox"/> 71-80%</td> <td><input type="checkbox"/> Don't Know</td> </tr> </table>	<input type="checkbox"/> 0%	<input type="checkbox"/> 21-30 %	<input type="checkbox"/> 51-60%	<input type="checkbox"/> 81-90 %	<input type="checkbox"/> 1-10%	<input type="checkbox"/> 31-40%	<input type="checkbox"/> 61-70%	<input type="checkbox"/> 100%	<input type="checkbox"/> 11-20%	<input type="checkbox"/> 41-50%	<input type="checkbox"/> 71-80%	<input type="checkbox"/> Don't Know				
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<input type="checkbox"/> 11-20%	<input type="checkbox"/> 41-50%	<input type="checkbox"/> 71-80%	<input type="checkbox"/> Don't Know														
6. What percentage of the treatment goals were met by the <u>parent</u> or <u>caregiver</u> at the time of discharge?	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 0%</td> <td><input type="checkbox"/> 21-30 %</td> <td><input type="checkbox"/> 51-60%</td> <td><input type="checkbox"/> 81-90 %</td> </tr> <tr> <td><input type="checkbox"/> 1-10%</td> <td><input type="checkbox"/> 31-40%</td> <td><input type="checkbox"/> 61-70%</td> <td><input type="checkbox"/> 100%</td> </tr> <tr> <td><input type="checkbox"/> 11-20%</td> <td><input type="checkbox"/> 41-50%</td> <td><input type="checkbox"/> 71-80%</td> <td><input type="checkbox"/> Don't Know</td> </tr> <tr> <td colspan="4"><input type="checkbox"/> NA (No caregiver/goals)</td> </tr> </table>	<input type="checkbox"/> 0%	<input type="checkbox"/> 21-30 %	<input type="checkbox"/> 51-60%	<input type="checkbox"/> 81-90 %	<input type="checkbox"/> 1-10%	<input type="checkbox"/> 31-40%	<input type="checkbox"/> 61-70%	<input type="checkbox"/> 100%	<input type="checkbox"/> 11-20%	<input type="checkbox"/> 41-50%	<input type="checkbox"/> 71-80%	<input type="checkbox"/> Don't Know	<input type="checkbox"/> NA (No caregiver/goals)			
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<input type="checkbox"/> NA (No caregiver/goals)																	
For each of the following, please estimate the amount of service the youth received during the current admission.																	
7. Type of Service	Amount of Service Received During Admission																
7.1. Assessment, including Psychological Testing	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown																
7.2. Individual therapy/counseling	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown																

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

Type of Service	Amount of Service Received During Admission
7.3. Group therapy (e.g., offense-specific therapy, substance abuse, sexual safety, grief and loss, problem solving)	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.4. Family therapy	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.5. Educational groups (e.g., teen parenting, early childhood development, smoking cessation, independent living skills)	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.6. Psychiatric services and medication management	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - DISCHARGE ASSESSMENT

Type of Service	Amount of Service Received During Admission
7.7. Expressive therapy (art, music, dance, theater)	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.8. Special services (physical, occupational, speech)	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.9. Recreational therapy (sports, equine, animal)	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.10. Vocational therapy	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

Type of Service	Amount of Service Received During Admission
7.11. Mentoring	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.12. Community service/Restorative justice services	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.13. Faith/spirituality services	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.14. Milieu therapy	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

Type of Service	Amount of Service Received During Admission
7.15. Services delivered in Youth's home	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.16. Community activities	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.17. Urinalysis	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
7.18. Evidence based services	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

Type of Service	Amount of Service Received During Admission
7.a. If other, please specify	_____
7.b. If other, number of hours.	<input type="checkbox"/> None <input type="checkbox"/> 1 hour (about 1 X per month) <input type="checkbox"/> 2 hours (about 2 X per month) <input type="checkbox"/> 3-5 hours (about weekly) <input type="checkbox"/> 6-10 hours (about 2x per week) <input type="checkbox"/> 11-15 hours (about 3x per week) <input type="checkbox"/> 16-20 hours (about 4x per week) <input type="checkbox"/> 20-25 hours (about 5x per week) <input type="checkbox"/> 25+ hours (about daily) <input type="checkbox"/> Unknown
8. Placement/Setting recommended by Residential provider	<input type="checkbox"/> Ready for Less Restrictive Placement <input type="checkbox"/> Move to another residential program - same Level of Care <input type="checkbox"/> Return to this residential program <input type="checkbox"/> Needs More Restrictive / Higher Level of Care
9. If <u>Less</u> Restrictive, what type is recommended?	<input type="checkbox"/> Home <input type="checkbox"/> Foster Home - Therapeutic <input type="checkbox"/> Foster Home - Regular <input type="checkbox"/> Group Home <input type="checkbox"/> Other (Specify below)
9.a. Other, please specify	_____
10. If <u>More</u> Restrictive, what type is recommended?	<input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> PRTF (Psychiatric Residential Treatment Facility) <input type="checkbox"/> Secure / Locked Facility (includes Detention) <input type="checkbox"/> Division of Youth Corrections (DYC) Commitment <input type="checkbox"/> Other (Specify below)
10.a. If Other, please specify	_____

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

	Type of Service	Amount of Service
<p>11. Ongoing treatment services recommended by provider at the time of discharge <i>Please 1) check all services that were recommended AND 2) enter the corresponding number from the list below for the Amount of Service recommended -</i></p> <p>1 None 2 1 hour (about 1 X per month) 3 2 hours (about 2 X per month) 4 3-5 hours (about weekly) 5 6-10 hours (about 2x per week) 6 11-15 hours (about 3x per week) 7 16-20 hours (about 4x per week) 8 20-25 hours (about 5x per week) 9 25+ hours (about daily) 99 Unknown</p>	<p><input type="checkbox"/> Home-based Family Preservation Services <input type="checkbox"/> Office-based Family Preservation Services <input type="checkbox"/> Day Treatment <input type="checkbox"/> Out-patient Family Therapy <input type="checkbox"/> Out-patient Individual Therapy <input type="checkbox"/> Out-patient Group Therapy <input type="checkbox"/> Substance Abuse Treatment <input type="checkbox"/> (Sex) Offense Specific Treatment <input type="checkbox"/> CHAFEE Services Chafee Foster Care Independence Program (CFCIP) <input type="checkbox"/> Independent Living / Emancipation Services <input type="checkbox"/> Other (Specify below)</p>	<p>_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p>
11.a. If Other, please specify	_____	
11.b. If Other, Amount of Service recommended – from list above.	_____	
12. To the best of your knowledge, were the provider discharge recommendations followed by the referring agency?	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	
12.a. If no, please indicate reason	_____	
13. <u>Actual</u> Discharge Placement	<p><input type="checkbox"/> Home with Primary Caregiver <input type="checkbox"/> Kinship / Relative Home <input type="checkbox"/> Foster Home - Therapeutic <input type="checkbox"/> Foster Home - Regular <input type="checkbox"/> Independent Living <input type="checkbox"/> Group Home <input type="checkbox"/> Another RCCF <input type="checkbox"/> Psychiatric Hospital <input type="checkbox"/> Detention <input type="checkbox"/> DYC Commitment <input type="checkbox"/> Other (Specify below) <input type="checkbox"/> Don't know</p>	
13.a. If Other, please specify	_____	
14. Approximately how often did the Caseworker/Case Manager attend staffings and/or visit the youth?	<p><input type="checkbox"/> Never <input type="checkbox"/> Rarely (Less than once per month) <input type="checkbox"/> Monthly <input type="checkbox"/> Twice per month <input type="checkbox"/> Weekly <input type="checkbox"/> Don't know</p>	

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

		Daily	Weekly or more often	2 X/Month	Monthly	Less than Monthly	Placing Agency Req. No Contact	NA	DK
15. For each of the following types of contact, please indicate the amount of contact in which the family participated during the youth's admission.	Family Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Telephone Calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Visiting on site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Number of overnight runaway episodes/AWOL events while in the program (Please estimate number and do not enter a range)	_____						<input type="checkbox"/> Don't know		
17. Number of overnight psychiatric hospitalizations while in the program (Please estimate number and do not enter a range)	_____						<input type="checkbox"/> Don't know		
18. Number of past suicide attempts resulting in injuries, poisoning or overdose requiring hospitalization (Please estimate number and do not enter a range)	_____						<input type="checkbox"/> Don't know		
19. Did the youth make homicidal threats while in the program?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know								
20. Primary Axis I Diagnosis	Code / Description: _____						<input type="checkbox"/> Don't know		
21. Secondary Axis I Diagnosis	Code / Description: _____						<input type="checkbox"/> Don't know <input type="checkbox"/> None		
22. Third Axis I Diagnosis	Code / Description: _____						<input type="checkbox"/> Don't know <input type="checkbox"/> None		
23. Primary Axis II Diagnosis	Code / Description: _____						<input type="checkbox"/> Don't know <input type="checkbox"/> None		
24. Secondary Axis II Diagnosis	Code / Description: _____						<input type="checkbox"/> Don't know <input type="checkbox"/> None		
25. Axis V / GAF (Score 1-100)	GAF Score: _____						<input type="checkbox"/> Don't know <input type="checkbox"/> None		
26 Indicate the total number of psychotropic medications in use at the time of intake other than those prescribed for Attention Deficit or Hyperactivity (Please Check all that apply)	_____						<input type="checkbox"/> Don't know		

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

<p>27. To the best of your knowledge, has the youth engaged in any type of criminal activity during his/her admission?</p>	<p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know </p>
<p>27.a. If Yes, specify type(s). Please check all that apply.</p>	<p> <input type="checkbox"/> Crimes against persons (e.g., sexual or other assault, robbery, menacing, reckless endangerment) <input type="checkbox"/> Crimes against property (e.g., trespassing, stolen property, shoplifting, burglary, arson, theft, destruction of property, fraud, motor vehicle theft) <input type="checkbox"/> Substance use-related violation/crimes (e.g., DUI/DWI, possession, distribution, public intoxication, positive drug screen) <input type="checkbox"/> Crimes/violations against public order (e.g., weapons offenses, non-violent sex offenses, disorderly conduct, abuse of animals, traffic violations [not DUI/DWI]) <input type="checkbox"/> Violations of court proceedings (e.g., not complying with terms of probation, parole) <input type="checkbox"/> Status offenses (e.g., curfew violation, truancy, runaway) <input type="checkbox"/> Other (Specify below) </p>
<p>27.b. If Other, please specify</p>	<p>_____</p>
<p>28. Indicate if any NEW charges were filed against the youth while s/he was in the program (Note: this does not include new disclosures for past offenses; only for behavior that occurred during placement.) Check all that apply:</p> <p>If there are no new charges, then do not select any items from the list.</p>	<p> <input type="checkbox"/> Crimes against persons (e.g., sexual or other assault, robbery, menacing, reckless endangerment) <input type="checkbox"/> Crimes against property (e.g., trespassing, stolen property, shoplifting, burglary, arson, theft, destruction of property, fraud, motor vehicle theft) <input type="checkbox"/> Substance use-related violation/crimes (e.g., DUI/DWI, possession, distribution, public intoxication, positive drug screen) <input type="checkbox"/> Crimes/violations against public order (e.g., weapons offenses, non-violent sex offenses, disorderly conduct, abuse of animals, traffic violations [not DUI/DWI]) <input type="checkbox"/> Violations of court proceedings (e.g., not complying with terms of probation, parole) <input type="checkbox"/> Status offenses (e.g., curfew violation, truancy, runaway) <input type="checkbox"/> Other (Specify below) </p>
<p>28.a. If Other, please specify</p>	<p>_____</p>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

Please refer to the CANS coding definitions while completing this section.

TRAUMA EXPERIENCES	0	1	2	3	NA
1. Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. School Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Natural or manmade disasters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Traumatic Grief/Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. War Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Witness to Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TRAUMATIC STRESS SYMPTOMS	0	1	2	3	
14. Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Re-experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD STRENGTHS	0	1	2	3	
19. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Interpersonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Optimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Talents/Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Spiritual/Religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Community Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LIFE DOMAIN FUNCTIONING	0	1	2	3	
29. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Developmental (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.1. Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.2. Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.3. Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.4. Self Care/Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.5. Specify I.Q.					
	YES	NO			
32.6. Does the child require any special assistive devices?					
32.6.a. If YES, please specify (Optional)					
32.7. Does the child require any special accommodations for home or school?					
32.7.a. If YES, please specify (Optional)					
LIFE DOMAIN FUNCTIONING (cont.)	0	1	2	3	NA

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

33. Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Job Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Sexual Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. School Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. School Achievement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. School Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ACCULTURATION	0	1	2	3	
42. Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43. Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44. Ritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD BEHAVIOR / EMOTIONAL NEEDS	0	1	2	3	
46. Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47. Attention/Impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50. Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51. Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52. Substance Abuse (if score is 2 or 3 on this question score the following 6 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.1. Severity of Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.2. Duration of Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.3. Stage of Recovery</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.4. Peer Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.5. Parental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>52.6. Environment Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
53. Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54. Eating Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55. Affect Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
56. Behavioral Regression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
57. Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58. Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD RISK BEHAVIORS	0	1	2	3	
59. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
60. .Self Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
61. Other Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

CHILD RISK BEHAVIORS (cont.)	0	1	2	3
62. Danger to Others (if score is 2 or 3 on this question score the following 14 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.1. History of Physical Abuse</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.2. History of Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.3. Witness to Domestic Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.4. Witness to Environmental Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.5. Bullying</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.6. Frustration Management</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.7. Hostility</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.8. Paranoid Thinking</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.9. Secondary gains from anger</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.10. Violent Thinking</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.11. Awareness of Violence Potential</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.12. Response to Consequences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.13. Commitment to Self-Control</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>62.14. Treatment Involvement</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Sexual Aggression (if score is 2 or 3 complete the following 10 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.1 Date of most recent sexually abusive behavior?</i>				
	YES	NO		
<i>63.2 Was sexual act against a family member?</i>				
<i>(Identity)</i>				
<i>63.3 Relationship</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.4 Physical Force/Threat</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.5 Planning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.6 Age Differential</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.7 Type of Sex Act</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.8 Response to Accusation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.9 Temporal Consistency</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.10 History of Sexual Behavior</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.11 Severity of Sexual Abuse</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>63.12 Prior Treatment</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO		
<i>63.13 Is the youth currently required to be on Colorado's Sex Offender Registry?</i>				
64. Runaway (if score is 2 or 3 complete the following 8 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.1. Frequency of Running</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.2. Consistency of Destination</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.3. Safety of Destination</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.4. Involvement in Illegal Activities</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.5. Likelihood of Return on Own</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.6. Involvement of Others</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.7. Realistic Expectations</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>64.8. Planning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

CHILD RISK BEHAVIORS (cont.)	0	1	2	3
65. Delinquency (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.1 Date of most recent delinquent behavior</i>				
<i>65.2 Seriousness</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.3 History</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.4 Planning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.5 Community Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.6 Peer Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.7 Parental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>65.8 Environmental Influences</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES		NO	
<i>65.9 During the past year has the youth committed acts of delinquency against property?</i>				
<i>65.10 During the past year has the youth committed acts of delinquency against people?</i>				
<i>65.11 Has the youth used a weapon in the commission of an act of delinquency?</i>				
<i>65.12 Has the youth committed any acts of delinquency involving illegal substances?</i>				
66. Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Fire Setting (if score is 2 or 3 complete the following 9 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.1 Date of the most recent fire-setting behavior?</i>				
	YES		NO	
<i>67.2 Was the child alone at the time of the incident or were there any other children involved?</i>				
<i>67.3 Seriousness</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.4 History</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.5 Planning</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.6 Use of accelerants</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.7 Intention to harm</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.8 Community Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.9 Response to Accusation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.10 Remorse</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>67.11 Likelihood of future fires</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Social Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Sexually Reactive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. Parental Criminal Behavior (biological parents(s))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS) - **DISCHARGE ASSESSMENT**

<p>71. Transition to Adulthood (<i>The following items are required for youth 17 and older at the time the form is completed</i>). However, any of these items can be rated regardless of age if they represent a need for a specific youth.</p> <p>A check indicates that the youth is under age 17 and the Transition to Adulthood Section will NOT be completed.</p>	<input type="checkbox"/>			
	0	1	2	3
<i>71.1. Independent Living Skills</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.2. Transportation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.3. Parenting Roles</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.4. Personality Disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.5. Intimate Relationships</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.6. Medication Compliance</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.7. Educational Attainment</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.8. Victimization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The next section, Caregiver Strengths concerns the youth's community-based caregiver(s).</p> <p>72. If the youth does NOT have one or more individuals who can reasonably be expected to function in this role, e.g., biological or adoptive parents, family, long-term foster parents, when the youth is out of residential care, please check here.</p> <p>A check indicates that the Caregiver Strengths Section will NOT be completed.</p>	<input type="checkbox"/>			
Caregiver Needs & Strengths (parents, relatives and prospective adoptive parents):	0	1	2	3
<i>72.1. Physical</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.2. Mental Health</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.3. Substance Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.4. Developmental</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.5. Supervision</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.6. Involvement</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.7. Knowledge</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.8. Organization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.9. Resources</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.10. Residential Stability</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.11. Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.12. Marital/Partner Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.13. Posttraumatic Reactions</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND
REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

YOUTH NAME: (B-4) _____ (B-5) _____ (B-6) _____ Study ID# _____ (B-7)
First Name MI Last Name (generated by ROCRS)

Provider/Agency Name: _____ (B-8)

Person completing Clinical Assessment: _____
Last Name First Name

ID # (Email address) of person completing Clinical Assessment: _____ (B-9)
(Assigned by ROCRS when user registers)

Assessment type: 4 month Post-Discharge Assessment (B-12)
 12 month Post-Discharge Assessment

Please check here if Post-Discharge Form was NOT completed: (B-13)
and select the reason below.

(B-14) Why was the form/interview not completed?

- Caregiver Refused Interview
- Youth Refused Interview (if 18 or older)
- Legal Representative Refused Interview
- No Response from Caregiver
- No Response from Legal Representative
- Insufficient/Inaccurate/Out-dated Client Information
- Administrative/Management Decision
- Other reason (Specify below)

If other, please specify: _____

(B-16) Primary source of information for completing form:

- Biological or Adoptive Parent
- Foster Parent
- Other Relative
- Unrelated Guardian
- County Child Welfare
- Youth Corrections
- Other reason (Specify below)

If other, please specify: _____

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

Please refer to the Guidelines for Completing the Colorado Variables – POST-DISCHARGE Assessment when completing this section:

1. Date Form/Interview Completed	____	____	____
	Month	Day	Year
2. Date of Discharge from RCCF completing the post discharge assessment.	____	____	____
	Month	Day	Year
3. Setting where the youth is living currently	<input type="checkbox"/> Home with Primary Caregiver <input type="checkbox"/> Kinship/Relative Care <input type="checkbox"/> Foster Home - Therapeutic <input type="checkbox"/> Foster Home – Regular <input type="checkbox"/> Independent Living (includes emancipated, living on own) <input type="checkbox"/> Group/CPA Home <input type="checkbox"/> RCCF (includes PRTF) <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Detention <input type="checkbox"/> DYC Commitment <input type="checkbox"/> Other (Specify below) <input type="checkbox"/> Unknown		
3. a. If Other, please specify	_____		
4. Check all settings where the child has lived for at least 24 hours since discharge	<input type="checkbox"/> Home with Primary Caregiver <input type="checkbox"/> Kinship/Relative Care <input type="checkbox"/> Foster Home - Therapeutic <input type="checkbox"/> Foster Home – Regular <input type="checkbox"/> Independent Living (includes emancipated, living on own) <input type="checkbox"/> Group/CPA Home <input type="checkbox"/> RCCF (includes PRTF) <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Detention <input type="checkbox"/> DYC Commitment <input type="checkbox"/> Other (Specify below) <input type="checkbox"/> Unknown		
4.a. If Other, please specify	_____		

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

<p>5. Treatment services that the child has received since discharge from RCCF. Please 1) check all services that were received AND 2) enter the corresponding number from the list below for the Amount of Service received.</p> <p>1 None 2 1 hour (about 1 X per month) 3 2 hours (about 2 X per month) 4 3-5 hours (about weekly) 5 6-10 hours (about 2x per week) 6 11-15 hours (about 3x per week) 7 16-20 hours (about 4x per week) 8 20-25 hours (about 5x per week) 9 25+ hours (about daily) 99 Unknown</p>	<table border="1"> <thead> <tr> <th data-bbox="641 380 1203 411">Type of Service</th> <th data-bbox="1203 380 1463 411">Amount of Service</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Home-based Family Preservation Services</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Office-based Family Preservation Services</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Day Treatment</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Out-patient Family Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Out-patient Individual Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Out-patient Group Therapy</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Substance Abuse Treatment</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> (Sex) Offense Specific Treatment</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> CHAFEE Services</td> <td></td> </tr> <tr> <td> Chafee Foster Care Independence Program (CFCIP)</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Psychiatric, Medication Monitoring</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Independent Living / Emancipation Services</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other (Specify below)</td> <td></td> </tr> </tbody> </table>	Type of Service	Amount of Service	<input type="checkbox"/> Home-based Family Preservation Services	_____	<input type="checkbox"/> Office-based Family Preservation Services	_____	<input type="checkbox"/> Day Treatment	_____	<input type="checkbox"/> Out-patient Family Therapy	_____	<input type="checkbox"/> Out-patient Individual Therapy	_____	<input type="checkbox"/> Out-patient Group Therapy	_____	<input type="checkbox"/> Substance Abuse Treatment	_____	<input type="checkbox"/> (Sex) Offense Specific Treatment	_____	<input type="checkbox"/> CHAFEE Services		Chafee Foster Care Independence Program (CFCIP)	_____	<input type="checkbox"/> Psychiatric, Medication Monitoring	_____	<input type="checkbox"/> Independent Living / Emancipation Services	_____	<input type="checkbox"/> Other (Specify below)	
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<input type="checkbox"/> Psychiatric, Medication Monitoring	_____																												
<input type="checkbox"/> Independent Living / Emancipation Services	_____																												
<input type="checkbox"/> Other (Specify below)																													
<p>5.a. If Other, please specify Type of Service</p>	<p>_____</p>																												
<p>5.b. If other, please specify Amount of Service. Enter the corresponding number from the list in item 5 for the Amount of Service received.</p>	<p>_____</p>																												
<p>6. To the best of your knowledge, were the provider discharge recommendations followed after discharge from RCCF?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No (please list reason below if known) <input type="checkbox"/> Unknown</p>																												
<p>6.a. Reason provider's discharge recommendations were not followed</p>	<p>_____</p>																												

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

<p>7. In addition to the services the child has received since discharge from RCCF, what additional services do you think would have been helpful to the child in supporting his or her community success? (Check all that apply)</p>	<p><input type="checkbox"/> Family preservation – in home services <input type="checkbox"/> Higher frequency or longer family preservation – in home services <input type="checkbox"/> Substance abuse services <input type="checkbox"/> Higher frequency of substance abuse services <input type="checkbox"/> Academic support <input type="checkbox"/> Offense specific services for sexual abuse treatment <input type="checkbox"/> Individual therapy <input type="checkbox"/> Medication coordination, psychiatric services <input type="checkbox"/> Independent living support <input type="checkbox"/> Basic life support (rent, food, clothing) <input type="checkbox"/> Child Welfare Services <input type="checkbox"/> Probation Services <input type="checkbox"/> Parole Services <input type="checkbox"/> Other (Specify below) <input type="checkbox"/> Unknown</p>
<p>7.a. If Other, please specify type of service</p>	<p>_____</p>
<p>8. In what academic or vocational schooling or programs has the child participated since discharge? (Select all responses that describe the youth's experiences during the time period.)</p>	<p><input type="checkbox"/> Regular attendance at K -12 school <input type="checkbox"/> Inconsistent attendance at K-12 school <input type="checkbox"/> Regular attendance at secondary school <input type="checkbox"/> Inconsistent attendance at secondary school <input type="checkbox"/> Expelled from school <input type="checkbox"/> Received GED or High School diploma <input type="checkbox"/> Enrolled in post secondary or vocational training <input type="checkbox"/> Unknown</p>
<p>9. Number of overnight runaway episodes / AWOLs since discharge from RCCF: (Please estimate number and do not enter a range)</p>	<p>_____</p>
<p>10. Number of overnight psychiatric hospitalizations since discharge from RCCF: (Please estimate number and do not enter a range)</p>	<p>_____</p>
<p>11. Number of suicide attempts resulting in injuries requiring hospitalization since discharge from RCCF: (Please estimate number and do not enter a range)</p>	<p>_____</p>
<p>12. Has the youth made homicidal threats since discharge from RCCF?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>13. Frequency of use of illegal substances since discharge from RCCF:</p>	<p><input type="checkbox"/> Never <input type="checkbox"/> Less than 1 X per month <input type="checkbox"/> Monthly <input type="checkbox"/> 2 X per month <input type="checkbox"/> Weekly <input type="checkbox"/> Daily</p>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

<p>14. Indicate the total number of psychotropic medications in use at the time of interview other than those prescribed for Attention Deficit or Hyperactivity (do not include medical conditions).</p>	<p>_____ <input type="checkbox"/> Don't know</p>
<p>15. Indicate if any NEW charges have been filed against the child since discharge from RCCF. Check all that apply:</p> <p>If there are no new charges, then do not select any items from the list.</p>	<p><input type="checkbox"/> Crimes against persons (e.g., sexual or other assault, robbery, menacing, reckless endangerment)</p> <p><input type="checkbox"/> Crimes against property (e.g., trespassing, stolen property, shoplifting, burglary, arson, theft, destruction of property, fraud, motor vehicle theft)</p> <p><input type="checkbox"/> Substance use-related violation/crimes (e.g., DUI/DWI, possession, distribution, public intoxication, positive drug screen)</p> <p><input type="checkbox"/> Crimes/violations against public order (e.g., weapons offenses, non-violent sex offenses, disorderly conduct, abuse of animals, traffic violations [not DUI/DWI])</p> <p><input type="checkbox"/> Violations of court proceedings (e.g., not complying with terms of probation, parole)</p> <p><input type="checkbox"/> Status offenses (e.g., curfew violation, truancy, runaway)</p> <p><input type="checkbox"/> Other (specify below)</p> <p><input type="checkbox"/> Unknown</p>
<p>15.a. If Other, please specify type of charges</p>	<p>_____</p>
<p>16. Indicate employment history since discharge from RCCF</p> <p>Check all that apply</p>	<p><input type="checkbox"/> Has not searched for a job</p> <p><input type="checkbox"/> Has searched for a job but did not find one</p> <p><input type="checkbox"/> Worked at a job and resigned</p> <p><input type="checkbox"/> Worked at a job and was fired</p> <p><input type="checkbox"/> Too young to be employed</p> <p><input type="checkbox"/> Currently employed</p> <p><input type="checkbox"/> Unknown</p>
<p>17. Unplanned parenthood, indicate yes or no to any unplanned parenthood.</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

Please refer to the CANS coding definitions while completing this section.

TRAUMA EXPERIENCES	0	1	2	3	NA
1. Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Community Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. School Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Natural or manmade disasters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Traumatic Grief/Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. War Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Witness to Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TRAUMATIC STRESS SYMPTOMS	0	1	2	3	
14. Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Re-experiencing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Avoidance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Numbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Dissociation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD STRENGTHS	0	1	2	3	
19. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Interpersonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Educational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Optimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Talents/Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Spiritual/Religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Community Life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LIFE DOMAIN FUNCTIONING	0	1	2	3	
29. Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Developmental (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.1. Cognitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.2. Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.3. Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.4. Self Care/Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32.5. Specify I.Q.					
	YES	NO			
32.6. Does the child require any special assistive devices?					
32.6.a. If YES, please specify (Optional)					
32.7. Does the child require any special accommodations for home or school?					
32.7.a. If YES, please specify (Optional)					
LIFE DOMAIN FUNCTIONING (cont.)	0	1	2	3	NA

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

33. Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
34. Job Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
36. Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
38. Sexual Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
39. School Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
40. School Achievement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
41. School Attendance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ACCULTURATION	0	1	2	3	
42. Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
43. Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
44. Ritual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
45. Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD BEHAVIOR / EMOTIONAL NEEDS	0	1	2	3	
46. Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
47. Attention/Impulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
48. Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
49. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
50. Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
51. Conduct	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52. Substance Abuse (if score is 2 or 3 on this question score the following 6 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.1. Severity of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.2. Duration of Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.3. Stage of Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.4. Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.5. Parental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
52.6. Environment Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
53. Attachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
54. Eating Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
55. Affect Dysregulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
56. Behavioral Regression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
57. Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
58. Anger Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
CHILD RISK BEHAVIORS	0	1	2	3	
59. Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
60. .Self Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
61. Other Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

CHILD RISK BEHAVIORS (cont.)	0	1	2	3
62. Danger to Others (if score is 2 or 3 on this question score the following 14 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.1. History of Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.2. History of Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.3. Witness to Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.4. Witness to Environmental Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.5. Bullying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.6. Frustration Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.7. Hostility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.8. Paranoid Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.9. Secondary gains from anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.10. Violent Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.11. Awareness of Violence Potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.12. Response to Consequences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.13. Commitment to Self-Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62.14. Treatment Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Sexual Aggression (if score is 2 or 3 complete the following 10 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.1 Date of most recent sexually abusive behavior?				
	YES		NO	
63.2 Was sexual act against a family member?				
(Identity)				
63.3 Relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.4 Physical Force/Threat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.5 Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.6 Age Differential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.7 Type of Sex Act	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.8 Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.9 Temporal Consistency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.10 History of Sexual Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.11 Severity of Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63.12 Prior Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES		NO	
63.13 Is the youth currently required to be on Colorado's Sex Offender Registry?				
64. Runaway (if score is 2 or 3 complete the following 8 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.1. Frequency of Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.2. Consistency of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.3. Safety of Destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.4. Involvement in Illegal Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.5. Likelihood of Return on Own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.6. Involvement of Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.7. Realistic Expectations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64.8. Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

CHILD RISK BEHAVIORS (cont.)	0	1	2	3
65. Delinquency (if score is 2 or 3 complete the following 7 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.1 Date of most recent delinquent behavior				
65.2 Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.3 History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.4 Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.5 Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.6 Peer Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.7 Parental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65.8 Environmental Influences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	YES		NO	
65.9 During the past year has the youth committed acts of delinquency against property?				
65.10 During the past year has the youth committed acts of delinquency against people?				
65.11 Has the youth used a weapon in the commission of an act of delinquency?				
65.12 Has the youth committed any acts of delinquency involving illegal substances?				
66. Judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67. Fire Setting (if score is 2 or 3 complete the following 9 items)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.1 Date of the most recent fire-setting behavior?				
	YES		NO	
67.2 Was the child alone at the time of the incident or were there any other children involved?				
67.3 Seriousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.4 History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.5 Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.6 Use of accelerants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.7 Intention to harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.8 Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.9 Response to Accusation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.10 Remorse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
67.11 Likelihood of future fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
68. Social Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
69. Sexually Reactive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
70. Parental Criminal Behavior (biological parents(s))	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THE COLORADO RESIDENTIAL OUTCOMES COLLECTION AND REPORTING SYSTEM (ROCRS): **POST-DISCHARGE ASSESSMENT**

<p>71. Transition to Adulthood <i>(The following items are required for youth 17 and older at the time the form is completed). However, any of these items can be rated regardless of age if they represent a need for a specific youth.</i></p> <p>A check indicates that the youth is under age 17 and the Transition to Adulthood Section will NOT be completed.</p>	<input type="checkbox"/>			
	0	1	2	3
<i>71.1. Independent Living Skills</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.2. Transportation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.3. Parenting Roles</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.4. Personality Disorders</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.5. Intimate Relationships</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.6. Medication Compliance</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.7. Educational Attainment</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>71.8. Victimization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>The next section, Caregiver Strengths concerns the youth's community-based caregiver(s).</p> <p>72. If the youth does NOT have one or more individuals who can reasonably be expected to function in this role, e.g., biological or adoptive parents, family, long-term foster parents, when the youth is out of residential care, please check here.</p> <p>A check indicates that the Caregiver Strengths Section will NOT be completed.</p>	<input type="checkbox"/>			
<p>Caregiver Needs & Strengths (parents, relatives and prospective adoptive parents):</p>	0	1	2	3
<i>72.1. Physical</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.2. Mental Health</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.3. Substance Use</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.4. Developmental</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.5. Supervision</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.6. Involvement</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.7. Knowledge</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.8. Organization</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.9. Resources</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.10. Residential Stability</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.11. Safety</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.12. Marital/Partner Violence</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>72.13. Posttraumatic Reactions</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Colorado C.A.N.S.

Child and Adolescent Needs and Strengths Assessment

USER'S INSTRUCTIONAL MANUAL

**Buddin Praed Foundation
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The Colorado CANS Assessment was adapted from the CANS-Comprehensive, an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Buddin Praed Foundation to ensure that it remains free to use. Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The Colorado CANS was developed after the Illinois version of the CANS, which included trauma items developed by the SAMHSA-funded National Child Traumatic Stress Network. For more information about alternative versions of the CANS please contact Melanie Lyons of the Buddin Praed Foundation. For more information on the **Colorado CANS** assessment tool contact: Skip Barber, CAFCA.

GENERAL INSTRUCTIONS

The **COLORADO C.A.N.S. ASSESSMENT** is currently being utilized for the Colorado Outcome Study sponsored by Colorado Association of Family and Children's Agencies (CAFCA) and the Colorado Health Foundation.

There are three different assessments used at **ADMISSION**, **DISCHARGE** and **POST-DISCHARGE** relative to the youth's residential treatment. The **FIRST** section of each assessment includes a number of questions designed specifically to help provide profiles of youth in Colorado residential programs. The questions are specific to the time of the assessment (Admission, Discharge or Post-Discharge). Please refer to the specific user guide for the assessment you are completing.

The **SECOND** section of all assessments includes the actual CANS items to be scored. The CANS items are the same in the Admission, Discharge and Post-Discharge assessments, but reflect the youth's and family's needs and strengths over the different time periods listed above. This guide is intended as the instructions for this component of the assessment.

You do not need to meet face-to-face with the child/youth to complete the Colorado CANS, although it is the expectation of study protocol that a face-to-face assessment occurs at the time of admission. Whether a face-to-face at discharge will be dependent on many factors, not the least of which is whether the discharge is planned. Contact with the Youth and family by phone is planned for assisting in the completion of the Post-Discharge CANS. Regardless of whether a face-to-face interview is possible in order to complete the CANS, knowing the Youth is essential to effectively score the assessment. You will need as much background information as possible to assist you with answering the questions. This might include intake assessments, psychological evaluations, education records, medical/health histories, prior treatment records, etc.

The CANS Approach to Rating

The CANS Assessment is presented in nine (9) sections or domains. Each domain contains several questions. Each question requires a rating/score of 0, 1, 2, or 3, which represents both a description of the youth's or family's status or functioning AND the raters' assessment of what type of action, if any, is needed for this need or strength in the current service plan. This manual provides the definition/description of each score for each choice item.

When considering action:

“0” indicates no need for action

“1” indicates a need for watchful waiting to see whether action is needed (i.e. flag it for later review to see if any circumstances change) or prevention planning

“2” indicates a need for action

“3” indicates the need for either immediate or intensive action

“NA” indicates that the question is Not Applicable to the youth.

Overall scoring guideline:

- First try to apply the definitions for each question.
- If there is no good fit, then consider the action levels
- If you still cannot decide between two options round towards no evidence/less severity.

In order to maximize the ease of use and interpretation, please note that two categories, **Child Strengths and Caregiver Strengths & Needs**, are rated in a **reverse logical manner**, i.e., a rating of '0' is seen as a positive strength.

With regard to rating strengths,

- If you can't decide to build or use, round toward the strength that needs building.

For some items, there are specific **Breakout Modules** that should be completed if the youth scores a „2“ or „3“. These Modules have been incorporated into the CANS Assessment form immediately following the trigger questions and can be identified because they have been **highlighted in red**. These modules go into more depth about the nature and severity of the specific issue. They are numbered as subsections of the triggering item. Please complete all modules as applicable based on the youth's score.

C.A.N.S. CODING DEFINITIONS AND GUIDELINES

Use these guidelines when scoring CANS Assessment Items for the Admissions, Discharge and Post-Discharge Assessments.

TRAUMA EXPERIENCES

These ratings are made based on lifetime exposure of trauma.

For **Trauma Experiences**, the following categories and action levels are used:

0 indicates a dimension where there is no evidence of any trauma of this type. No evidence includes not having any information about a particular experience. Therefore if you don't know then score the item as a zero.

1 indicates a dimension where a single incident of trauma occurred or suspicion exists of trauma experiences.

2 indicates a dimension on which the child has experienced multiple traumas.

3 indicates a dimension which describes repeated and severe incidents of trauma with medical and physical consequences.

1. SEXUAL ABUSE

This rating describes child's experience of sexual abuse or the impact of the abuse on child's functioning.

0 There is no evidence that child has experienced sexual abuse.

1 Child has experienced single incident of sexual abuse with no penetration.

2 Child has experienced multiple incidents of sexual abuse without penetration or a single incident of penetration.

3 Child has experienced severe, chronic sexual abuse that could include penetration or associated physical injury.

2. Physical Abuse

This rating describes the degree of severity of the child's physical abuse.

0 There is no evidence that child has experienced physical abuse.

1 There is a suspicion that child has experienced physical abuse but no confirming evidence. Spanking without physical harm or intention to commit harm also qualifies.

2 Child has experienced a moderate level of physical abuse and/or repeated forms of physical punishment (e.g. hitting, punching).

3 Child has experienced severe and repeated physical abuse with intent to do harm and that causes sufficient physical harm to necessitate hospital treatment.

3. Emotional Abuse

This rating describes the degree of severity of emotional abuse, including verbal and nonverbal forms.

- 0 There is no evidence that child has experienced emotional abuse.
- 1 Child has experienced mild emotional abuse. For instance, child may experience some insults or is occasionally referred to in a derogatory manner by caregivers.
- 2 Child has experienced moderate degree of emotional abuse. For instance, child may be consistently denied emotional attention from caregivers, insulted or humiliated on an ongoing basis, or intentionally isolated from others.
- 3 Child has experienced significant emotional abuse over an extended period of time (at least one year). For instance, child is completely ignored by caregivers, or threatened/terrorized by others.

4. NEGLECT

This rating describes the degree of severity of neglect.

- 0 There is no evidence that child has experienced neglect.
- 1 Child has experienced minor or occasional neglect. Child may have been left at home alone with no adult supervision or there may be occasional failure to provide adequate supervision of child.
- 2 Child has experienced a moderate level of neglect. This may include occasional unintended failure to provide adequate food, shelter, or clothing with corrective action.
- 3 Child has experienced a severe level of neglect including prolonged absences by adults, without minimal supervision, and failure to provide basic necessities of life on a regular basis.

5. MEDICAL TRAUMA

This rating describes the degree of severity of medical trauma.

- 0 There is no evidence that child has experienced any medical trauma.
- 1 Child has experienced mild medical trauma including minor surgery (e.g. stitches, bone setting).
- 2 Child has experienced moderate medical trauma including major surgery or injuries requiring hospitalization.
- 3 Child has experienced life threatening medical trauma.

6. WITNESS TO FAMILY VIOLENCE

This rating describes the degree of severity of exposure to family violence.

- 0 There is no evidence that child has witnessed family violence.
- 1 Child has witnessed one episode of family violence.
- 2 Child has witnessed repeated episodes of family violence but no significant injuries (i.e. requiring emergency medical attention) have been witnessed.
- 3 Child has witnessed repeated and severe episode of family violence or has had to intervene in episodes of family violence. Significant injuries have occurred and have been witnessed by the child as a direct result of the violence.

7. COMMUNITY VIOLENCE

This rating describes the degree of severity of exposure to community violence.

- 0 There is no evidence that child has witnessed or experienced violence in the community.
- 1 Child has witnessed occasional fighting or other forms of violence in the community. Child has not been directly impacted by the community violence (i.e. violence not directed at self, family, or friends) and exposure has been limited.
- 2 Child has witnessed the significant injury of others in his/her community, or has had friends/family members injured as a result of violence or criminal activity in the community, or is the direct victim of violence/criminal activity that was not life threatening, or has witnessed/experienced chronic or ongoing community violence.
- 3 Child has witnessed or experienced the death of another person in his/her community as a result of violence, or is the direct victim of violence/criminal activity in the community that was life threatening, or has experienced chronic/ongoing impact as a result of community violence (e.g. family member injured and no longer able to work).

8. SCHOOL VIOLENCE

This rating describes the degree of severity of exposure to school violence.

- 0 There is no evidence that child has witnessed violence in the school setting.
- 1 Child has witnessed occasional fighting or other forms of violence in the school setting. Child has not been directly impacted by the violence (i. e. violence not directed at self or close friends) and exposure has been limited.
- 2 Child has witnessed the significant injury of others in his/her school setting, or has had friends injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in the school setting leading to minor injury, or has witnessed ongoing/chronic violence in the school setting.
- 3 Child has witnessed the death of another person in his/her school setting, or has had friends who were seriously injured as a result of violence or criminal activity in the school setting, or has directly experienced violence in the school setting leading to significant injury or lasting impact.

9. NATURAL OR MANMADE DISASTERS

This rating describes the degree of severity of exposure to either natural or man-made disasters.

- 0 There is no evidence that child has been exposed to natural or man-made disasters.
- 1 Child has been exposed to disasters second hand (i.e. on television, hearing others discuss disasters). This would include second hand exposure to natural disasters such as a fire or earthquake or man-made disaster, including car accident, plane crashes, or bombings.
- 2 Child has been directly exposed to a disaster or witnessed the impact of a disaster on a family or friend. For instance, a child may observe a caregiver who has been injured in a **car accident** or fire or watch his neighbor's house burn down.
- 3 Child has been directly exposed to a disaster that caused significant harm or death to a loved one or there is an ongoing impact or life disruption due to the disaster (e.g. house burns down, caregiver loses job).

10. TRAUMATIC GRIEF/SEPARATION

This rating describes the level of traumatic grief due to death or loss or separation from significant caregivers. It is the current adjustment to a loss. It is different than the other items in the trauma module in that it is not a static item (whether something occurred or not) but a process item (the nature of the Youth's adjustment to a significant loss).

- 0 There is no evidence that the child has experienced traumatic grief or separation from significant caregivers.
- 1 Child is experiencing some level of traumatic grief due to death or loss of a significant person or distress from caregiver separation in a manner that is appropriate given the recent nature of loss or separation.
- 2 Child is experiencing a moderate level of traumatic grief or difficulties with separation in a manner that impairs function in certain but not all areas. This could include withdrawal or isolation from others.
- 3 Child is experiencing significant traumatic grief or separation reactions. Child exhibits impaired functioning across several areas (e.g. interpersonal relationships, school) for a significant period of time following the loss or separation.

11. WAR AFFECTED

This rating describes the degree of severity of exposure to war, political violence, or torture. Violence or trauma related to Terrorism is not included here.

- 0 There is no evidence that child has been exposed to war, political violence, or torture.
- 1 Child did not live in war-affected region or refugee camp, but family was affected by war. Family members directly related to the child may have been exposed to war, political violence, or torture; family may have been forcibly displaced due to the war, or both. This does not include children who have lost one or both parents during the war.
- 2 Child has been affected by war or political violence. He or she may have witnessed others being injured in the war, may have family members who were hurt or killed in the war, and may have lived in an area where bombings or fighting took place. Child may have lost one or both parents during the war or one or both parents may be so physically or psychologically disabled from war so that they are not able to provide adequate caretaking of child. Child may have spent extended amount of time in refugee camp.
- 3 Child has experienced the direct affects of war. Child may have feared for their own life during war due to bombings, shelling, very near to them. They may have been directly injured, tortured or kidnapped. Some may have served as soldiers, guerrillas or other combatants in their home countries.

12. TERRORISM AFFECTED

This rating describes the degree to which a child has been affected by terrorism. Terrorism is defined as "the calculated use of violence or the threat of violence to inculcate fear, intended to coerce or to intimidate governments or societies in the pursuit of goals that are generally political, religious, or ideological." Terrorism includes attacks by individuals acting in isolation (e.g. sniper attacks).

- 0 There is no evidence that child has been affected by terrorism or terrorist activities.
- 1 Child's community has experienced an act of terrorism, but the child was not directly impacted by the violence (e.g. child lives close enough to site of terrorism that they may have visited before or child recognized the location when seen on TV, but child's family and neighborhood infrastructure was not directly affected). Exposure has been limited to pictures on television.
- 2 Child has been affected by terrorism within his/her community, but did not directly witness the attack. Child may live near the area where attack occurred and be accustomed to visiting regularly in the past, infrastructure of child's daily life may be disrupted due to attack (e.g. utilities or school), and child may see signs of the attack in neighborhood (e.g. destroyed building). Child may know people who were injured in the attack.
- 3 Child has witnessed the death of another person in a terrorist attack, or has had friends or family members seriously injured as a result of terrorism, or has directly been injured by terrorism leading to significant injury or lasting impact.

13. WITNESS/VICTIM TO CRIMINAL ACTIVITY

*This rating describes the degree of severity of exposure to criminal activity. **Criminal activity is defined as something a person could be arrested for.***

- 0 There is no evidence that child has been victimized or witnessed significant criminal activity.
- 1 Child is a witness of significant criminal activity.
- 2 Child is a direct victim of criminal activity or witnessed the victimization of a family or friend.
- 3 Child is a victim of criminal activity that was life threatening or caused significant physical harm or child witnessed the death of a loved one.

TRAUMATIC STRESS SYMPTOMS

These ratings describe a range of reactions that children and adolescents may exhibit to any of the variety of traumatic experiences described above. Unlike the Trauma Experiences which are cumulative over the child's lifetime, these symptoms are rated based on how the child is doing over the past 30 days.

For **Trauma Stress Symptoms**, the following categories and action levels are used:

0 indicates a dimension where there is *no evidence* of any trauma of this type. No evidence includes not having any information about a particular experience. Therefore if you don't know then score the item as a zero.

1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.

2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.

3 indicates a dimension that requires immediate or intensive action.

14. ADJUSTMENT TO TRAUMA

This item covers the youth's reaction to any of a variety of traumatic experiences -- such as emotional, physical, or sexual abuse, separation from family members, witnessing violence, or the victimization or murder of family members or close friends. This dimension covers both adjustment disorders and posttraumatic stress disorder from DSM-IV. This is a cause and effect item that describes how the child is adjusting to trauma experienced, in the present day.

0 Child has not experienced any significant trauma or has adjusted well to traumatic experiences.

1 Child has some mild adjustment problems to trauma. Child may have an adjustment disorder or other reaction that might ease with the passage of time. Or, child may be recovering from a more extreme reaction to a traumatic experience.

2 Child has marked adjustment problems associated with traumatic experiences. Child may have nightmares or other notable symptoms of adjustment difficulties.

3 Child has post-traumatic stress difficulties as a result of traumatic experience. Symptoms may include intrusive thoughts, hyper-vigilance, constant anxiety, and other common symptoms of Post Traumatic Stress Disorder (PTSD).

15. REEXPERIENCING

These symptoms consist of difficulties with intrusive memories or reminders of traumatic events, including nightmares, flashbacks, intense reliving of the events, and repetitive play with themes of specific traumatic experiences. These symptoms are part of the DSM-IV criteria for PTSD.

- 0 This rating is given to a child with no evidence of intrusive symptoms.
- 1 This rating is given to a child with some problems with intrusions, including occasional nightmares about traumatic events.
- 2 This rating is given to a child with moderate difficulties with intrusive symptoms. This child may have more recurrent frightening dreams with or without recognizable content or recurrent distressing thoughts, images, perceptions or memories of traumatic events. This child may exhibit trauma-specific reenactments through repetitive play with themes of trauma or intense physiological reactions at exposure to traumatic cues.
- 3 This rating is given to a child with severe intrusive symptoms. This child may exhibit trauma-specific reenactments that include sexually or physically traumatizing other children or sexual play with adults. This child may also exhibit persistent flashbacks, illusions or hallucinations that make it difficult for the child to function.

16. AVOIDANCE

These symptoms include efforts to avoid stimuli associated with traumatic experiences. These symptoms are part of the DSM-IV criteria for PTSD.

- 0 This rating is given to a child with no evidence of avoidance symptoms.
- 1 This rating is given to a child who exhibits some problems with avoidance. This child may exhibit one primary avoidant symptom, including efforts to try and avoid thoughts, feelings or conversations associated with the trauma.
- 2 This rating is given to a child with moderate symptoms of avoidance. In addition to avoiding thoughts or feelings associated with the trauma, the child may also avoid activities, places, or people that arouse recollections of the trauma.
- 3 This rating is given to a child who exhibits significant or multiple avoidant symptoms. This child may avoid thoughts and feelings as well as situations and people associated with the trauma and have an inability to recall important aspects of the trauma.

17. NUMBING

These symptoms include numbing responses that are part of the DSM-IV criteria for PTSD. These responses are not present before the trauma.

- 0 This rating is given to a child with no evidence of numbing responses.
- 1 This rating is given to a child who exhibits some problems with numbing. This child may have a restricted range of affect or an inability to express or experience certain emotions (e.g., anger or sadness).
- 2 This rating is given to a child with moderate difficulties with numbing responses. This child may have a blunted or flat emotional state or have difficulty experiencing intense emotions or feel consistently detached or estranged from others following the traumatic experience.
- 3 This rating is given to a child with significant numbing responses or multiple symptoms of numbing. This child may have a markedly diminished interest or participation in significant activities and a sense of a foreshortened future.

18. DISSOCIATION

Symptoms included in this dimension are daydreaming, spacing or blanking out, forgetfulness, emotional numbing, fragmentation, detachment, and rapid changes in personality often associated with traumatic experiences. This dimension may be used to rate dissociative disorders (e.g., Dissociative Disorder NOS, Dissociative Identity Disorder) but can also exist when other diagnoses are primary (e.g., PTSD, depression).

- 0 This rating is given to a child with no evidence of dissociation.
- 1 This rating is given to a child with minor dissociative problems, including some emotional numbing, avoidance or detachment, and some difficulty with forgetfulness, daydreaming, spacing or blanking out.
- 2 This rating is given to a child with a moderate level of dissociation. This can include amnesia for traumatic experiences or inconsistent memory for trauma (e.g., remembers in one context but not another), more persistent or perplexing difficulties with forgetfulness (e.g., loses things easily, forgets basic information), frequent daydreaming or trance-like behavior, depersonalization and/or derealization. This rating would be used for someone who meets criteria for Dissociative Disorder Not Otherwise Specified or another diagnosis that is specified “with dissociative features.”
- 3 This rating is given to a child with severe dissociative disturbance. This can include significant memory difficulties associated with trauma that also impede day to day functioning. Child is frequently forgetful or confused about things he/she should know about (e.g., no memory for activities or whereabouts of previous day or hours). Child shows rapid changes in personality or evidence of distinct personalities. Child who meets criteria for Dissociative Identity Disorder or a more severe level of Dissociative Disorder NOS would be rated here.

Child Strengths

These ratings describe a range of assets that children and adolescents may possess that can facilitate healthy development. An absence of a strength is not necessarily a need but an indication that strength building activities are indicated. In general strengths are more trait-like, stable characteristics; however, the 30 day rating window still applies unless overridden by the action levels as described below.

For **Child's Strengths**, the following categories and action levels are used:

- 0 indicates a domain where strengths exist that can be used as a centerpiece for a strength-based plan.
- 1 indicates a domain where strengths exist but require some strength building efforts in order for them to serve as a focus of a strength-based plan.
- 2 indicates a domain where strengths have been identified but require significant strength building efforts before they can be effectively utilized in as a focus of a strength-based plan.
- 3 indicates a domain in which efforts are needed in order to identify potential strengths for strength building efforts. In contrast to clinical scales where if you don't know you score the item a zero, with strengths if no information is available then score the item as a three. If the child has no family (just as in parental rights terminated children, then score a three for no resources being available.

19. Family

Family refers to all biological or adoptive relatives with whom the child or youth remains in contact along with other individuals in relationships with these relatives.

- 0 Significant family strengths. This level indicates a family with much love and mutual respect for each other. Family members are central in each other's lives. Child is fully included in family activities.
- 1 Moderate level of family strengths. This level indicates a loving family with generally good communication and ability to enjoy each other's company. There may be some problems between family members. Child is generally included.
- 2 Mild level of family strengths. Family is able to communicate and participate in each other's lives; however, family members may not be able to provide significant emotional or concrete support for each other. Child is often not included in family activities.
- 3 This level indicates a child with no known family strengths. Child is not included in normal family activities. A parental rights terminated child in long-term foster care and/or residential treatment with permanent connections would be scored here.

20. INTERPERSONAL

This rating refers to the interpersonal skills of the child or youth both with peers and adults.

- 0 Significant interpersonal strengths. Child is seen as well liked by others and has significant ability to form and maintain positive relationships with both peers and adults. Individual has multiple close friends and is friendly with others.
- 1 Moderate level of interpersonal strengths. Child has formed positive interpersonal relationships with peers and/or other non-caregivers. Child may have one friend, if that friendship is a healthy „best friendship“ model.
- 2. Mild level of interpersonal strengths. Child has some social skills that facilitate positive relationships with peers and adults but may not have any current relationships, but has a history of making and maintaining healthy friendships with others.
- 3 This level indicates a child with no known interpersonal strengths. Child currently does not have any friends nor has he/she had any friends in the past. Child does not have positive relationships with adults.

21. EDUCATIONAL

This rating refers to the strengths of the school system and may or may not reflect any specific educational skills possessed by the child or youth.

- 0 This level indicates a child who is in school and is involved with an educational plan that appears to exceed expectations. School works exceptionally well with family and caregivers to create a special learning environment. A child in a mainstream educational system who does not require an individual plan would be rated here.
 - 1 This level indicates a child who is in school and has a plan that appears to be effective. School works fairly well with family and caregivers to ensure appropriate educational development.
 - 2 This level indicates a child who is in school but has a plan that does not appear to be effective.
 - 3 This level indicates a child who is either not in school or is in a school setting that does not further his/her education.
- NA Not applicable

22. VOCATIONAL

Generally this rating is reserved for adolescents and is not applicable for children 12 years and under. Computer skills would be rated here.

- 0 This level indicates an adolescent with vocational skills who is currently working in a natural environment.
- 1 This level indicates an adolescent with pre-vocational and some vocational skills but limited work experience.
- 2 This level indicates an adolescent with some pre-vocational skills. This also may indicate a child or youth with a clear vocational preference.
- 3 This level indicates an adolescent with no known or identifiable vocational or pre-vocational skills and no expression of any future vocational preferences.

NA Indicates a child 12 years of age or younger.

23. WELL-BEING

This rating should be based on the psychological strengths that the child or adolescent might have developed including both the ability to enjoy positive life experiences and manage negative life experiences. This should be rated independent of the child's current level of distress.

- 0 This level indicates a child with exceptional psychological strengths. Both coping and savoring skills are well developed.
- 1 This level indicates a child with good psychological strengths. The person has solid coping skills for managing distress or solid savoring skills for enjoying pleasurable events.
- 2 This level indicates a child with limited psychological strengths. For example, a person with very low self-esteem would be rated here.
- 3 This level indicates a child with no known or identifiable psychological strengths. This may be due to intellectual impairment or serious psychiatric disorders.

24. OPTIMISM

This rating should be based on the child or adolescent's sense of him/herself in his/her own future. This is intended to rate the child's positive future orientation.

- 0 Child has a strong and stable optimistic outlook on his/her life. Child is future oriented.
- 1 Child is generally optimistic. Child is likely able to articulate some positive future vision.
- 2 Child has difficulties maintaining a positive view of him/herself and his/her life. Child may vary from overly optimistic to overly pessimistic.
- 3 Child has difficulties seeing any positives about him/herself or his/her life.

25. TALENT/INTERESTS

This rating should be based broadly on any talent, creative or artistic skill a child or adolescent may have including art, theatre, music, athletics, etc.

- 0 This level indicates a child with significant creative/artistic strengths. A child/youth who receives a significant amount of personal benefit from activities surrounding a talent would be rated here.
- 1 This level indicates a child with a notable talent. For example, a youth who is involved in athletics or plays a musical instrument, etc. would be rated here.
- 2 This level indicates a child who has expressed interest in developing a specific talent or talents even if they have not developed that talent to date.
- 3 This level indicates a child with no known talents, interests, or hobbies.

26. SPIRITUAL/RELIGIOUS

This rating should be based on the child or adolescent's and their family's involvement in spiritual or religious beliefs and activities.

- 0 This level indicates a child with strong moral and spiritual strengths. Child may be very involved in a religious community or may have strongly held spiritual or religious beliefs that can sustain or comfort him/her in difficult times.
- 1 This level indicates a child with some moral and spiritual strengths. Child may be involved in a religious community.
- 2 This level indicates a child with few spiritual or religious strengths. Child may have little contact with religious institutions.
- 3 This level indicates a child with no known spiritual or religious involvement.

27. COMMUNITY LIFE

*This rating should be based on the child or adolescent's level of involvement in the cultural aspects of life in his/her community. **This scale assesses meaningful connections to the community. The connections may include relative/extended-family connections if this is a resource for socialization and support.***

- 0 This level indicates a child with extensive and substantial, long-term ties with the community. For example, individual may be a member of a community group (e.g. Girl or Boy Scout etc.) for more than one year, may be widely accepted by neighbors, or involved in other community activities, informal networks, etc.
- 1 This level indicates a child with significant community ties although they may be relatively short term (e.g. past year).
- 2 This level indicates a child with limited ties and/or supports from the community.
- 3 This level indicates a child with no known ties or supports from the community.

28. RELATIONSHIP PERMANENCE

This rating refers to the stability of significant relationships in the child or youth's life. This likely includes family members but may also include other individuals.

- 0 This level indicates a child who has very stable relationships. Family members, friends, and community have been stable for most of his/her life and are likely to remain so in the foreseeable future. Child is involved with both parents.
 - 1 This level indicates a child who has had stable relationships but there is some concern about instability in the near future (one year) due to transitions, illness, or age. A child who has a stable relationship with only one parent may be rated here.
 - 2 This level indicates a child who has had at least one stable relationship over his/her lifetime but has experienced other instability through factors such as divorce, moving, removal from home, and death.
 - 3 This level indicates a child who does not have any stability in relationships.
- NA Not applicable

LIFE DOMAIN FUNCTIONING

These ratings describe how children and adolescents are doing in their various environments or life domains. The domains were identified from the children's research literature on wraparound philosophy. Good functioning in all life domains is the goal of a lifetime developmental framework.

For **Life Functioning Domains**, the following categories and action levels are used:

- 0 indicates a life domain in which the child is excelling. This is an area of considerable strength. This dimension is also used when there is no evidence or information to make a determination. If you don't have enough information then score the item as a zero.
- 1 indicates a life domain in which the child is doing OK. This is an area of potential strength.
- 2 indicates a life domain in which the child is having problems. Help is needed to improve functioning into an area of strength.
- 3 indicates a life domain in which the child is having significant problems. Intensive help is needed to improve functioning into an area of strength.

29. FAMILY

Family ideally should be defined by the child; however, in the absence of this knowledge consider biological relatives and their significant others with whom the child still has contact as the definition of family.

- 0 Child is doing well in relationships with family members.
- 1 Child is doing adequately in relationships with family members although some problems may exist. For example, some family members may have some problems in their relationships with child.
- 2 Child is having moderate problems with parents, siblings and/or other family members. Frequent arguing, difficulties in maintaining any positive relationship may be observed.
- 3 Child is having severe problems with parents, siblings, and/or other family members. This would include problems of domestic violence, constant arguing, etc.

30. LIVING SITUATION

This item refers to how the child is functioning in their current living arrangement which could be a relative, a temporary foster home, shelter, etc.

- 0 No evidence of problems with functioning in current living environment.
- 1 Mild problems with functioning in current living situation. Caregivers concerned about child's behavior in living situation.
- 2 Moderate to severe problems with functioning in current living situation. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the residence. Parents or current foster care setting is thinking that they might not be able to manage the child's needs

- 3 Profound problems with functioning in current living situation. Child is at immediate risk of being removed from living situation due to his/her behaviors. **A decision by the caretakers has already been made that the child must be moved.**

31. SOCIAL FUNCTIONING

This item refers to the child's social functioning from a developmental perspective.

- 0 Child is on a healthy social development pathway.
- 1 Child is having some minor problems with his/her social functioning.
- 2 Child is having some moderate problems with his/her social functioning.
- 3 Child is experiencing severe disruptions in his/her social functioning.

32. DEVELOPMENTAL/INTELLECTUAL

*This rating describes the child's development as compared to standard developmental milestones such as talking, walking, toileting, cooperative play, etc. **If the child receives a score of two or three on this question please complete the Developmental Disability Module (questions 32.1-32.4)***

- 0 No evidence of developmental problems or mental retardation.
- 1 Evidence of a mild developmental delay or low IQ (70 to 85)
- 2 Evidence of a pervasive developmental disorder including Autism, Tourette's, Down's syndrome or other significant developmental delay or child's has mild mental retardation (50 to 69).
- 3 Severe developmental disorder or IQ below 50.

DEVELOPMENTAL DISABILITY (DD) MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 32

32.1 COGNITIVE

Please rate the highest level from the past 30 days

- 0 Child's intellectual functioning appears to be in normal range. There is no reason to believe that the child has any problems with intellectual functioning.
- 1 Child has low IQ (70 to 85) or has identified learning challenges.
- 2 Child has mild mental retardation. IQ is between 55 and 70.
- 3 Child has moderate to profound mental retardation. IQ is less than 55.

32.2 COMMUNICATION

Please rate the highest level from the past 30 days

- 0 Child's receptive and expressive communication appears developmentally appropriate. There is no reason to believe that the child has any problems communicating.
- 1 Child has receptive communication skills but limited expressive communication skills
- 2 Child has both limited receptive and expressive communication skills.
- 3 Child is unable to communicate.

32.3 DEVELOPMENTAL

Please rate the highest level from the past 30 days

0 Child's development appears within normal range. There is no reason to believe that the child has any developmental problems.

1 Evidence of a mild developmental delay.

2 Evidence of a pervasive developmental disorder including Autism, Tourette's, Down's syndrome or other significant developmental delay.

3 Severe developmental disorder.

32.4 SELF-CARE DAILY LIVING SKILLS

Please rate the highest level from the past 30 days

0 Child's self-care and daily living skills appear developmentally appropriate. There is no reason to believe that the child has any problems performing daily living skills.

1 Child requires verbal prompting on self-care tasks or daily living skills.

2 Child requires assistance (physical prompting) on self-care tasks or attendant care on one self-care task (e.g. eating, bathing, dressing, and toileting).

3 Child requires attendant care on more than one of the self-care tasks-eating, bathing, dressing, toileting.

Please fill in the blank or answer yes or no for the following items:

32.5 SPECIFY IQ

32.6 DOES THE CHILD REQUIRE ANY SPECIAL ASSISTIVE DEVICES

32.7 DOES THE CHILD REQUIRE ANY SPECIAL ACCOMODATIONS

33. RECREATIONAL

This item is intended to reflect the child's access to and use of leisure time activities.

0 Child has and enjoys positive recreation activities on an ongoing basis.

1 Child is doing adequately with recreational activities although some problems may exist.

2 Child is having moderate problems with recreational activities. Child may experience some problems with effective use of leisure time.

3 Child has no access to or interest in recreational activities. Child has significant difficulties making use of leisure time.

34. JOB FUNCTIONING

This item is intended to describe functioning in vocational settings. If a child or youth is not working, rate a '3'. Generally this item is intended for children 12 years of age or older but if the child is working (no matter what the age) please rate the level of job functioning.

0 Child is gainfully employed in a job and performing well.

1 Child is gainfully employed but may have some difficulties at work.

2 Child works intermittently for money (e.g. babysitting) or child has job history but is currently not working.

3 Child has no job history.

NA Not applicable because a child is 12 years of age or younger.

35. LEGAL

This item involves only the child's (not the families') involvement with the legal system.

- 0 Child has no known legal difficulties.
- 1 Child has a history of legal problems but currently is not involved with the legal system.
- 2 Child has some legal problems and is currently involved in the legal system.
- 3 Child has serious current or pending legal difficulties that place him/her at risk for a court ordered out of home placement.

36. MEDICAL

This item refers to the child's health.

- 0 Child is healthy.
- 1 Child has mild/treatable medical problems that require medical treatment.
- 2 Child has chronic illness that requires ongoing medical intervention.
- 3 Child has life threatening illness or medical condition.

37. PHYSICAL

This item describes any physical limitations the child may experience due to health or other factors.

- 0 Child has no physical limitations.
- 1 Child has some physical condition that places mild limitations on activities. Conditions such as impaired hearing or vision would be rated here. Rate here, treatable medical conditions that result in physical limitations (e.g. asthma).
- 2 Child has physical condition that notably impacts activities. Sensory disorders such as blindness, deafness, or significant motor difficulties would be rated here.
- 3 Child has severe physical limitations due to multiple physical conditions.

38. SEXUAL DEVELOPMENT

*This rating describes issues around sexual development including developmentally inappropriate sexual behavior and problematic sexual behavior. **Sexual orientation or gender identity issues should only be rated here if they are leading to difficulties.***

- 0 No evidence of any problems with sexual development.
- 1 Mild to moderate problems with sexual development. May include concerns about sexual identity or anxiety about the reactions of others.
- 2 Significant problems with sexual development. May include multiple older partners or high-risk sexual behavior.
- 3 Profound problems with sexual development. This level would include prostitution, very frequent risky sexual behavior, or sexual aggression.

39. SCHOOL BEHAVIOR

This item rates the behavior of the child or youth in school or school-like settings (e.g. Head Start, pre-school). A rating of 3 would indicate a child who is still having problems after special efforts have been made, i.e., problems in a special education class.

- 0 No evidence of behavior problems at school or day care. Child is behaving well.
- 1 Child is having mild behavioral problems at school. May be related to either relationships with teachers or peers. A single detention might be rated here.
- 2 Child is having moderate behavioral difficulties at school. He/she is disruptive and may receive sanctions including suspensions or multiple detentions.
- 3 Child is having severe problems with behavior in school. He/she is frequently or severely disruptive. School placement may be in jeopardy due to behavior.

NA Not applicable for children five years and younger

40. SCHOOL ACHIEVEMENT

This item describes academic achievement and functioning.

- 0 Child is doing well in school.
 - 1 Child is doing adequately in school, although some problems with achievement exist.
 - 2 Child is having moderate problems with school achievement. He/she may be failing some subjects.
 - 3 Child is having severe achievement problems. He/she may be failing most subjects or is more than one year behind same age peers in school achievement.
- NA Not applicable for children five years and younger

41. SCHOOL ATTENDANCE

If school is not in session, rate the last 30 days when school was in session.

- 0 No evidence of attendance problems. Child attends regularly.
- 1 Child has some problems attending school, although he/she generally goes to school. He/she may miss up to one day per week on average. Or, he/she may have had moderate to severe problems in the past six months but has been attending school regularly in the past month.
- 2 Child is having problems with school attendance. He/she is missing at least two days per week on average.
- 3 Child is generally truant, has been expelled or is refusing to go to school.

ACCULTURATION

All children are members of some identifiable cultural group. These ratings describe possible problems that children or adolescents may experience with the relationship between their cultural membership and the predominant culture in which he/she lives.

For **Acculturation**, the following categories and action levels are used:

- 0** indicates a dimension where there is no evidence of any needs. This dimension is also used when there is no evidence or information to make a determination. If you don't have enough information then score the item as a zero.
- 1** indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
- 2** indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
- 3** indicates a dimension that requires immediate or intensive action.

42. LANGUAGE

This item includes both spoken and sign language.

- 0 Child and family speak English well.
- 1 Child and family speak some English but potential communication problems exist due to limits on vocabulary or understanding of the nuances of the language.
- 2 Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention but qualified individual can be identified within natural supports.
- 3 Child and/or significant family members do not speak English. Translator or native language speaker is needed for successful intervention and no such individual is available from among natural supports.

43. IDENTITY

Cultural identity refers to the child's view of him/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.

- 0 Child has clear and consistent cultural identity and is connected to others who share his/her cultural identity.
- 1 Child is experiencing some confusion or concern regarding cultural identity.
- 2 Child has significant struggles with his/her own cultural identity. Child may have cultural identity but is not connected with others who share this culture.
- 3 Child has no cultural identity or is experiencing significant problems due to conflict regarding his/her cultural identity.

44. RITUAL

*Cultural rituals are activities and traditions that are culturally specific including the celebration of holidays such as kwanza, cinco de mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media). **Included in this category maybe things like the loss of language due to the lack of opportunity to use it.***

- 0 Child and family are consistently able to practice rituals consistent with their cultural identity.
- 1 Child and family are generally able to practice rituals consistent with their cultural identity; however, they sometimes experience some obstacles to the performance of these rituals.
- 2 Child and family experience significant barriers and are sometimes prevented from practicing rituals consistent with their cultural identity.
- 3 Child and family are unable to practice rituals consistent with their cultural identity.

45. CULTURE STRESS

*Culture stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual's own cultural identity and the predominant culture in which he/she lives. **Being the victim of discrimination and racism (which is broadly defined as a negative reaction to your culture by others) would be included here.***

- 0 No evidence of stress between individual's cultural identity and current living situation.
- 1 Some mild or occasional stress resulting from friction between the individual's cultural identity and his/her current living situation.
- 2 Individual is experiencing cultural stress that is causing problems of functioning in at least one life domain.
- 3 Individual is experiencing a high level of cultural stress that is making functioning in any life domain difficult under the present circumstances.

CHILD BEHAVIOR/EMOTIONAL NEEDS

These ratings identify the behavioral health needs of the child or adolescent. While the CANS is not a diagnostic tool, it is designed to be consistent with diagnostic communication. In DSM-IV a diagnosis is defined by a set of symptoms that is associated with either dysfunction or distress. This definition is consistent with the ratings of „2“ or „3“ as defined by the action levels below:

For **Behavioral/Emotional Needs**, the following categories and symbols are used:

- 0 indicates a dimension where there is no evidence of any needs.
- 1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
- 2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
- 3 indicates a dimension that requires immediate or intensive action.

46. PSYCHOSIS

*This item is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia and Psychotic disorders (unipolar, bipolar, NOS). The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, and bizarre/idiosyncratic behavior. **Included in this dimension are drug induced psychoses.***

- 0 This rating indicates a child with no evidence of thought disturbances. Both thought processes and content are within normal range.
- 1 This rating indicates a child with evidence of mild disruption in thought processes or content. The child may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This also includes children with a history of hallucinations but none currently. The category would be used for children who are subthreshold for one of the DSM diagnoses listed above.
- 2 This rating indicates a child with evidence of moderate disturbance in thought processes or content. The child may be somewhat delusional or have brief or intermittent hallucinations. The child's speech may be at times quite tangential or illogical. This level would be used for children who meet the diagnostic criteria for one of the disorders listed above.
- 3 This rating indicates a child with severe psychotic disorder. The child frequently is experiencing symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. Command hallucinations would be coded here. This level is used for extreme cases of the diagnoses listed above.

47. ATTENTION DEFICIT/IMPULSE CONTROL

Symptoms of Attention Deficit and Hyperactivity Disorder and Impulse Control Disorder would be rated here. Inattention/distractibility not related to opposition would also be rated here. Symptoms may be caused by a variety of clinical conditions including bipolar disorder.

- 0 This rating is used to indicate a child with no evidence of attention/hyperactivity problems.
- 1 This rating is used to indicate a child with evidence of mild problems with attention/hyperactivity or impulse control problems. Child may have some difficulties staying on task for an age appropriate time period.
- 2 This rating is used to indicate a child with moderate symptoms of attention/hyperactivity or impulse control problems. A child who meets DSM-IV diagnostic criteria for ADHD would be rated here.
- 3 This rating is used to indicate a child with severe impairment of attention or dangerous impulse control problems. Frequent impulsive behavior is observed or noted that carries considerable safety risk (e.g. running into the street, dangerous driving or bike riding). A child with profound symptoms of ADHD would be rated here.

48. DEPRESSION

Symptoms included in this dimension are irritable or depressed mood, social withdrawal, and anxious mood; sleep disturbances, weight/eating disturbances, and loss of motivation. This dimension can be used to rate symptoms of the following psychiatric disorders as specified in DSM-IV: Depression (unipolar, dysthymia, NOS), Bipolar,

- 0 This rating is given to a child with no emotional problems. No evidence of depression.
- 1 This rating is given to a child with mild emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior.
- 2 This rating is given to a child with a moderate level of emotional disturbance. Any diagnosis of depression would be coded here. This level is used to rate children who meet the criteria for an affective disorder listed above.
- 3 This rating is given to a child with a severe level of depression. This would include a child who stays at home or in bed all day due to depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. Disabling forms of depressive diagnoses would be coded here. This level is used to indicate an extreme case of one of the disorders listed above.

49. ANXIETY

This item describes the child's level of fearfulness, worrying or other characteristics of anxiety.

- 0 No evidence of any anxiety or fearfulness.
- 1 History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders.
- 2 Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.
- 3 Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain

50. OPPOSITIONAL BEHAVIOR (COMPLIANCE WITH AUTHORITY)

This item is intended to capture how the child relates to authority. Oppositional behavior is different from conduct disorder in that the emphasis of the behavior is on non-compliance to authority rather than on seriously breaking social rules, norms, and laws.

- 0 This rating indicates that the child/adolescent is generally compliant.
- 1 This rating indicates that the child/adolescent has mild problems with compliance to some rules or adult instructions. Child may occasionally talk back to teacher, parent/caregiver; there may be letters or calls from school.
- 2 This rating indicates that the child/adolescent has moderate problems with compliance to rules or adult instructions. A child who meets the criteria for Oppositional Defiant Disorder in DSM-IV would be rates here.
- 3 This rating indicates that the child/adolescent has severe problems with compliance to rules or adult instructions. A child rated at this level would be a severe care of Oppositional Defiant Disorder. They would be virtually always noncompliant. Child repeatedly ignores authority.

51. CONDUCT

These symptoms include antisocial behaviors like shoplifting, lying, vandalism, cruelty to animals, and assault. This dimension would include the symptoms of Conduct Disorder as specified in DSM-IV.

- 0 This rating indicates a child with no evidence of behavior disorder.
- 1 This rating indicates a child with a mild level of conduct problems. The child may have some difficulties in school and home behavior. Problems are recognizable but not notably deviant for age, sex, and community. This might include occasional truancy, repeated severe lying, or petty theft from family.
- 2 This rating indicates a child with a moderate level of conduct disorder. This could include episodes of planned aggressive or other anti-social behavior. A child rated at this level should meet the criteria for a diagnosis of Conduct Disorder.
- 3 This rating indicates a child with a severe Conduct Disorder. This could include frequent episodes of unprovoked, planned aggressive or other anti-social behavior.

52. SUBSTANCE ABUSE

These symptoms include use of alcohol and illegal drugs, the misuse of prescription medications and the inhalation of any substance for recreational purposes. This rating is consistent with DSM-IV Substance-related Disorders.

- 0 This rating is for a child who has no substance use difficulties at the present time. If the person is in recovery for greater than 1 year, they should be coded here, although this is unlikely for a child or adolescent.
- 1 This rating is for a child with mild substance use problems that might occasionally present problems of living for the person (intoxication, loss of money, reduced school performance, parental concern). This rating would be used for someone early in recovery (less than 1 year) who is currently abstinent for at least 30 days.
- 2 This rating is for a child with a moderate substance abuse problem that both requires treatment and interacts with and exacerbates the psychiatric illness. Substance abuse problems consistently interfere with the ability to function optimally but do not completely preclude functioning in an unstructured setting.
- 3 This rating is for a child with a severe substance dependence condition that presents a significant complication to the coordination of care (e.g. need for detoxification) of the individual. A substance-exposed infant who demonstrates symptoms of substance dependence would be rated here.

SUBSTANCE ABUSE MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 65

52.1 SEVERITY OF USE

Please rate the highest level from the past 30 days

- 0 Youth is currently abstinent and has maintained abstinence for at least six months.
- 1 Youth is currently abstinent but only in the past 30 days or youth has been abstinent for more than 30 days but is living in an environment that makes substance abuse difficult.
- 2 Youth actively uses alcohol or drugs but not daily.
- 3 Youth uses alcohol and/or drugs on a daily basis.

52.2 DURATION OF USE

Please rate the highest level from the past 30 days

- 0 Youth has begun use in the past year.
- 1 Youth has been using alcohol or drugs for at least one year but has had periods of at least 30 days where he/she did not have any use.
- 2 Youth has been using alcohol or drugs for at least one year (but less than five years), but not daily.
- 3 Youth has been using alcohol or drugs daily for more than the past year or intermittently for at least five years.

52.3 STAGE OF RECOVERY

Please rate the highest level from the past 30 days

- 0 Youth is in maintenance stage of recovery. Youth is abstinent and able to recognize and avoid risk factors for future alcohol or drug use.
- 1 Youth is actively trying to use treatment to remain abstinent.
- 2 Youth is in contemplation phase, recognizing a problem but not willing to take steps to recovery.
- 3 Youth is in denial regarding the existence of any substance abuse problem.

52.4 PEER INFLUENCES

Please rate the highest level from the past 30 days

- 0 Youth's primary peer social network does not engage in alcohol or drug use.
- 1 Youth has peers in his/her primary peer social network who do not engage in alcohol or drug use.
- 2 Youth predominantly has peers who engage in alcohol or drug use but youth is not a member of a gang.
- 3 Youth is a member of a peer group that consistently engages in alcohol and/or drug use.

52.5 PARENTAL INFLUENCES

Please rate the highest level from the past 30 days

- 0 There is no evidence that youth's parents have ever engaged in substance abuse.
- 1 One of youth's parents has history of substance abuse but not in the past year.
- 2 One or both of youth's parents have been intoxicated with alcohol or drugs in the presence of the youth.
- 3 One or both of youth's parents use alcohol or drugs with the youth.

52.6 ENVIRONMENT INFLUENCES

Please rate the environment around the youth's living situation

- 0 No evidence that the youth's environment stimulates or exposes the youth to any alcohol or drug use.
- 1 Mild problems in the youth's environment that might expose the youth to alcohol or drug use.
- 2 Moderate problems in the youth's environment that clearly expose the youth to alcohol or drug use.
- 3 Severe problems in the youth's environment that stimulates the youth to engage in alcohol or drug use.

53. ATTACHMENT DIFFICULTIES

*This item should be rated within the context of the child's significant parental or caregiver relationships. **With younger child difficulties are most evident in their relationships with parents/caregivers. With adolescents difficulties are most evident in relationships with peers.***

- 0 No evidence of attachment problems. Caregiver-child relationship is characterized by mutual satisfaction of needs and child's development of a sense of security and trust. Caregiver appears able to respond to child cues in a consistent, appropriate manner, and child seeks age-appropriate contact with caregiver for both nurturing and safety needs.
- 1 Mild problems with attachment. There is some evidence of insecurity in the child-caregiver relationship. Caregiver may at times have difficulty accurately reading child bids for attention and nurturance; may be inconsistent in response; or may be occasionally intrusive. Child may have mild problems with separation (e.g., anxious/clingy behaviors in the absence of obvious cues of danger) or may avoid contact with caregiver in age-inappropriate way. Child may have minor difficulties with appropriate physical/emotional boundaries with others.
- 2 Moderate problems with attachment. Attachment relationship is marked by sufficient difficulty as to require intervention. Caregiver may consistently misinterpret child cues, act in an overly intrusive way, or ignore/avoid child bids for attention/nurturance. Child may have ongoing difficulties with separation, may consistently avoid contact with caregivers, and may have ongoing difficulties with physical or emotional boundaries with others.
- 3 Severe problems with attachment. Child is unable to form attachment relationships with others (e.g., chronic dismissive/avoidant/detached behavior in care giving relationships) OR child presents with diffuse emotional/physical boundaries leading to indiscriminate attachment with others. Child is considered at ongoing risk due to the nature of his/her attachment behaviors. A child who meets the criteria for an Attachment Disorder in DSM-IV would be rated here. Child may have experienced significant early separation from or loss of caregiver, or have experienced chronic inadequate care from early caregivers, or child may have individual vulnerabilities (e.g., mental health, developmental **disabilities**) that **interfere with the formation of positive attachment relationships.**

54. EATING DISTURBANCES

These symptoms include problems with eating including disturbances in body image, refusal to maintain normal body weight, recurrent episodes of binge eating and hoarding food. Problems with being significantly overweight would be scored here. These ratings are consistent with DSM-IV Eating Disorders.

- 0 This rating is for a child with no evidence of eating disturbances.
- 1 This rating is for a child with a mild level of eating disturbance. This could include some preoccupation with weight, calorie intake, or body size or type when of normal weight or below weight. This could also include some binge eating patterns.
- 2 This rating is for a child with a moderate level of eating disturbance. This could include a more intense preoccupation with weight gain or becoming fat when underweight, restrictive eating habits or excessive exercising in order to maintain below normal weight, and/or emaciated body appearance. This level could also include more notable binge eating episodes that are followed by compensatory behaviors in order to prevent weight gain (e.g., vomiting, use of laxatives, excessive exercising). This child may meet criteria for a DSM-IV Eating Disorder (Anorexia or Bulimia Nervosa).
- 3 This rating is for a child with a more severe form of eating disturbance. This could include significantly low weight where hospitalization is required or excessive binge-purge behaviors (at least once per day).

55. AFFECT DYSREGULATION

These symptoms include difficulties modulating or expressing emotions, intense fear or helplessness, difficulties regulating sleep/wake cycle, and inability to fully engage in activities. These symptoms may be tied to trauma but may not be.

- 0 This rating is given to a child with no difficulties regulating emotional responses. Emotional responses are appropriate to the situation.
 - 1 This rating is given to a child with some minor difficulties with affect regulation. This child could have some difficulty tolerating intense emotions and become somewhat jumpy or irritable in response to emotionally charged stimuli, or more watchful or hypervigilant in general. This child may have some difficulty sustaining involvement in activities for any length of time.
 - 2 This rating is given to a child with moderate problems with affect regulation. This child may be unable to modulate emotional responses. This child may exhibit marked shifts in emotional responses (e.g., from sadness to irritability to anxiety) or have contained emotions with a tendency to lose control of emotions at various points (e.g., normally restricted affect punctuated by outbursts of anger or sadness). This child may also exhibit persistent anxiety, intense fear or helplessness, or lethargy/loss of motivation.
 - 3 This rating is given to a child with severe problems with highly dysregulated affect. This child may have more rapid shifts in mood and an inability to modulate emotional responses (feeling out of control of their emotions). This child may also exhibit tightly contained emotions with intense outbursts under stress. Alternately, this child may be characterized by extreme lethargy, loss of motivation or drive, and no ability to concentrate or sustain engagement in activities (i.e., emotionally "shut down").
- NA Not applicable due to child's age; see section for children 0 to 5 years old.

56. BEHAVIORAL REGRESSIONS

These ratings are used to describe shifts in previously adaptive functioning evidenced in regressions in behaviors or physiological functioning.

- 0 This rating is given to a child with no evidence of behavioral regression.
 - 1 This rating is given to a child with some regressions in age-level of behavior (e.g., thumb sucking, whining when age inappropriate).
 - 2 This rating is given to a child with moderate regressions in age-level of behavior including loss of ability to engage with peers, stopping play or exploration in environment that was previously evident, or occasional bedwetting.
 - 3 This rating is given to a child with more significant regressions in behaviors in an earlier age as demonstrated by changes in speech or loss of bowel or bladder control.
- NA Not applicable.

57. SOMATIZATION

These symptoms include the presence of recurrent physical complaints without apparent physical cause or conversion-like phenomena (e.g., pseudoseizures).

- 0 This rating is for a child with no evidence of somatic symptoms.
 - 1 This rating indicates a child with a mild level of somatic problems. This could include occasional headaches, stomach problems (nausea, vomiting), joint, limb or chest pain without medical cause.
 - 2 This rating indicates a child with a moderate level of somatic problems or the presence of conversion symptoms. This could include more persistent physical symptoms without a medical cause or the presence of several different physical symptoms (e.g., stomach problems, headaches, backaches). This child may meet criteria for a somatoform disorder. Additionally, the child could manifest any conversion symptoms here (e.g., pseudoseizures, paralysis).
 - 3 This rating indicates a child with severe somatic symptoms causing significant disturbance in school or social functioning. This could include significant and varied symptomatic disturbance without medical cause.
- NA Not applicable.

58. ANGER CONTROL

This item captures the youth's ability to identify and manage their anger when frustrated.

- 0 This rating indicates a child with no evidence of any significant anger control problems.
 - 1 This rating indicates a child with some problems with controlling anger. He/she may sometimes become verbally aggressive when frustrated. Peers and family members are aware of and may attempt to avoid stimulating angry outbursts.
 - 2 This rating indicates a child with moderate anger control problems. His/her temper has gotten him/her in significant trouble with peers, family, and/or school. This level may be associated with some physical violence. Others are likely quite aware of anger potential.
 - 3 This rating indicates a child with severe anger control problems. His/her temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.
- NA Not applicable due to child's age.

CHILD RISK BEHAVIORS

Risk behaviors are the types of things that can get children and adolescents in trouble or put them in danger of harming themselves or others. Notice that the time frames for the ratings change, particularly for the „1“ and „3“ ratings away from the standard 30 day rating window.

For **Risk Behaviors**, the following categories and action levels are used:

- 0 indicates a dimension where there is no evidence of any needs. This dimension is also used when there is *no evidence or information* to make a determination. If you don't have enough information then score the item as a zero.
- 1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
- 2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
- 3 indicates a dimension that requires immediate or intensive action.

59. SUICIDE RISK

This rating describes both suicidal and significant self-injurious behavior. A rating of 2 or 3 would indicate the need for a safety plan.

- 0 Child has no evidence or history of suicidal or self-injurious behaviors.
- 1 History of suicidal or self-injurious behaviors or significant ideation but no self-injurious behavior during the past 30 days.
- 2 Recent, (last 30 days) but not acute (today) suicidal ideation or gesture. Self-injurious in the past 30 days (including today) without suicidal ideation or intent.
- 3 Current suicidal ideation and intent in the past 24 hours.

60. SELF-MUTILATION

This rating includes repetitive physically harmful behavior that generally serves as a self-soothing function to the child. Symptoms may include cutting, burning, hair pulling, slapping, head-banging, etc.

- 0 No evidence of any forms of self-mutilation (e.g. cutting, burning, face slapping, head banging)
- 1 History of self-mutilation but none evident in the past 30 days.
- 2 Engaged in self mutilation that does not require medical attention.
- 3 Engaged in self mutilation that requires medical attention.

61. OTHER SELF HARM

This rating includes reckless and dangerous behaviors that, while not intended to harm self or others, place the child or others at some jeopardy. Suicidal or self-mutilative behaviors are NOT rated here. Stupid and reckless activities may include unprotected sex with multiple partners, driving while intoxicated, other potentially dangerous activities while impaired, street racing, street surfing (standing on a moving vehicle), etc.

- 0 No evidence of behaviors that place the child at risk of physical harm.
- 1 History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
- 2 Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
- 3 Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

62. DANGER TO OTHERS

This rating includes actual and threatened violence. Imagined violence, when extreme, may be rated here. A rating of 2 or 3 would indicate the need for a safety plan. If child scores a 2 or 3 then please complete the Violence Module (questions 62.1-62.14).

- 0 Child has no evidence or history of aggressive behaviors or significant verbal aggression towards others (including people and animals).
- 1 History of aggressive behavior or verbal aggression towards others but no aggression during the past 30 days. History of fire setting (not in past year) would be rated here.
- 2 Occasional or moderate level of aggression towards others including aggression during the past 30 days or more recent verbal aggression.
- 3 Frequent or dangerous (significant harm) level of aggression to others. Child or youth is an immediate risk to others.

VIOLENCE MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 62

Historical Risk Factors

Historical risk factors are rated over the lifetime of the youth.

62.1 HISTORY OF PHYSICAL ABUSE

- 0 No evidence of a history of physical abuse.
- 1 Youth has experienced corporal punishment.
- 2 Youth has experienced physical abuse on one or more occasions from care giver or parent.
- 3 Youth has experienced extreme physical abuse that has resulted in physical injuries that required medical care

62.2 HISTORY OF VIOLENCE

- 0 No evidence of any history of violent behavior by the youth.
- 1 Youth has engaged in mild forms of violent behavior including vandalism, minor destruction of property, physical fights in which no one was injured (e.g. shoving, wrestling).
- 2 Youth has engaged in moderate forms of violent behavior including fights in which participants were injured. Cruelty to animals would be rated here unless it resulted in significant injury or death of the animal.
- 3 Youth has initiated unprovoked violent behaviors on other people that resulted in injuries to these people. Cruelty to animals that resulted in significant injury or death to the animal would be rated here.

62.3 WITNESS TO DOMESTIC VIOLENCE

- 0 No evidence that youth has witnessed domestic violence.
- 1 Youth has witnessed physical violence in household on at least one occasion but the violence did not result in injury.
- 2 Youth has witnessed repeated domestic violence that has resulted in the injury of at least one family member that required medical treatment.
- 3 Youth has witness to murder or rape of a family member

62.4 WITNESS TO ENVIRONMENTAL VIOLENCE

- 0 No evidence that youth has witnessed violence in his/her environment and does not watch an excessive amount of violent media
- 1 Youth has not witness violence in her environment and but watches an excessive amount of violent media including movies and video games.
- 2 Youth has witnessed at least one occasion of violence in his/her environment.
- 3 Youth has witnessed a murder or rape.

Emotional/Behavioral Risks

Emotional/Behavioral Risks are rated based on the past 30 days

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 62

62.5 BULLYING

- 0 Youth has never engaged in bullying at school or in the community.
- 1 Youth has been involved with groups that have bully other youth either in school or the community; however, youth has not had a leadership role in these groups.
- 2 Youth has bullied other youth in school or community. Youth has either bullied the other youth individually or led a group that bullied youth
- 3 Youth has repeated utilized threats or actual violence to bully youth in school and/or community.

62.6 FRUSTRATION MANAGEMENT

- 0 Youth appears to be able to manage frustration well. No evidence of problems of frustration management.
- 1 Youth has some mild problems with frustration. He/she may anger easily when frustrated; however, he/she is able to calm self down following an angry outburst.
- 2 Youth has problems managing frustration. His/her anger when frustrated is causing functioning problems in school, at home, or with peers.
- 3 Youth becomes explosive and dangerous to others when frustrated. He/she demonstrates little self control in these situations and others must intervene to restore control

62.7 HOSTILITY

- 0 Youth appears to not experience or express hostility except in situations where most people would become hostile
- 1 Youth appears hostile but does not express it. Others experience youth as being angry.
- 2 Youth expresses hostility regularly.
- 3 Youth is almost always hostile either in expression or appearance. Others may experience youth as „full of rage“ or „seething“

62.8 PARANOID THINKING

- 0 Youth does not appear to engage in any paranoid thinking.
- 1 Youth is suspicious of others but is able to test out these suspicions and adjust their thinking appropriately.
- 2 Youth believes that others are „out to get“ him/her. Youth has trouble accepting that these beliefs may not be accurate. Youth at times is suspicious and guarded but at other times can be open and friendly.
- 3 Youth believes that others plan to cause them harm. Youth is nearly always suspicious and guarded.

62.9 SECONDARY GAINS FROM ANGER

- 0 Youth either does not engage in angry behavior or, when they do become angry, does not appear to derive any benefits from this behavior.
- 1 Youth unintentionally has benefited from angry behavior; however, there is no evidence that youth intentionally uses angry behavior to achieve desired outcomes.
- 2 Youth sometimes uses angry behavior to achieve desired outcomes with parents, caregivers, teachers, or peers.
- 3 Youth routinely uses angry behavior to achieve desired outcomes with parents, caregivers, teachers or peers. Others in youth’s life appear intimidated.

62.10 VIOLENT THINKING

- 0 There is no evidence that youth engages in violent thinking.
- 1 Youth has some occasional or minor thoughts about violence.
- 2 Youth has violent ideation. Language is often characterized as having violent themes and problem solving often refers to violent outcomes.
- 3 Youth has specific homicidal ideation or appears obsessed with thoughts about violence. For example, a youth who spontaneously and frequently draws only violent images may be rated here.

Resiliency Factors

Resiliency Factors are rated based on the past 30 days

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 62

62.11 AWARENESS OF VIOLENCE POTENTIAL

- 0 Youth is completely aware of his/her level of risk of violence. Youth knows and understands risk factors. Youth accepts responsibility for past and future behaviors. Youth is able to anticipate future challenging circumstances. A youth with no violence potential would be rated here.
- 1 Youth is generally aware of his/her potential for violence. Youth is knowledgeable about his/her risk factors and is generally able to take responsibility. Youth may be unable to anticipate future circumstances that may challenge him/her.
- 2 Youth has some awareness of his/her potential for violence. Youth may have tendency to blame others but is able to accept some responsibility for his/her actions.

3 Youth has no awareness of his/her potential for violence. Youth may deny past violent acts or explain them in terms of justice or as deserved by the victim.

62.12 RESPONSE TO CONSEQUENCES

- 0 Youth is clearly and predictably responsive to identified consequences. Youth is regularly able to anticipate consequences and adjust behavior.
- 1 Youth is generally responsive to identified consequences; however, not all appropriate consequences have been identified or he/she may sometimes fail to anticipate consequences.
- 2 Youth responds to consequences on some occasions but sometimes does not appear to care about consequences for his/her violent behavior
- 3 Youth is unresponsive to consequences for his/her violent behavior.

62.13 COMMITMENT TO SELF CONTROL

- 0 Youth fully committed to controlling his/her violent behavior.
- 1 Youth is generally committed to control his/her violent behavior; however, youth may continue to struggle with control in some challenging circumstances
- 2 Youth ambivalent about controlling his/her violent behavior.
- 3 Youth not interested in controlling his/her violent behavior at this time.

62.14 TREATMENT INVOLVEMENT

- 0 Youth fully involved in his/her own treatment. Family supports treatment as well.
- 1 Youth or family involved in treatment but not both. Youth may be somewhat involved in treatment, while family members are active or youth may be very involved in treatment while family members are unsupportive
- 2 Youth and family are ambivalent about treatment involvement. Youth and/or family may be skeptical about treatment effectiveness or suspicious about clinician intentions.
- 3 Youth and family are uninterested in treatment involvement. A youth with treatment needs who is not currently in treatment would be rated here.

63. SEXUAL AGGRESSION

Sexually abusive behavior includes both aggressive sexual behavior and sexual behavior in which the child or adolescent takes advantage of a younger or less powerful child through seduction, coercion, force, or threat of force. Included in this dimension are sexually exploitive activities due to power differential: significant age differences or abuse of a position of authority. If the child scores a 2 or 3 to this question please complete the Sexually Aggressive Behavior Module (questions 63.1-63.10).

- 0 No evidence of problems with sexual behavior in the past year.
- 1 Mild problems of sexually abusive behavior. For example, occasional inappropriate sexually aggressive/harassing language or behavior.
- 2 Moderate problems with sexually abusive behavior, For example, frequent inappropriate sexual behavior. Frequent disrobing would be rated here only if it was sexually provocative. Frequent inappropriate touching would be rated here.
- 3 Severe problems with sexually abusive behavior. This would include the rape or sexual abuse of another person involving sexual penetration.

SEXUALLY ABUSIVE BEHAVIOR

(SAB) MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 63

Note: Sexually abusive behavior is defined as non-consenting sexual activity initiated by the abuser in which one of the following conditions apply: use or threat of physical force, age differential, power differential. A child or youth is only assessed on this dimension if they were an active abuser in this form of sexual abuse of another person.

63.1 DATE OF MOST RECENT SEXUALLY ABUSIVE BEHAVIOR

Please fill in date

63.2 WAS SEXUAL ACT AGAINST A FAMILY MEMBER

Please answer yes or no and fill in identity if known

63.3 RELATIONSHIP

Please rate the most recent episode of sexual behavior

- 0 No evidence of victimizing others. All parties in sexual activity appear to be consenting. No power differential.
- 1 Although parties appear to be consenting, there is a significant power differential between parties in the sexual activity with this child or adolescent being in the position of authority.
- 2 Child is clearly victimizing at least one other individual with sexually abusive behavior.
- 3 Child is severely victimizing at least one other individual with sexually abusive behavior. This may include physical harm that results from either the sexual behavior or physical force associated with sexual behavior.

63.4 PHYSICAL FORCE/THREAT

Please rate the highest level from the most recent episode of sexual behavior

- 0 No evidence of the use of any physical force or threat of force in either the commission of the sex act nor in attempting to hide it.
- 1 Evidence of the use of the threat of force in an attempt to discourage the victim from reporting the sex act.
- 2 Evidence of the use of mild to moderate force in the sex act. There is some physical harm or risk of physical harm.
- 3 Evidence of severe physical force in the commission of the sex act. Victim harmed or at risk for physical harm from the use of force.

63.5 PLANNING

Please rate the highest level from the most recent episode of sexual behavior

- 0 No evidence of any planning. Sexual activity appears entirely opportunistic.
- 1 Some evidence of efforts to get into situations where likelihood of opportunities for sexual activity are enhanced.
- 2 Evidence of some planning of sex act.
- 3 Considerable evidence of predatory sexual behavior in which victim is identified prior to the act, and the act is premeditated.

63.6 AGE DIFFERENTIAL

Please rate the highest level from the most recent episode of sexual behavior

- 0 Ages of the perpetrator and victim and/or participants essentially equivalent (less than 3 years apart).
- 1 Age differential between perpetrator and victim and/or participants is 3 to 4 years.
- 2 Age differential between perpetrator and victim at least 5 years, but perpetrator less than 13 years old.
- 3 Age differential between perpetrator and victim at least 5 years and perpetrator 13 years old or older.

63.7 TYPE OF SEX ACT

Please rate the highest level from the most recent episode of sexual behavior

- 0 Sex act(s) involve touching or fondling only.
- 1 Sex act(s) involve fondling plus possible penetration with fingers or oral sex.
- 2 Sex act(s) involve penetration into genitalia or anus with body part.
- 3 Sex act involves physically dangerous penetration due to differential size or use of an object.

63.8 RESPONSE TO ACCUSATION

Please rate the highest level from the past 30 days

- 0 Child admits to behavior and expresses remorse and desire to not repeat.
- 1 Child partially admits to behaviors and expresses some remorse.
- 2 Child admits to behavior but does not express remorse.
- 3 Child neither admits to behavior nor expresses remorse. Child is in complete denial.

63.9 TEMPORAL CONSISTENCY

- 0 This level indicates a child who has never exhibited sexually abusive behavior or who has developed this behavior only in the past three months following a clear stressor.
- 1 This level indicates a child who has been sexually abusive during the past two years OR child who has become sexually abusive in the past three months despite the absence of any clear stressors.
- 2 This level indicates a child who has been sexually abusive for an extended period of time (e.g. more than two years), but who has had significant symptom-free periods.
- 3 This level indicates a child who has been sexually abusive for an extended period of time (e.g. more than two years) without significant symptom-free periods.

63.10 HISTORY OF SEXUALLY ABUSIVE BEHAVIOR (toward others)

- 0 Child or adolescent has only one incident of sexually abusive behavior that has been identified and/or investigated.
- 1 Child or adolescent has two or three incidents of sexually abusive behavior that have been identified and/or investigated.
- 2 Child or adolescent has four to ten incidents of sexually abusive behavior that have been identified and/or investigated with more than one victim
- 3 Child or adolescent has more than ten incidents of sexually abusive behavior with more than one victim.

63.11 SEVERITY OF SEXUAL ABUSE

- 0 No history of any form of sexual abuse.
- 1 History of occasional fondling or being touched inappropriately, however, not occurring on a regular basis or by someone in a caregiver capacity or suspicion of history of sexual abuse without confirming evidence.
- 2 This level is to indicate a moderate level of sexual abuse. This may involve a child who has been fondled on an ongoing basis or sexually penetrated (anal or genital) once by someone not in a caregiver capacity.
- 3 This level is to indicate a severe level of sexual abuse involving penetration on an ongoing basis by someone either in a caregiver capacity or in close emotional relation to the child.

63.12 PRIOR TREATMENT

- 0 No history of prior treatment or history of outpatient treatment with notable positive outcomes.
- 1 History of outpatient treatment which has had some degree of success.
- 2 History residential treatment where there has been successful completion of program.
- 3 History of residential or outpatient treatment condition with little or no success.

64. RUNAWAY

In general, to classify as a runaway or elopement, the child is gone overnight or very late into the night. Impulsive behavior that represents an immediate threat to personal safety would also be rated here. If the child scores a 2 or 3 to this question please complete the Runaway Module (questions 64.1-64.8)

- 0 This rating is for a child with no history of running away and no ideation involving escaping from the present living situation.
- 1 This rating is for a child with no recent history of running away but who has expressed ideation about escaping present living situation or treatment. Child may have threatened running away on one or more occasions or have a history (lifetime) of running away but not in the past year.
- 2 This rating is for a child who has run away from home once or run away from one treatment setting within the past year. Also rated here is a child who has run away to home (parental or relative) in the past year.
- 3 This rating is for a child who has (1) run away from home and/or treatment settings within the last 7 days or (2) run away from home and/or treatment setting twice or more overnight during the past 30 days. Destination is not a return to home of parent or relative.

RUNAWAY MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 64

64.1 FREQUENCY OF RUNNING

- 0 Youth has only run once in past year
- 1 Youth has run on multiple occasions in past year.
- 2 Youth runs often but not always.
- 3 Youth runs at every opportunity.

64.2 CONSISTENCY OF DESTINATION

- 0 Youth always runs to the same location
- 1 Youth generally runs to the same location or neighborhood
- 2 Youth runs to the same community but the specific locations change
- 3 Youth runs to no planned destination.

64.3 SAFETY OF DESTINATION

- 0 Youth runs to a safe environment that meets his/hers basic needs (e.g. food, shelter).
- 1 Youth runs to generally safe environments; however, they might be somewhat unstable or variable.
- 2 Youth runs to generally unsafe environments that cannot meet his/her basic needs.
- 3 Youth runs to very unsafe environments where the likelihood that he/she will be victimized is high.

64.4 INVOLVEMENT IN ILLEGAL ACTIVITIES

- 0 Youth does not engage in illegal activities while on run beyond those involved with the running itself.
- 1 Youth engages in status offenses beyond those involved with the running itself while on run (e.g. curfew violations, underage drinking)
- 2 Youth engages in delinquent activities while on run.
- 3 Youth engages in dangerous delinquent activities while on run (e.g. prostitution)

64.5 LIKELIHOOD OF RETURN ON OWN

- 0 Youth will return from run on his/her own without prompting.
- 1 Youth will return from run when found but not without being found.
- 2 Youth will make him/her difficult to find and/or might passively resist return once found.
- 3 Youth makes repeated and concerted efforts to hide so as to not be found and/or resists return.

64.6 INVOLVEMENT WITH OTHERS

- 0 Youth runs by self with no involvement of others. Others may discourage behavior or encourage youth to return from run.
- 1 Others enable youth running by not discouraging youth's behavior.
- 2 Others involved in running by providing helping youth not be found.
- 3 Youth actively is encouraged to run by others. Others actively cooperate to facilitate running behavior.

64.7 REALISTIC EXPECTATIONS

- 0 Youth has realistic expectations about the implications of his/her running behavior.
- 1 Youth has reasonable expectations about the implications of his/her running behavior but may be hoping for a somewhat „optimistic“ outcome.
- 2 Youth has unrealistic expectations about the implications of their running behavior.
- 3 Youth has obviously false or delusional expectations about the implications of their running behavior.

64.8 PLANNING

- 0 Running behavior is completely spontaneous and emotionally impulsive.
- 1 Running behavior is somewhat planned but not carefully.
- 2 Running behavior is planned.
- 3 Running behavior is carefully planned and orchestrated to maximize likelihood of not being found.

65. DELINQUENCY

This rating includes both criminal behavior and status offenses that may result from child or youth failing to follow required behavioral standards (e.g. truancy). Sexual offenses should be included as criminal behavior. If the child scores a 2 or 3 to this question please complete the Juvenile Justice Module (questions 65.1-65.7).

- 0 Child shows no evidence or has no history of criminal or delinquent behavior.
- 1 History of criminal or delinquent behavior but none in the past 30 days. **Status offenses** in the past 30 days would be rated here.
- 2 Moderate level of criminal activity including a high likelihood of crimes committed in the past 30 days. Examples would include vandalism, shoplifting, etc.
- 3 Serious level of criminal or delinquent activity in the past 30 days. Examples would include car theft, residential burglary, gang involvement, etc.

JUVENILE JUSTICE (JJ) MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 65

65.1 DATE OF MOST RECENT DELINQUENT BEHAVIOR

Please fill in date

65.2 SERIOUSNESS

Please rate the highest level from the past 30 days

- 0 Youth has engaged only in status violations (e.g. curfew).
- 1 Youth has engaged in delinquent behavior.
- 2 Youth has engaged in criminal behavior.
- 3 Youth has engaged in delinquent criminal behavior that places other citizens at risk of significant physical harm.

65.3 HISTORY

Please rate using time frames provided in the anchors

- 0 Current criminal behavior is the first known occurrence.
- 1 Youth has engaged in multiple delinquent acts in the past one year.
- 2 Youth has engaged in multiple delinquent acts for more than one year but has had periods of at least 3 months where he/she did not engage in delinquent behavior.
- 3 Youth has engaged in multiple criminal or delinquent acts for more than one year without any period of at least 3 months where he/she did not engage in criminal or delinquent behavior.

65.4 PLANNING

Please rate the highest level from the past 30 days

- 0 No evidence of any planning. Delinquent behavior appears opportunistic or impulsive.
- 1 Evidence suggests that youth places him/herself into situations where the likelihood of delinquent behavior is enhanced.
- 2 Evidence of some planning of delinquent behavior
- 3 Considerable evidence of significant planning of delinquent behavior. Behavior is clearly premeditated.

65.5 COMMUNITY SAFETY

Please rate the highest level from the past 30 days

- 0 Youth presents no risk to the community. He/she could be unsupervised in the community
- 1 Youth engages in behavior that represents a risk to community property.
- 2 Youth engages in behavior that places community residents in some danger of physical harm. This danger may be an indirect effect of the youth's behavior.
- 3 Youth engages in behavior that directly places community members in danger of significant physical harm.

65.6 PEER INFLUENCES

Please rate the highest level from the past 30 days

- 0 Youth's primary peer social network does not engage in delinquent behavior.
- 1 Youth has peers in his/her primary peer social network who do not engage in delinquent behavior but has some peers who do.
- 2 Youth predominantly has peers who engage in delinquent behavior but youth is not a member of a gang.
- 3 Youth is a member of a gang whose membership encourages or requires illegal behavior as an aspect of gang membership.

65.7 PARENTAL INFLUENCES

The item assesses the parental influences and is defined broadly as whoever has been in a parental role for the youth. Please rate the highest level from the past 30 days

- 0 There is no evidence that youth's parents have ever engaged in criminal behavior.
- 1 One of youth's parents has history of criminal behavior but youth has not been in contact with this parent for at least one year.
- 2 One of youth's parents has history of criminal behavior and youth has been in contact with this parent in the past year.
- 3 Both of youth's parents have history of criminal behavior.

65.8 ENVIRONMENTAL INFLUENCES

Please rate the environment around the youth's living situation

- 0 No evidence that the child's environment stimulates or exposes the child to any criminal behavior.
- 1 Mild problems in the child's environment that might expose the child to criminal behavior.
- 2 Moderate problems in the child's environment that clearly expose the child to criminal behavior.
- 3 Severe problems in the child's environment that stimulate the child to engage in criminal behavior.

Please answer yes or no to the following questions:

65.9 DURING THE PAST YEAR HAS THE YOUTH COMMITTED ACTS OF DELINQUENCY AGAINST PROPERTY

65.10 DURING THE PAST YEAR HAS THE YOUTH COMMITTED ACTS OF DELINQUENCY AGAINST PEOPLE

65.11 HAS THE YOUTH USED A WEAPON IN COMMISSION OF AN ACT OF DELINQUENCY

65.12 HAS THE YOUTH COMMITTED ANY ACTS OF DELINQUENCY INVOLVING ILLEGAL SUBSTANCES

66. JUDGMENT

This item describes the child's decision-making processes and awareness of consequences.

- 0 No evidence of problems with judgment or poor decision making that result in harm.
 - 1 History of problems with judgment in which the child makes decisions that are in some way harmful. For example, a child who has a history of hanging out with other children who shoplift.
 - 2 Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being.
 - 3 Problems with judgment that place the child at risk of significant physical harm.
- NA Not applicable

67. FIRE SETTING

This item refers to behavior involving the intentional setting of fires that might be dangerous to the child or others. This does not include the use of candles or incense or matches to smoke. If the child scores a 2 or 3 to this question please complete the Fire Setting Module (questions 67.1-67.9).

- 0 No evidence or history of fire setting behavior
- 1 History or fire-setting but not in past six months
- 2 Recent fire setting behavior (in past six months) but not of the type that has endangered the lives of others (e.g. playing with matches) OR repeated fire setting behavior over a period of at least two years even if not in the past six months.
- 3 Acute threat of fire setting. Set fire that endangered the lives of others (e.g. attempting to burn down a house).
- NA Not applicable

FIRE SETTING MODULE

SCORE ONLY IF CHILD RECEIVED A TWO OR THREE ON QUESTION 67

67.1 DATE OF THE MOST RECENT FIRE-SETTING BEHAVIOR

67.2 WAS THE CHILD ALONE AT THE TIME OF THE INCIDENT OR WERE THERE ANY OTHER CHILDREN INVOLVED

67.3 SERIOUSNESS

Please rate most recent incident

- 0 Child has engaged in fire setting that resulted in only minor damage (e.g. camp fire in the back yard which scorched some lawn).
- 1 Child has engaged in fire setting that resulted only in some property damage that required repair.
- 2 Child has engaged in fire setting which caused significant damage to property (e.g. burned down house).
- 3 Child has engaged in fire setting that injured self or others.

67.4 HISTORY

Please rate using time frames provided in the anchors

- 0 Only one known occurrence of fire setting behavior.
- 1 Youth has engaged in multiple acts of fire setting in the past year.
- 2 Youth has engaged in multiple acts of fire setting for more than one year but has had periods of at least 6 months where he/she did not engage in fire setting behavior.
- 3 Youth has engaged in multiple acts of fire setting for more than one year without any period of at least 3 months where he/she did not engage in fire setting behavior.

67.5 PLANNING

Please rate most recent incident

- 0 No evidence of any planning. Fire setting behavior appears opportunistic or impulsive.
- 1 Evidence suggests that youth places him/herself into situations where the likelihood of fire setting behavior is enhanced.
- 2 Evidence of some planning of fire setting behavior.
- 3 Considerable evidence of significant planning of fire setting behavior. Behavior is clearly premeditated.

67.6 USE OF ACCELERANTS

Please rate most recent incident

- 0 No evidence of any use of accelerants (e.g., gasoline). Fire setting involved only starters such as matches or a lighter.
- 1 Evidence suggests that the fire setting involved some use of mild accelerants (e.g. sticks, paper) but no use of liquid accelerants.
- 2 Evidence that fire setting involved the use of a limited amount of liquid accelerants but that some care was taken to limit the size of the fire.
- 3 Considerable evidence of significant use of accelerants in an effort to secure a very large and dangerous fire.

67.7 INTENTION TO HARM

Please rate most recent incident

- 0 Child did not intend to harm others with fire. He/she took efforts to maintain some safety.
- 1 Child did not intend to harm others but took no efforts to maintain safety.
- 2 Child intended to seek revenge or scare others but did not intend physical harm, only intimidation.
- 3 Child intended to injure or kill others.

67.8 COMMUNITY SAFETY

Please rate highest level in the past 30 days

- 0 Child presents no risk to the community. He/she could be unsupervised in the community.
- 1 Child engages in fire setting behavior that represents a risk to community property.
- 2 Child engages in fire setting behavior that places community residents in some danger of physical harm. This danger may be an indirect effect of the youth's behavior.
- 3 Child engages in fire setting behavior that intentionally places community members in danger of significant physical harm. Child attempts to use fires to hurt others.

67.9 RESPONSE TO ACCUSATION

Please rate highest level in the past 30 days

- 0 Child admits to behavior and expresses remorse and desire to not repeat.
- 1 Child partially admits to behaviors and expresses some remorse.
- 2 Child admits to behavior but does not express remorse.
- 3 Child neither admits to behavior nor expresses remorse. Child is in complete denial.

67.10 REMORSE

Please rate highest level in the past 30 days

- 0 Child accepts responsibility for behavior and is truly sorry for any damage/risk caused. Child is able to apologize directly to effected people.
- 1 Child accepts responsibility for behavior and appears to be sorry for any damage/risk caused. However, child is unable or unwilling to apologize to effected people.
- 2 Child accepts some responsibility for behavior but also blames others. May experience sorrow at being caught or receiving consequences. May express sorrow/remorse but only in an attempt to reduce consequences.
- 3 Child accepts no responsibility and does not appear to experience any remorse.

67.11 LIKELIHOOD OF FUTURE FIRE SETTING

Please rate highest level in the past 30 days

- 0 Child is unlikely to set fires in the future. Child able and willing to exert self-control over fire setting.
- 1 Child presents mild to moderate risk of fire setting in the future. Should be monitored but does not require ongoing treatment/intervention.
- 2 Child remains at risk of fire setting if left unsupervised. Child struggles with self-control.
- 3 Child presents a real and present danger of fire setting in the immediate future. Child unable or unwilling to exert self-control over fire setting behavior.

68. SOCIAL BEHAVIOR

This rating describes obnoxious social behaviors that a child engages in to intentionally force adults to sanction him/her. This item should reflect problematic social behaviors (socially unacceptable behavior for the culture and community in which he/she lives) that put the child at some risk of sanctions (e.g. not excessive shyness or lack of social skills). These behaviors are done with a purpose to elicit a response from an adult. It is for obnoxiousness with an objective. It is attention seeking.

- 0 Child shows no evidence of problematic social behaviors.
- 1 Mild level of problematic social behaviors. This might include occasionally inappropriate social behavior that forces adults to sanction the child. Infrequent inappropriate comments to strangers or unusual behavior in social settings might be included at this level.
- 2 Moderate level of problematic social behaviors. Social behavior is causing problems in the child's life. Child may be intentionally getting in trouble in school or at home.
- 3 Severe level of problematic social behaviors. This would be indicated by frequent seriously inappropriate social behavior that force adults to seriously and/or repeatedly sanction the child. Social behaviors are sufficiently severe that they place the child at risk of significant sanctions (e.g. expulsion, removal from the community).

69. SEXUALLY REACTIVE BEHAVIORS

Sexually reactive behavior includes both age-inappropriate sexualized behaviors that may place a child at risk for victimization or risky sexual practices.

- 0 No evidence of problems with sexually reactive behaviors or high-risk sexual behaviors.
- 1 Some evidence of sexually reactive behavior. Child may exhibit occasional inappropriate sexual language or behavior, flirts when age-inappropriate, or engages in unprotected sex with single partner. This behavior does not place child at great risk. A history of sexually provocative behavior would be rated here.
- 2 Moderate problems with sexually reactive behavior that place child at some risk. Child may exhibit more frequent sexually provocative behaviors in a manner that impairs functioning, engage in promiscuous sexual behaviors or have unprotected sex with multiple partners.
- 3 Significant problems with sexually reactive behaviors. Child exhibits sexual behaviors that place child or others at immediate risk.

70. PARENTAL CRIMINAL BEHAVIOR

This item rates the criminal behavior of both biological and stepparents, whether rights have been terminated or not and regardless of any anticipated further involvement with the youth.

- 0 There is no evidence that youth's parents have ever engaged in criminal behavior.
- 1 One of youth's parents has a history of criminal behavior but youth has not been in contact with this parent for at least one year.
- 2 One of youth's parents has a history of criminal behavior resulting in a conviction or incarceration and youth has been in contact with this parent in the past year.
- 3 Both of youth's parents have history of criminal behavior resulting in incarceration.

71. TRANSITION TO ADULTHOOD

The following items are required for youth 17 and older. However, any of these items can be rated regardless of age if they represent a need for a specific youth.

71.1 INDEPENDENT LIVING SKILLS

This rating focuses on the presence or absence of short or long-term risks associated with impairments in independent living abilities.

- 0 This level indicates a person who is fully capable of independent living. No evidence of any deficits that could impede maintaining own home.
- 1 This level indicates a person with mild impairment of independent living skills. Some problems exist with maintaining reasonable cleanliness, diet and so forth. Problems with money management may occur at this level. These problems are generally addressable with training or supervision.
- 2 This level indicates a person with moderate impairment of independent living skills. Notable problems with completing tasks necessary for independent living are apparent. Difficulty with cooking, cleaning, and self-management when unsupervised would be common at this level. Problems are generally addressable with in-home services.

- 3 This level indicates a person with profound impairment of independent living skills. This individual would be expected to be unable to live independently given their current status. Problems require a structured living environment.

71.2. TRANSPORTATION

This item is used to rate the level of transportation required to ensure that the individual could effectively participate in his/her own treatment and in other life activities. Only unmet transportation needs should be rated here.

- 0 The individual has no transportation needs.
- 1 The individual has occasional transportation needs (e.g., appointments). These needs would be no more than weekly and not require a special vehicle.
- 2 The individual has occasional transportation needs that require a special vehicle or frequent transportation needs (e.g., daily to work or therapy) that do not require a special vehicle.
- 3 The individual requires frequent (e.g., daily to work or therapy) transportation in a special vehicle.

71.3. PARENTING ROLES

This item is intended to rate the individual in any caregiver roles. For example, an individual with a son or daughter or an individual responsible for an elderly parent or grandparent would be rated here. Include pregnancy as a parenting role.

- 0 The individual has no role as a parent.
- 1 The individual has responsibilities as a parent but is currently able to manage these responsibilities.
- 2 The individual has responsibilities as a parent and either the individual is struggling with these responsibilities or they are currently interfering with the individual's functioning in other life domains.
- 3 The individual has responsibilities as a parent and the individual is currently unable to meet these responsibilities or these responsibilities are making it impossible for the individual to function in other life domains.

71.4. PERSONALITY DISORDER

This rating identifies the presence of any DSM-IV Axis II personality disorder

- 0 No evidence of symptoms of a personality disorder.
- 1 Evidence of mild degree, probably sub-threshold for the diagnosis of a personality disorder. For example, mild but consistent dependency in relationships might be rated here; or, some evidence of antisocial or narcissistic behavior. An unconfirmed suspicion of the presence of a diagnosable personality disorder would be rated here.
- 2 Evidence of sufficient degree of personality disorder to warrant a DSM-IV Axis II diagnosis.
- 3 Evidence of a severe personality disorder that has significant implications for the Individual's long-term functioning. Personality disorder dramatically interferes with the individual's ability to function independently.

71.5. INTIMATE RELATIONSHIPS

This item is used to rate the individuals current status in terms of romantic/intimate relationships.

- 0 Adaptive partner relationship. Individual has a strong, positive, partner relationship with another adult. This adult functions as a member of the family.
- 1 Mostly adaptive partner relationship. Individual has a generally positive partner relationship with another adult. This adult may not function as a member of the family.
- 2 Limited adaptive partner relationship. Individual is currently not involved in any partner relationship with another adult.
- 3 Significant difficulties with partner relationships. Individual is currently involved in a negative, unhealthy relationship with another adult.

71.6. MEDICATION COMPLIANCE

This rating focuses on the level of the individual's willingness and participation in taking prescribed medications.

- 0 This level indicates a person who takes any prescribed medications as prescribed and without reminders, or a person who is not currently on any psychotropic medication.
- 1 This level indicates a person who will take prescribed medications routinely, but who sometimes needs reminders to maintain compliance. Also, a history of medication noncompliance but no current problems would be rated here.
- 2 This level indicates a person who is somewhat non-compliant. This person may be resistant to taking prescribed medications or this person may tend to overuse his or her medications. He/she might comply with prescription plans for periods of time (1-2 weeks) but generally does not sustain taking medication in prescribed dose or protocol.
- 3 This level indicates a person who has refused to take prescribed medications during the past 30-day period or a person who has abused his or her medications to a significant degree (i.e., overdosing or over using medications to a dangerous degree).

71.7. EDUCATIONAL ATTAINMENT

This rates the degree to which the individual has completed his/her planned education.

- 0 Individual has achieved all educational goals or has none but educational attainment has no impact on lifetime vocational functioning.
- 1 Individual has set educational goals and is currently making progress towards achieving them.
- 2 Individual has set educational goals but is currently not making progress towards achieving them.
- 3 Individual has no educational goals and lack of educational attainment is interfering with individual's lifetime vocational functioning.

71.8. VICTIMIZATION

This item is used to examine a history and level of current risk for victimization.

- 0 This level indicates a person with no evidence of recent victimization and no significant history of victimization within the past year. The person may have been robbed or burglarized on one or more occasions in the past, but no pattern of victimization exists. Person is not presently at risk for re-victimization.
- 1 This level indicates a person with a history of victimization but who has not been victimized to any significant degree in the past year. Person is not presently at risk for re-victimization.
- 2 This level indicates a person who has been recently victimized (within the past year) but is not in acute risk of re-victimization. This might include physical or sexual abuse, significant psychological abuse by family or friend, extortion or violent crime.
- 3 This level indicates a person who has been recently victimized and is in acute risk of re-victimization. Examples include working as a prostitute and living in an abusive relationship.

72. CAREGIVER NEEDS AND STRENGTHS

These ratings should be done with a focus on permanency plan caregivers. Caregiver ratings should be completed by household. If multiple households are involved in the permanency planning, then this section should be completed once for each household under consideration.

For **Caregiver Needs and Strengths** the following definitions and action levels apply:

- 0 indicates a dimension where there is no evidence of any caregiver needs. This is strength.
- 1 indicates a dimension that requires monitoring, watchful waiting, or preventive activities.
- 2 indicates a dimension that requires action to ensure that this identified need or risk behavior is addressed.
- 3 indicates a dimension that requires immediate or intensive action. **This dimension is also used when there is no evidence or information to make a determination. If you don't have enough information then score the item as a three.**

72. 1 PHYSICAL HEALTH

Physical health includes medical and physical challenges faced by the caregiver(s)

- 0 Caregiver(s) has no physical health limitations that impact assistance or attendant care.
- 1 Caregiver(s) has some physical health limitations that interfere with provision of assistance or attendant care.
- 2 Caregiver(s) has significant physical health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.

3 Caregiver(s) is physically unable to provide any needed assistance or attendant care.

72.2 MENTAL HEALTH

This item refers to the caregiver's mental health status. Serious mental illness would be rated as a '2' or '3' unless the individual is in recovery.

- 0 Caregiver(s) has no mental health limitations that impact assistance or attendant care.
- 1 Caregiver(s) has some mental health limitations that interfere with provision of assistance or attendant care.
- 2 Caregiver(s) has significant mental health limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
- 3 Caregiver(s) is unable to provide any needed assistance or attendant care due to serious mental illness.

72.3 SUBSTANCE USE

This item rates the caregiver's pattern of alcohol and/or drug use. Substance-related disorders would be rated as a '2' or '3' unless the individual is in recovery.

- 0 Caregiver(s) has no substance-related limitations that impact assistance or attendant care.
- 1 Caregiver(s) has some substance-related limitations that interfere with provision of assistance or attendant care.
- 2 Caregiver(s) has significant substance-related limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
- 3 Caregiver(s) is unable to provide any needed assistance or attendant care due to serious substance dependency or abuse.

72.4 DEVELOPMENTAL

This item describes the caregiver's developmental status in terms of low IQ, mental retardation or other developmental disabilities.

- 0 Caregiver(s) has no developmental limitations that impact assistance or attendant care.
- 1 Caregiver(s) has some developmental limitations that interfere with provision of assistance or attendant care.
- 2 Caregiver(s) has significant developmental limitations that prevent them from being able to provide some needed assistance or make attendant care difficult.
- 3 Caregiver(s) is unable to provide any needed assistance or attendant care due to serious developmental disabilities.

72.5 SUPERVISION

This rating is used to determine the caregiver's capacity to provide the level of monitoring and discipline needed by the child.

- 0 This rating is used to indicate a caregiver circumstance in which supervision and monitoring are appropriate and functioning well.
- 1 This level indicates a caregiver circumstance in which supervision is generally adequate but inconsistent. This may include a placement in which one member is capable of appropriate monitoring and supervision but others are not capable or not consistently available.
- 2 This level indicates a caregiver circumstance in which appropriate supervision and monitoring are very inconsistent and frequently absent.
- 3 This level indicates a caregiver circumstance in which appropriate supervision and monitoring are nearly always absent or inappropriate.

72.6 INVOLVEMENT WITH CARE

This rating should be based on the level of involvement the caregiver(s) has in the planning and provision of child welfare and related services.

- 0 This level indicates a caregiver(s) who is actively involved in the planning and/or implementation of services and is able to be an effective advocate on behalf of the child or adolescent.
- 1 This level indicates a caregiver(s) who is consistently involved in the planning and/or implementation of services for the child or adolescent but is not an active advocate on behalf of the child or adolescent.
- 2 This level indicates a caregiver(s) who is minimally involved in the care of the child or adolescent. Caregiver may visit individual when in out of home placement, but does not become involved in service planning and implementation.
- 3 This level indicates a caregiver(s) who is uninvolved with the care of the child or adolescent. Caregiver may want individual out of home or fails to visit individual when in residential placement. Caregivers not wishing involvement with their child or attempting to dump responsibility for their child are rated here.

72.7 KNOWLEDGE

This rating should be based on caregiver's knowledge of the specific strengths of the child and any problems experienced by the child and their ability to understand the rationale for the treatment or management of these problems.

- 0 This level indicates that the present caregiver is fully knowledgeable about the child's psychological strengths and weaknesses, talents and limitations.
- 1 This level indicates that the present caregiver, while being generally knowledgeable about the child, has some mild deficits in knowledge or understanding of either the child's psychological condition or his/her talents, skills and assets.
- 2 This level indicates that the caregiver does not know or understand the child well and that significant deficits exist in the caregiver's ability to relate to the child's problems and strengths.
- 3 This level indicates that the present caregiver has little or no understanding of the child's current condition. The placement is unable to cope with the child given his/her status at the time, not because of the needs of the child but because the caregiver does not understand or accept the situation.

72.8 ORGANIZATION

This rating should be based on the ability of the caregiver to participate in or direct the organization of the household, services, and related activities.

- 0 Caregiver(s) is well organized and efficient.
- 1 Caregiver(s) has minimal difficulties with organizing or maintaining household to support needed services. For example, may be forgetful about appointments or occasionally fails to call back case manager.
- 2 Caregiver(s) has moderate difficulties with organizing or maintaining household to support needed services.
- 3 Caregiver(s) is unable to organize household to support needed services.

72.9 RESOURCES

This item refers to the financial and social assets (extended family) and resources that the caregiver(s) can bring to bear in addressing the multiple needs of the child and family.

- 0 Caregiver(s) has sufficient resources so that there are few limitations on what can be provided for the child.
- 1 Caregiver(s) has the necessary resources to help address the child's major and basic needs but those resources might be stretched.
- 2 Caregiver(s) has limited resources (e.g. a grandmother living in same town who is sometimes available to watch the child).
- 3 Caregiver(s) has severely limited resources that are available to assist in the care and treatment of the child.

72.10 RESIDENTIAL STABILITY

*This item rates the caregiver's current and likely future housing circumstances. **This is not an indicator of the child's likelihood to be moved but of the caregiver's stability.***

- 0 This rating indicates a family/caregiver in stable housing with no known risks of instability.
- 1 This rating indicates a family/caregiver who is currently in stable housing but there are significant risks of housing disruption (e.g. loss of job).
- 2 This rating indicates a family/caregiver who has moved frequently or has very unstable housing.
- 3 This rating indicates a family/caregiver who is currently homeless.

72.11 SAFETY

*This rating refers to the safety of the assessed child. **This rating reflects the likelihood that Child Protective Services will become involved with the family or is currently engaged with the family.** It does not refer to the safety of other family or household members based on any danger presented by the assessed child.*

- 0 This level indicates that the present placement is as safe or safer for the child (in his or her present condition) as could be reasonably expected.
- 1 This level indicates that the present placement environment presents some mild risk of neglect, exposure to undesirable environments (e.g. drug use or gangs in neighborhood, etc.) but that no immediate risk is present.
- 2 This level indicates that the present placement environment presents a moderate level of risk to the child, including such things as the risk of neglect or abuse or exposure to individuals who could harm the child.
- 3 This level indicates that the present placement environment presents a significant risk to the well being of the child. Risk of neglect or abuse is imminent and immediate. Individuals in the environment offer the potential of significantly harming the child.

72.12 MARITAL/PARTNER VIOLENCE

This rating describes the degree of difficulty or conflict in the caregiver relationship.

- 0 Caregivers appear to be functioning adequately. There is no evidence of notable conflict in the caregiver relationship. Disagreements are handled in an atmosphere of mutual respect and equal power.
- 1 Mild to moderate level of family problems including marital difficulties and caregiver arguments. Caregivers are generally able to keep arguments to a minimum when child is present. Occasional difficulties in conflict resolution or use of power and control by one partner over another.
- 2 Significant level of caregiver difficulties including frequent arguments that often escalate to verbal aggression or the use of verbal aggression by one partner to control the other. Child often witnesses these arguments between caregivers or the use of verbal aggression by one partner to control the other.
- 3 Profound level of caregiver or marital violence that often escalates to mutual attacks or the use of physical aggression by one partner to control the other. These episodes may exacerbate child's difficulties or put the child at greater risk.

72.13 CAREGIVER POSTTRAUMATIC REACTIONS

This rating describes posttraumatic reactions faced by caregiver(s), including emotional numbing and avoidance, nightmares and flashbacks that are related to their child's or their own traumatic experiences.

- 0 Caregiver has adjusted to traumatic experiences without notable posttraumatic stress reactions.
- 1 Caregiver has some mild adjustment problems related to their child's or their own traumatic experiences. Caregiver may exhibit some guilt about their child's trauma or become somewhat detached or estranged from others.
- 2 Caregiver has moderate adjustment difficulties related to traumatic experiences. Caregiver may have nightmares or flashbacks of the trauma.
- 3 Caregiver has significant adjustment difficulties associated with traumatic experiences. include intrusive thoughts, hyper vigilance, and constant anxiety.

APPENDIX D

PROFILE OF YOUTH AT ADMISSION (ROCRS Data)

Table D-1: Demographic and History Characteristics of Youth by Gender of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Gender		Total
	Male	Female	
<u>Age at Admission</u> ^{**}	(n=696)	(n=489)	(n=1,185)
• 5-11 Years	16.5%	8.4%	13.2%
• 12-14 Years	27.4%	22.7%	25.5%
• 15-17 Years	46.0%	62.4%	52.7%
• 18 or Older	10.1%	6.5%	8.6%
<u>Hispanic Ethnicity</u>	(n=692)	(n=494)	(n=1,186)
• Yes	32.9%	32.6%	32.8%
• No	67.1%	67.4%	67.2%
<u>Race/Ethnicity</u>	(n=614)	(n=417)	(n=1,031)
• Caucasian	72.5%	65.7%	69.7%
• African American	20.2%	24.4%	21.8%
• Asian	1.0%	1.2%	1.1%
• American Indian/Alaskan	5.5%	8.2%	6.6%
• Hawaiian/Pacific Islander	0.8%	0.7%	0.8%
<u>Dependency/Neglect at Admit</u> ^{2**}	(n=654)	(n=447)	(n=1,101)
• Yes	39.9%	44.3%	41.7%
• No	60.1%	55.7%	58.3%
<u>Type of Dep./Neglect Involvement</u> ^{2*}	(n=246)	(n=181)	(n=427)
• Involuntary Placement	72.4%	80.7%	75.9%
• Court Action Pending	11.8%	8.3%	10.3%
• Voluntary Placement	15.9%	11.0%	13.8%
<u>Special Education Approved</u> ^{2*}	(n=681)	(n=417)	(n=1,098)
• Yes	63.3%	51.6%	58.8%
• No	36.7%	48.4%	41.2%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Race/ethnic information is adjusted for Hispanic ethnicity, which was coded separately.

Table D-2: Selected Placement Characteristics and History of Youth by Gender of Youth at Admission (Percent of Youth) ¹			
Characteristic ²	Gender		Total
	Male	Female	
<u>Placing Authority**</u>	(n=701)	(n=493)	(n=1,194)
• CDHS/County	59.8%	54.8%	57.7%
• CDYC	22.1%	12.2%	18.0%
• BHO/HB1116/HB1351	6.4%	9.3%	7.6%
• Private/Out of State	11.4%	23.5%	16.4%
<u>Expected LOS in Placement³</u>	(n=705)	(n=502)	(n=1,207)
• < 3 months	59.1%	60.8%	59.8%
• 4-6 months	3.0%	3.6%	3.2%
• 7-12 months	34.8%	32.3%	33.7%
• 13-24 months	2.7%	3.0%	2.8%
• > 24 months	0.4%	0.4%	0.4%
• Mean ³	(7.0 mo.)	(6.9 mo.)	(7.0 mo.)
<u>Prior OOH Placement History?***</u>	(n=696)	(n=497)	(n=1,193)
• Yes	73.7%	68.6%	71.6%
• No	26.3%	31.4%	28.4%
<u>Setting Immediately Before Placement**</u>	(n=670)	(n=421)	(n=1,091)
• Home with Primary Caregiver	15.8%	14.7%	15.4%
• Kinship-Relative Care	3.7%	3.3%	3.6%
• Foster Home-Therapeutic	1.0%	2.4%	1.6%
• Foster Home-Regular	7.9%	9.5%	8.5%
• Independent Living	0.3%	0.2%	0.3%
• Group-CPA Home	3.1%	2.4%	2.8%
• RCCF (Includes PRTF)	13.7%	12.4%	13.2%
• Psychiatric Hospital	11.6%	16.4%	13.5%
• Detention	32.5%	33.7%	33.0%
• DYC Commitment	10.1%	5.0%	8.2%
<u>Number of Past Runs from Facility**</u>	(n=705)	(n=502)	(n=1,207)
• None	73.6%	67.1%	70.9%
• 1	8.1%	8.4%	8.2%
• 2 or more	18.3%	24.5%	20.9%
<u>Number of Past Runs from Home*</u>	(n=705)	(n=502)	(n=1,207)
• None	67.2%	55.8%	62.5%
• 1	6.1%	4.6%	5.5%
• 2 or more	26.7%	39.6%	32.1%
<u>Number of Past Admissions to Psychiatric Hospital</u>	(n=705)	(n=502)	(n=1,207)
• None	57.4%	50.2%	54.4%
• 1	14.8%	17.7%	16.0%
• 2 or more	27.8%	32.1%	29.6%

Table D-2: Selected Placement Characteristics and History of Youth by Gender of Youth at Admission (Percent of Youth) ¹			
Characteristic ²	Gender		Total
	Male	Female	
<u>Number of Past Homicidal Threats</u>	(n=620)	(n=374)	(n=994)
• Yes	31.8%	30.7%	31.4%
• No	68.2%	69.3%	68.6%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Only computed on youth whose expected length of stay was greater than “0” months.

Table D-3: Caretaker Characteristics by Gender of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Gender		Total
	Male	Female	
<u>Status of Parental Rights</u>	(n=670)	(n=451)	(n=1,121)
• Intact	74.8%	78.0%	76.1%
• Pending or Terminated	25.2%	22.0%	23.9%
<u>Youth Currently Adopted^{2**}</u>	(n=700)	(n=471)	(n=1,171)
• Yes	14.6%	20.6%	17.0%
• No	85.4%	79.4%	83.0%
<u>Caretaker Agrees with Placement?</u>	(n=585)	(n=352)	(n=937)
• Yes	94.4%	94.0%	94.2%
• No	5.6%	6.0%	5.8%
<u>Caretaker Supports Placement?</u>	(n=567)	(n=333)	(n=900)
• Yes	93.8%	95.8%	94.6%
• No	6.2%	4.2%	5.4%
<u>Caretaker Wants Child Home?^{2**}</u>	(n=538)	(n=332)	(n=870)
• Yes	76.8%	75.6%	76.3%
• No	23.2%	24.4%	23.7%
<u>Caretaker has Reliable Transportation?</u>	(n=509)	(n=304)	(n=813)
• Yes	88.4%	84.9%	87.1%
• No	11.6%	15.1%	12.9%
<u>Distance from RCCE</u>	(n=578)	(n=361)	(n=939)
• 20 miles or less	37.4%	27.7%	33.7%
• 21-50 miles	27.7%	23.3%	26.0%
• 51-100 miles	15.6%	15.8%	15.7%
• > 100 miles	19.4%	33.2%	24.7%
<u>How Long to Facility</u>	(n=567)	(n=352)	(n=919)
• 30 minutes or less	34.2%	28.1%	31.9%
• 31 minutes to 1 hour	31.6%	23.0%	28.3%
• > 1 hour, but < 2 hours	14.3%	15.3%	14.7%
• 2 hours or more	19.9%	33.5%	25.1%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-4: Diagnostic Characteristics of Youth by Gender of Youth at Admission
 (Percent of Youth)¹

Characteristic ²	Gender		Total
	Male	Female	
<u>3 Most Frequent Diagnoses Axis I</u>	(n=698) Conduct/Antisocial (28.7%) Mood D/O (27.8%) PTSD (16.9%)	(n=485) Mood D/O (41.2%) PTSD (21.6%) Conduct/Antisocial (14.4%)	(n=1,183) Mood D/O (33.3%) Conduct/Antisocial (22.8%) PTSD (18.9%)
<u>Axis II Disorders</u>	(n=24) Dev Delay/MR (83.3%) Personality D/O (16.7%)	(n=50) Personality D/O (64.0%) Dev Delay/MR (36.0%)	(n=74) Dev Delay/MR (51.4%) Personality D/O (48.6%)
<u>Number of Total Diagnoses</u>	(n=705)	(n=502)	(n=1,207)
• 1	21.6%	14.5%	18.6%
• 2	35.6%	32.9%	34.5%
• 3	39.3%	41.0%	40.0%
• 4 or more	2.6%	8.2%	4.9%
<u>Axis V (GAF score)³</u>	(n=705)	(n=502)	(n=1,207)
• 30 or less	11.8%	15.5%	13.3%
• 31-40	27.1%	36.9%	31.2%
• 41-50	36.5%	34.5%	35.6%
• 51-60	18.4%	10.4%	15.1%
• 61-70	5.7%	2.6%	4.4%
• > 70	0.6%	0.2%	0.4%
• Mean	(46.6)	(43.0)	(45.1)

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ The GAF (Global Assessment of Functioning) is a numeric scale (1-100) that rates social, occupational and psychological functioning. The highest score of any youth at admission was 75. Scores of "0" are not included in the proportions or the mean score.

Table D-5: CANS Special Modules: Percent of Youth with Actionable Scores by Gender of Youth at Admission (i.e., 2 or 3 on items that trigger each of 7 Special Modules)

Characteristic ²	Gender		Total
	Male	Female	
<u>Developmental Disabilities</u>	(n=673)	(n=421)	(n=1,094)
• Yes	10.8%	10.5%	10.7%
• No	89.2%	89.5%	89.3%
<u>Substance Abuse**</u>	(n=673)	(n=421)	(n=1,094)
• Yes	21.5%	33.7%	26.2%
• No	78.5%	66.3%	73.8%
<u>Danger to Others</u>	(n=673)	(n=421)	(n=1,094)
• Yes	34.6%	24.9%	30.9%
• No	65.4%	75.1%	69.1%
<u>Sexual Aggression</u>	(n=673)	(n=421)	(n=1,094)
• Yes	14.4%	4.0%	10.4%
• No	85.6%	96.0%	89.6%
<u>Runaway*</u>	(n=672)	(n=417)	(n=1,089)
• Yes	19.2%	36.7%	25.9%
• No	80.8%	63.3%	74.1%
<u>Delinquency**</u>	(n=673)	(n=420)	(n=1,093)
• Yes	18.3%	11.2%	15.6%
• No	81.7%	88.8%	84.4%
<u>Fire Setting</u>	(n=671)	(n=420)	(n=1,091)
• Yes	4.0%	2.1%	3.3%
• No	96.0%	97.9%	96.7%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-6: Juvenile Justice History by Gender of Youth at Admission (Percent of Youth)¹

Characteristic ²	Gender		Total
	Male	Female	
<u>Delinquency at Admission^{2**}</u>	(n=692)	(n=483)	(n=1,175)
• Yes	60.3%	40.2%	52.0%
• No	39.7%	59.8%	48.0%
<u>Type of Delinquency Involved²</u>	(n=402)	(n=181)	(n=583)
• Adjudicated	69.7%	78.5%	72.4%
• Court Action Pending	30.3%	21.5%	27.6%

Table D-6: Juvenile Justice History by Gender of Youth at Admission
 (Percent of Youth)¹

Characteristic ²	Gender		Total
	Male	Female	
<u>Ever Adjudicated for a Crime?</u> **	(n=683)	(n=423)	(n=1,106)
• Yes	53.6%	44.2%	50.0%
• No	46.4%	55.8%	50.0%
<u>If Yes, Number of Different Types of Crimes</u> **	(n=705)	(n=502)	(n=1,27)
• None	45.1%	61.4%	51.9%
• 1	23.4%	20.3%	22.1%
• 2	15.5%	9.0%	12.8%
• 3 or more	16.0%	9.4%	13.3%
<u>If Yes, Types of Crimes</u>	(n=705)	(n=502)	(n=1,207)
• Crimes Against Persons	34.9%	20.7%	29.0%
• Crimes Against Property**	31.6%	19.9%	26.8%
• Substance Use Related**	10.9%	7.8%	9.6%
• Crimes Against Public Order	6.4%	3.4%	5.1%
• Violations of Court Proceedings*	15.3%	7.8%	12.2%
• Status Offenses	13.2%	10.4%	12.0%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-7: CANS Scale Scores by Gender of Youth at Admission¹

(Mean Score)

CANS Dimensions ²	Gender		Total
	Male	Female	
<u>Trauma Scale</u> **	(n=673)	(n=421)	(n=1,094)
• Mean	(8.4)	(8.5)	(8.4)
<u>Behavioral Emotional Needs</u>	(n=674)	(n=421)	(n=1,095)
• Mean	(11.4)	(11.2)	(11.3)
<u>Life Domain Scale</u>	(n=673)	(n=421)	(n=1,094)
• Mean	(10.0)	(10.0)	(10.0)
<u>Risk Behavior Scale</u> *	(n=673)	(n=421)	(n=1,094)
• Mean	(8.6)	(8.4)	(8.5)
<u>Child Strengths Scale</u> **	(n=672)	(n=421)	(n=1,093)
• Mean	(15.0)	(14.8)	(14.9)
<u>Caregiver Strengths Scale</u> ³	(n=540)	(n=335)	(n=875)
• Mean	(6.9)	(6.6)	(6.8)

¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that goes from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths; 0 or 1 on individual items.) Lyons, JS (2009) *Communimetrics: A communication theory of measurement for human services*. New York: Springer.

² Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Youth who were identified as not having caregivers were excluded from the analysis.

Table D-8: ROCRS CANS Scale Scores: Percent of Actionable Items in each Domain by Gender of Youth at Admission
(Percent of Items scored as Actionable, i.e., rated as 2 or 3)

ROCRS CANS Dimensions ¹	Gender		Total
	Male	Female	
<u>Trauma Experiences (13 Items)**²</u>	(n=705)	(n=502)	(n=1,207)
• Percent Actionable	(82.0)	(70.9)	(77.4)
<u>Trauma Symptoms (Max=5 Items)**</u>	(n=705)	(n=502)	(n=1,207)
• Percent Actionable	(59.6)	(55.8)	(58.0)
<u>Behavioral Emotional Needs (13 Items)</u>	(n=705)	(n=502)	(n=1,207)
• Percentage Actionable	(92.8)	(80.1)	(87.5)
<u>Life Domain Scale (17 Items)*</u>	(n=705)	(n=502)	(n=1,207)
• Percentage Actionable	(92.8)	(80.9)	(87.8)
<u>Risk Behavior Scale (12 Items)**</u>	(n=705)	(n=502)	(n=1,207)
• Percentage Actionable	(88.1)	(75.1)	(82.7)
<u>Transition to Adult (8 Items)³</u>	(n=201)	(n=194)	(n=395)
• Percentage Actionable	(68.2)	(63.4)	(65.8)
<u>Child Strengths Scale (10 Items)</u>	(n=705)	(n=502)	(n=1,207)
• Percentage Actionable	(90.2)	(79.9)	(85.9)
<u>Caregiver Strengths Scale (13 Items)⁴</u>	(n=573)	(n=417)	(n=990)
• Percentage Actionable	(56.4)	(48.2)	(52.9)

¹ Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

² Traumatic Experiences and Traumatic Symptoms were calculated separately.

³ Youth under age 17 were excluded from analysis.

⁴ Youth who were identified as not having Caregivers were excluded from analysis.

Table D-9: Demographic and History Characteristics of Youth by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Gender**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Male	73.7%	63.2%	51.2%	68.6%	58.7%
• Female	26.3%	36.8%	48.8%	31.4%	41.3%
<u>Hispanic Ethnicity</u>	(n=155)	(n=296)	(n=611)	(n=102)	(n=1,164)
• Yes	31.6%	35.5%	32.1%	31.4%	32.8%
• No	68.4%	64.5%	67.9%	68.6%	67.2%
<u>Race/Ethnicity³</u>	(n=130)	(n=253)	(n=537)	(n=92)	(n=1,012)
• Caucasian	78.5%	69.6%	68.9%	67.4%	70.2%
• African American	14.6%	24.1%	22.2%	18.5%	21.3%
• Asian	—	0.8%	1.7%	—	1.1%
• American Indian/Alaskan	5.4%	5.1%	6.7%	12.0%	6.6%
• Hawaiian/Pacific Islander	1.5%	0.4%	0.6%	2.2	0.8%
<u>Dependency/Neglect at Admit²**</u>	(n=154)	(n=274)	(n=565)	(n=90)	(n=1,083)
• Yes	54.5%	44.9%	38.6%	27.8%	41.6%
• No	45.5%	55.1%	61.4%	72.2%	58.4%

Table D-9: Demographic and History Characteristics of Youth by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Type of Dep./Neglect Involvement?</u> ^{2*}	(n=81)	(n=111)	(n=202)	(n=24)	(n=418)
• Involuntary Placement	63.0%	76.6%	80.7%	79.2%	76.1%
• Court Action Pending	11.1%	10.8%	9.9%	8.3%	10.3%
• Voluntary Placement	25.9%	12.6%	9.4%	12.5%	13.6%
<u>Special Education Approved?</u> ^{2**}	(n=148)	(n=273)	(n=564)	(n=95)	(n=1,080)
• Yes	66.2%	63.0%	56.6%	47.4%	58.7%
• No	33.8%	37.0%	43.4%	52.6%	41.3%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Statistical tests indicate areas of significant differences between/among groups. These differences are noted as * $p \leq .05$ (the probability of the outcome occurring by chance alone is less than or equal to 5%) and ** $p \leq .01$ (the probability is less than or equal to 1%). Thus, for example, our database includes a significantly higher proportion of males than females and a significantly higher proportion of youth with than without special education plans.

³ Race/ethnic information is adjusted for Hispanic ethnicity, which was coded separately.

Table D-10: Selected Placement Characteristics and History of Youth by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Placing Authority (funding bed)</u> ^{2**}	(n=155)	(n=300)	(n=620)	(n=101)	(n=1,176)
• CDHS/COUNTY	83.9%	66.0%	54.0%	18.8%	58.0%
• CDYC	--	5.0%	19.4%	77.2%	18.1%
• BHO/HB1116/1351	7.7%	11.3%	7.3%	—	7.7%
• PVT/Out of State	7.7%	17.7%	19.0%	4.0%	15.9%
<u>Expected LOS in Placement</u> ^{2**3}	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• < 3 months	73.1%	65.2%	55.5%	53.9%	60.2%
• 4-6 months	7.1%	2.6%	2.7%	2.9%	3.3%
• 7-12 months	18.6%	29.8%	38.1%	36.3%	33.2%
• 13-24 months	0.6%	2.0%	3.4%	5.9%	2.9%
• ≥ 24 months	0.6%	0.3%	0.3%	1.0%	0.4%
• Mean ³	(5.7 mo.)	(6.2 mo.)	(7.4 mo.)	(8.4 mo.)	(7.0 mo.)
<u>Prior OOH Placement History?</u> ^{2**}	(n=154)	(n=300)	(n=616)	(n=101)	(n=1,171)
• Yes	74.0%	66.0%	71.3%	87.1%	71.6%
• No	26.0%	34.0%	28.7%	12.9%	28.4%

Table D-10: Selected Placement Characteristics and History of Youth by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Setting Immediately Before Placement**</u>	(n=147)	(n=260)	(n=571)	(n=97)	(n=1,075)
• Home with Primary Caregiver	21.1%	23.5%	12.6%	2.1%	15.4%
• Kinship-Relative Care	8.8%	5.8%	1.8%	1.0%	3.6%
• Foster Home-Therapeutic	3.4%	2.3%	0.9%	1.0%	1.6%
• Foster Home-Regular	25.2%	6.9%	5.6%	5.2%	8.6%
• Independent Living	—	—	0.5%	—	0.3%
• Group-CPA Home	0.7%	4.6%	2.5%	2.1%	2.7%
• RCCF (Includes PRTF)	10.2%	14.2%	12.4%	18.6%	13.1%
• Psychiatric Hospital	27.9%	15.8%	11.2%	—	13.6%
• Detention	2.7%	23.8%	45.2%	29.9%	32.8%
• DYC Commitment	—	3.1%	7.4%	40.2%	8.3%
<u>Prior OOH Placement History?***</u>	(n=154)	(n=300)	(n=616)	(n=101)	(n=1,171)
• Yes	74.0%	66.0%	71.3%	87.1%	71.6%
• No	26.0%	34.0%	28.7%	12.9%	28.4%
<u>Number of Past Runs from Facility**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• None	94.2%	81.8%	63.0%	53.9%	71.1%
• 1	2.6%	4.3%	10.7%	13.7%	8.3%
• 2 or more	3.2%	13.9%	26.2%	32.4%	20.6%
<u>Number of Past Runs from Home**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• None	92.9%	72.8%	53.0%	48.0%	62.9%
• 1	2.6%	5.3%	5.4%	9.8%	5.4%
• 2 or more	4.5%	21.9%	41.6%	42.2%	31.7%
<u>Number of Past Admissions to Psychiatric Hospital</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• None	47.4%	57.3%	54.6%	54.9%	54.3%
• 1	17.9%	13.6%	16.2%	20.6%	16.1%
• 2 or more	34.6%	29.1%	29.3%	24.5%	29.5%
<u>History of Past Homicidal Threats**</u>	(n=139)	(n=243)	(n=512)	(n=87)	(n=981)
• Yes	45.3%	35.4%	27.9%	18.4%	31.4%
• No	54.7%	64.6%	72.1%	81.6%	68.6%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Only computed on youth whose expected length of stay was greater than “0” months.

Table D-11: Caretaker Characteristics by Age of Youth at Admission
 (Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Status of Parental Rights**</u>	(n=152)	(n=278)	(n=582)	(n=91)	(n=1,103)
• Intact	55.9%	75.9%	80.9%	78.0%	76.0%
• Pending or Terminated	44.1%	24.1%	19.1%	22.0%	24.0%
<u>Youth Currently Adopted</u>	(n=153)	(n=290)	(n=610)	(n=100)	(n=1,153)
• Yes	16.3%	19.0%	15.9%	20.0%	17.1%
• No	83.7%	81.0%	84.1%	80.0%	82.9%
<u>Caregiver Agrees with Placement?</u>	(n=130)	(n=236)	(n=481)	(n=75)	(n=922)
• Yes	92.3%	93.2%	94.6%	97.3%	94.1%
• No	7.7%	6.8%	5.4%	2.7%	5.9%
<u>Caregiver Supports Placement?</u>	(n=121)	(n=226)	(n=466)	(n=72)	(n=885)
• Yes	90.1%	96.0%	94.4%	97.2%	94.5%
• No	9.9%	4.0%	5.6%	2.8%	5.5%
<u>Caregiver Wants Child Home?***</u>	(n=120)	(n=207)	(n=447)	(n=82)	(n=856)
• Yes	81.7%	91.3%	75.4%	34.1%	76.2%
• No	18.3%	8.7%	24.6%	65.9%	23.8%
<u>Caregiver has Reliable Transportation?</u>	(n=112)	(n=202)	(n=415)	(n=75)	(n=804)
• Yes	88.4%	87.1%	85.5%	92.0%	86.9%
• No	11.6%	12.9%	14.5%	8.0%	13.1%
<u>Distance from RCCF*</u>	(n=121)	(n=233)	(n=490)	(n=83)	(n=927)
• 20 miles or less	36.4%	38.2%	30.6%	39.8%	34.1%
• 21-50 miles	19.8%	25.8%	26.5%	33.7%	26.1%
• 51-100 miles	19.8%	16.7%	15.1%	9.6%	15.6%
• ≥ 100 miles	24.0%	19.3%	27.8%	16.9%	24.2%
<u>How Long to Facility</u>	(n=121)	(n=229)	(n=475)	(n=81)	(n=906)
• 30 minutes or less	28.9%	35.4%	30.1%	40.7%	32.2%
• 31 minutes to 1 hour	27.3%	26.6%	28.6%	33.3%	28.4%
• > 1 hour, < 2 hours	18.2%	17.0%	13.7%	8.6%	14.7%
• 2 hours or more	25.6%	21.0%	27.6%	17.3%	24.7%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-12: Diagnostic Characteristics of Youth by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>3 Most Frequent Diagnoses: Axis I</u>	(n=155) PTSD (40.6%) Mood D/O (20.6%) Psychotic D/O (11.0%)	(n=298) Mood D/O (33.2%) Conduct/Antiso c(20.1%) PTSD (17.8%)	(n=613) Mood D/O (36.7%) Conduct/Antiso c(26.4%) PTSD (14.2%)	(n=101) Mood D/O (32.7%) Conduct/Antiso c(32.7%) PTSD (18.8%)	(n=1,183) Mood D/O (33.3%) Conduct/Antisocial (22.8%) PTSD (18.9%)
<u>Axis II Disorders</u>	(n=5) Dev Delay/MR (100%)	(n=17) Dev Delay/MR (70.6%) Personality D/O (29.4%)	(n=47) Personality D/O (61.7%) Dev Delay/MR (38.3%)	(n=4) Dev Delay/MR (75.0%) Personality D/O (25.0%)	(n=74) Dev Delay/MR (51.4%) Personality D/O (48.6%)
<u>Number of Diagnoses**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• 1	26.3%	22.2%	16.2%	11.8%	18.6%
• 2	42.9%	35.8%	32.5%	31.4%	34.6%
• 3	27.6%	37.1%	43.0%	52.9%	40.3%
• 4 or more	2.6%	3.6%	6.4%	2.9%	4.9%
<u>Axis V (GAF score)^{4**3}</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• 30 or less	7.7%	6.3%	14.2%	32.4%	12.9%
• 31-40	23.1%	40.4%	32.3%	7.8%	31.1%
• 41-50	57.7%	30.1%	35.5%	21.6%	35.9%
• 51-60	10.9%	17.9%	13.8%	23.5%	15.3%
• 61-70	—	5.0%	3.8%	13.7%	4.5%
• ≥ 70	0.6%	0.3%	0.3%	1.0%	0.4%
• Mean	(43.9)	(44.5)	(44.7)	(54.0)	(45.2)

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ The GAF (Global Assessment of Functioning) is a numeric scale (1-100) that rates social, occupational and psychological functioning. The highest score of any youth at admission was 75. Scores of “0” are not included in the proportions or the mean score.

Table D-13: CANS Special Modules: Percent of Youth with Actionable Scores by Age of Youth at Admission (i.e., scores of 2 or 3 on items that trigger each of 7 Special Modules) (Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Developmental Disabilities</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Yes	14.9%	12.1%	8.9%	10.2%	10.7%
• No	85.1%	87.9%	91.1%	89.8%	89.3%
<u>Substance Abuse**</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Yes	0.6%	12.1%	36.0%	48.9%	25.9%
• No	99.4%	87.9%	64.0%	51.1%	74.1%
<u>Danger to Others**</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Yes	39.6%	38.1%	27.6%	14.8%	30.9%
• No	60.4%	61.9%	72.4%	85.2%	69.1%
<u>Sexual Aggression**</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Yes	10.4%	16.1%	6.8%	17.0%	10.5%
• No	89.6%	83.9%	93.2%	83.0%	89.5%
<u>Runaway**</u>	(n=154)	(n=272)	(n=557)	(n=88)	(n=1,071)
• Yes	10.4%	15.8%	34.6%	22.7%	25.4%
• No	89.6%	84.2%	65.4%	77.3%	74.6%
<u>Delinquency**</u>	(n=154)	(n=272)	(n=561)	(n=88)	(n=1,075)
• Yes	2.6%	15.1%	17.6%	25.0%	15.4%
• No	97.4%	84.9%	82.4%	75.0%	84.6%
<u>Fire Setting</u>	(n=154)	(n=272)	(n=559)	(n=88)	(n=1,073)
• Yes	3.2%	4.8%	3.2%	—	3.4%
• No	96.8%	95.2%	96.8%	100%	96.6%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-14: Juvenile Justice History by Age of Youth at Admission (Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Delinquency at Admission^{2**}</u>	(n=154)	(n=295)	(n=608)	(n=101)	(n=1,158)
• Yes	8.4%	47.8%	60.0%	81.2%	51.9%
• No	91.6%	52.2%	40.0%	18.8%	48.1%
<u>Type of Delinquency Involvement^{2**}</u>	(n=12)	(n=138)	(n=345)	(n=79)	(n=574)
• Adjudicated	33.3%	52.9%	77.1%	93.7%	72.6%
• Court Action Pending	66.7%	47.1%	22.9%	6.3%	27.4%
<u>Ever Adjudicated for a Crime^{2**}</u>	(n=153)	(n=268)	(n=567)	(n=101)	(n=1,089)
• Yes	3.9%	41.8%	59.8%	88.1%	50.1%
• No	96.1%	58.2%	40.2%	11.9%	49.9%

Table D-14: Juvenile Justice History by Age of Youth at Admission
(Percent of Youth)¹

Characteristic ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>If Yes, Number of Different Types of Crimes**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• None	95.5%	60.9%	42.7%	12.7%	51.7%
• 1	3.8%	25.2%	23.2%	38.2%	22.4%
• 2	0.6%	6.6%	16.3%	27.5%	12.7%
• 3 or more	--	7.3%	17.8%	21.6%	13.1%
<u>If Yes, Types of Crimes</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Crimes against persons**	2.6%	22.2%	34.1%	56.9%	28.9%
• Crimes against property**	1.3%	18.9%	34.4%	43.1%	26.8%
• Substance use related**	--	4.0%	12.3%	23.5%	9.5%
• Crimes against public order*	--	5.3%	5.8%	6.9%	5.0%
• Violations of court proceedings**	--	7.0%	16.5%	18.6%	12.1%
• Status offenses**	0.6%	7.3%	16.3%	17.6%	12.1%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-15: CANS Scale Scores by Age of Youth at Admission¹

(Mean score)

CANS Dimensions ²	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Trauma Scale</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Mean	(9.3)	(8.6)	(8.1)	(8.4)	(8.4)
<u>Behavioral Emotional Needs*</u>	(n=154)	(n=273)	(n=562)	(n=88)	(n=1,077)
• Mean	(11.5)	(11.9)	(11.2)	(10.1)	(11.4)
<u>Life Domain Scale**</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Mean	(8.2)	(10.6)	(10.4)	(9.2)	(10.0)
<u>Risk Behavior Scale**</u>	(n=154)	(n=273)	(n=561)	(n=88)	(n=1,076)
• Mean	(7.2)	(9.0)	(8.8)	(7.6)	(8.5)
<u>Child Strengths Scale*</u>	(n=154)	(n=273)	(n=561)	(n=87)	(n=1,075)
• Mean	(14.3)	(15.1)	(15.2)	(13.7)	(14.9)
<u>Caregiver Strengths Scale³</u>	(n=110)	(n=225)	(n=464)	(n=60)	(n=859)
• Mean	(7.5)	(7.2)	(6.5)	(6.8)	(6.8)

¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that goes from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths; 0 or 1 on individual items.) Lyons, JS (2009) *Communimetrics: A communication theory of measurement for human services*. New York: Springer.

² Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Youth who were identified as not having caregivers were excluded from the analysis.

**Table D-16: ROCRS CANS Scale Scores: Percent of Actionable Items in each Domain by Age of Youth at Admission
(Percent of Items scored as Actionable, i.e., rated as 2 or 3)**

ROCRS CANS Dimensions ¹	Age of Youth at Admission				Total
	5-11 years	12-14 years	15-17 years	≥18 years	
<u>Trauma Experiences (13 Items)**²</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percent Actionable	(90.4%)	(76.5%)	(75.4%)	(73.5%)	(77.5%)
<u>Trauma Symptoms (Max=5 Items)**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percent Actionable	(79.5%)	(60.6%)	(52.8%)	(51.0%)	(58.1%)
<u>Behavioral/Emotional Needs (13 Items)**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percentage Actionable	(96.8%)	(89.1%)	(86.6%)	(77.5%)	(87.8%)
<u>Life Domain Scale (17 Items)**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percentage Actionable	(96.2%)	(89.1%)	(87.0%)	(79.4%)	(88.1%)
<u>Risk Behavior Scale (12 Items)**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percentage Actionable	(87.2%)	(85.4%)	(82.9%)	(70.6%)	(83.0%)
<u>Transition to Adult (8 Items)³</u>	N/A	N/A	(n=295)	(n=100)	(n=395)
• Percentage Actionable			(63.4%)	(73.0%)	(65.8%)
<u>Child Strengths Scale (10 Items)**</u>	(n=156)	(n=302)	(n=625)	(n=102)	(n=1,185)
• Percentage Actionable	(94.2%)	(88.1%)	(85.0%)	(75.5%)	(86.2%)
<u>Caregiver Strengths Scale (13 Items)⁴</u>	(n=112)	(n=255)	(n=529)	(n=74)	(n=970)
• Percentage Actionable	(60.7%)	(59.2%)	(49.3%)	(50.0%)	(53.3%)

¹ Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

² Traumatic Experiences and Traumatic Symptoms were calculated separately.

³ Youth under age 17 were excluded from analysis.

⁴ Youth who were identified as not having Caregivers were excluded from analysis.

**Table D-17: Demographic and History Characteristics of Youth at Admission by Parental Rights
(Percent of Youth)¹**

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Age at Admission**</u>	(n=838)	(n=265)	(n=1,103)
• 5-11 Years	10.1%	25.3%	13.8%
• 12-14 Years	25.2%	25.3%	25.2%
• 15-17 Years	56.2%	41.9%	52.8%
• 18 or Older	8.5%	7.5%	8.3%
<u>Gender</u>	(n=853)	(n=268)	(n=1,121)
• Male	58.7%	63.1%	59.8%
• Female	41.3%	36.9%	40.2%
<u>Hispanic Ethnicity</u>	(n=838)	(n=264)	(n=1,102)
• Yes	32.7%	32.6%	32.7%
• No	67.3%	67.4%	67.3%

Table D-17: Demographic and History Characteristics of Youth at Admission by Parental Rights
(Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Race/Ethnicity</u>	(n=727)	(n=236)	(n=963)
• Caucasian	71.0%	69.1%	70.5%
• African American	21.3%	20.3%	21.1%
• Asian	1.1%	1.3%	1.1%
• American Indian/Alaskan	6.1%	8.1%	6.5%
• Hawaiian/Pacific Islander	0.6%	1.3%	0.7%
<u>Dependency/Neglect at Admit^{2**}</u>	(n=781)	(n=255)	(n=1,036)
• Yes	34.6%	60.0%	40.8%
• No	65.4%	40.0%	59.2%
<u>Type of Dep./Neglect Involvement^{2*}</u>	(n=259)	(n=137)	(n=396)
• Involuntary Placement	76.8%	73.0%	75.5%
• Court Action Pending	7.7%	16.1%	10.6%
• Voluntary Placement	15.4%	10.9%	13.9%
<u>Special Education Approved^{2*}</u>	(n=779)	(n=252)	(n=1,031)
• Yes	57.5%	64.7%	59.3%
• No	42.5%	35.3%	40.7%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Race/ethnic information is adjusted for Hispanic ethnicity, which was coded separately.

Table D-18: Selected Placement Characteristics and History of Youth by Parental Rights at Admission
(Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Placing Authority^{**}</u>	(n=850)	(n=267)	(n=1,117)
• CDHS/County	51.1%	76.8%	57.2%
• CDYC	19.9%	12.0%	18.0%
• BHO/HB1116/HB1351	9.4%	3.7%	8.1%
• Private/Out of State	19.3%	7.5%	16.5%
<u>Expected LOS in Placement³</u>	(n=853)	(n=268)	(n=1,121)
• < 3 months	59.8%	59.3%	59.7%
• 4-6 months	3.5%	3.4%	3.5%
• 7-12 months	33.5%	34.3%	33.7%
• 13-24 months	2.6%	3.0%	2.7%
• > 24 months	0.6%	--	0.4%
• Mean ³	(7.0 mo.)	(6.8 mo.)	(7.0 mo.)
<u>Prior OOH Placement History^{2**}</u>	(n=847)	(n=261)	(n=1,108)
• Yes	67.2%	87.7%	72.0%
• No	32.8%	12.3%	28.0%

Table D-18: Selected Placement Characteristics and History of Youth by Parental Rights at Admission
 (Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Setting Immediately Before Placement**</u>	(n=780)	(n=246)	(n=1,026)
• Home with Primary Caregiver	18.1%	8.1%	15.7%
• Kinship-Relative Care	3.2%	4.9%	3.6%
• Foster Home-Therapeutic	1.4%	1.6%	1.5%
• Foster Home-Regular	5.1%	19.5%	8.6%
• Independent Living	0.3%	0.4%	0.3%
• Group-CPA Home	2.4%	4.1%	2.8%
• RCCF (Includes PRTF)	11.7%	17.5%	13.1%
• Psychiatric Hospital	12.8%	16.3%	13.6%
• Detention	37.1%	19.5%	32.8%
• DYC Commitment	7.9%	8.1%	8.0%
<u>Number of Past Runs from Facility**</u>	(n=853)	(n=268)	(n=1,121)
• None	74.3%	62.7%	71.5%
• 1	7.9%	7.5%	7.8%
• 2 or More	17.8%	29.9%	20.7%
<u>Number of Past Runs from Home*</u>	(n=853)	(n=268)	(n=1,121)
• None	61.4%	67.5%	62.9%
• 1	4.6%	6.7%	5.1%
• 2 or More	34.0%	25.7%	32.0%
<u>Number of Past Admissions to Psychiatric Hospital</u>	(n=853)	(n=268)	(n=1,121)
• None	55.0%	50.4%	53.9%
• 1	15.5%	18.3%	16.1%
• 2 or More	29.5%	31.3%	30.0%
<u>Number of Past Homicidal Threats</u>	(n=708)	(n=229)	(n=937)
• Yes	31.8%	33.2%	32.1%
• No	68.2%	66.8%	67.9%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Only computed on youth whose expected length of stay was greater than “0” months.

Table D-19: Caretaker Characteristics of Youth at Admission by Parental Rights
 (Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Youth Currently Adopted**</u>	(n=838)	(n=264)	(n=1,102)
• Yes	15.8%	22.7%	17.4%
• No	84.2%	77.3%	82.6%
<u>Caregiver Agrees with Placement?</u>	(n=724)	(n=168)	(n=892)
• Yes	94.6%	94.0%	94.5%
• No	5.4%	6.0%	5.5%

Table D-19: Caretaker Characteristics of Youth at Admission by Parental Rights (Percent of Youth) ¹			
Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Caregiver Supports Placement?*</u>	(n=696)	(n=158)	(n=854)
• Yes	95.4%	90.5%	94.5%
• No	4.6%	9.5%	5.5%
<u>Caregiver Wants Child Home?***</u>	(n=680)	(n=150)	(n=830)
• Yes	81.6%	56.0%	77.0%
• No	18.4%	44.0%	23.0%
<u>Caregiver has Reliable Transportation?</u>	(n=644)	(n=128)	(n=772)
• Yes	87.1%	90.6%	87.7%
• No	12.9%	9.4%	12.3%
<u>Distance from RCCF</u>	(n=742)	(n=144)	(n=886)
• 20 miles or less	34.4%	29.9%	33.6%
• 21-50 miles	25.2%	31.3%	26.2%
• 51-100 miles	15.0%	18.1%	15.5%
• > 100 miles	25.5%	20.8%	24.7%
<u>How Long to Facility</u>	(n=728)	(n=144)	(n=872)
• 30 minutes or less	32.6%	29.2%	32.0%
• 31 minutes to 1 hour	27.6%	32.6%	28.4%
• > 1 hour, but < 2 hours	13.9%	16.7%	14.3%
• 2 hours or more	26.0%	21.5%	25.2%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-20: Diagnostic Characteristics of Youth at Admission by Parental Rights (Percent of Youth) ¹			
Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>3 Most Frequent Diagnoses Axis I</u>	(n=842)	(n=265)	(n=1,183)
	Mood D/O	PTSD	Mood D/O
	(36.9%)	(31.3%)	(33.3%)
	Conduct/Antisocial	Mood D/O	Conduct/Antisocial
(25.2%)	(24.9%)	(22.8%)	
PTSD	Conduct/Antisocial	PTSD	
(14.3%)	(14.3%)	(18.9%)	
<u>Axis II Disorders</u>	(n=51)	(n=18)	(n=74)
	Personality D/O	Dev Delay/MR	Dev Delay/MR
(52.9%)	(61.1%)	(51.4%)	
Dev Delay/MR	Personality D/O	Personality D/O	
(47.1%)	(38.9%)	(48.6%)	
<u>Number of Total Diagnoses</u>	(n=853)	(n=268)	(n=1,121)
• 1	18.6%	20.1%	19.0%
• 2	33.6%	37.3%	34.5%
• 3	41.5%	36.9%	40.4%
• 4 or more	4.9%	4.5%	4.8%

Table D-20: Diagnostic Characteristics of Youth at Admission by Parental Rights
 (Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Axis V (GAF score)</u> ³	(n=853)	(n=268)	(n=1,121)
• 30 or less	12.8%	14.2%	13.1%
• 31-40	33.3%	26.1%	31.6%
• 41-50	34.5%	38.8%	35.5%
• 51-60	14.9%	15.3%	15.0%
• 61-70	4.5%	4.9%	4.5%
• > 70	0.1%	0.7%	0.3%
• Mean	(44.9)	(45.7)	(45.1)

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ The GAF (Global Assessment of Functioning) is a numeric scale (1-100) that rates social, occupational and psychological functioning. The highest score of any youth at admission was 75. Scores of “0” are not included in the proportions or the mean score.

Table D-21: CANS Special Modules: Percent of Youth with Actionable Scores at Admission by Parental Rights
 (i.e., 2 or 3 on items that trigger each of 7 Special Modules)

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Developmental Disabilities</u>	(n=769)	(n=254)	(n=1,023)
• Yes	10.4%	12.6%	10.9%
• No	89.6%	87.4%	89.1%
<u>Substance Abuse**</u>	(n=769)	(n=254)	(n=1,023)
• Yes	30.0%	12.2%	25.6%
• No	70.0%	87.8%	74.4%
<u>Danger to Others</u>	(n=769)	(n=254)	(n=1,023)
• Yes	31.6%	31.1%	31.5%
• No	68.4%	68.9%	68.5%
<u>Sexual Aggression</u>	(n=769)	(n=254)	(n=1,023)
• Yes	10.0%	13.8%	10.9%
• No	90.0%	86.2%	89.1%
<u>Runaway*</u>	(n=765)	(n=253)	(n=1,018)
• Yes	27.7%	20.6%	25.9%
• No	72.3%	79.4%	74.1%
<u>Delinquency**</u>	(n=768)	(n=254)	(n=1,022)
• Yes	17.7%	9.8%	15.8%
• No	82.3%	90.2%	84.2%
<u>Fire Setting</u>	(n=766)	(n=254)	(n=1,020)
• Yes	3.7%	2.4%	3.3%
• No	96.3%	97.6%	96.7%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-22: Juvenile Justice History of Youth at Admission by Parental Rights
(Percent of Youth)¹

Characteristic ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Delinquency at Admission?</u> ^{***}	(n=833)	(n=266)	(n=1,099)
• Yes	54.9%	42.5%	51.9%
• No	45.1%	57.5%	48.1%
<u>Type of Delinquency Involved?</u>	(n=440)	(n=102)	(n=542)
• Adjudicated	73.6%	65.7%	72.1%
• Court Action Pending	26.4%	34.3%	27.9%
<u>Ever Adjudicated for a Crime?</u> ^{***}	(n=789)	(n=253)	(n=1,042)
• Yes	53.9%	37.5%	49.9%
• No	46.1%	62.5%	50.1%
<u>If Yes, Number of Different Types of Crimes</u> ^{**}	(n=853)	(n=268)	(n=1,121)
• None	47.7%	62.3%	51.2%
• 1	23.7%	17.5%	22.2%
• 2	13.7%	10.8%	13.0%
• 3 or more	14.9%	9.3%	13.6%
<u>If Yes, Types of Crimes</u>	(n=853)	(n=268)	(n=1,121)
• Crimes Against Persons	29.7%	27.2%	29.1%
• Crimes Against Property ^{**}	29.9%	18.7%	27.2%
• Substance Use Related ^{**}	11.6%	3.4%	9.6%
• Crimes Against Public Order	5.7%	4.5%	5.4%
• Violations of Court Proceedings [*]	13.7%	9.0%	12.6%
• Status Offenses	13.4%	9.0%	12.3%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

Table D-23: CANS Scale Scores of Youth at Admission by Parental Rights¹
(Mean Score)

CANS Dimensions ²	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Trauma Scale**</u>	(n=769)	(n=254)	(n=1,023)
• Mean	(7.7)	(10.6)	(8.4)
<u>Behavioral Emotional Needs</u>	(n=769)	(n=255)	(n=1,024)
• Mean	(11.3)	(11.8)	(11.4)
<u>Life Domain Scale</u>	(n=769)	(n=254)	(n=1,023)
• Mean	(10.0)	(10.0)	(10.0)
<u>Risk Behavior Scale*</u>	(n=769)	(n=254)	(n=1,023)
• Mean	(8.7)	(8.1)	(8.6)
<u>Child Strengths Scale**</u>	(n=769)	(n=253)	(n=1,022)
• Mean	(14.5)	(16.1)	(14.9)
<u>Caregiver Strengths Scale³</u>	(n=697)	(n=131)	(n=828)
• Mean	(6.9)	(6.4)	(6.8)

¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that goes from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths; 0 or 1 on individual items.) *Lyons, JS (2009) Communimetrics .A communication theory of measurement for human services. New York: Springer.*

² Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Youth who were identified as not having caregivers were excluded from the analysis.

Table D-24: ROCRS CANS Scale Scores:
Percent of Actionable Items in each Domain of Youth at Admission by Parental Rights
(Percent of Items scored as Actionable, i.e., rated as 2 or 3)

ROCRS CANS Dimensions ¹	Parental Rights		Total
	Intact	Pending/Terminated	
<u>Trauma Experiences (13 Items)**²</u>	(n=853)	(n=268)	(n=1,121)
• Percent Actionable	(74.2)	(88.8)	(77.7)
<u>Trauma Symptoms (Max=5 Items)**</u>	(n=853)	(n=268)	(n=1,121)
• Percent Actionable	(53.2)	(74.6)	(58.3)
<u>Behavioral Emotional Needs (13 Items)</u>	(n=853)	(n=268)	(n=1,121)
• Percentage Actionable	(87.7)	(89.9)	(88.2)
<u>Life Domain Scale (17 Items)*</u>	(n=853)	(n=268)	(n=1,121)
• Percentage Actionable	(87.5)	(92.2)	(88.6)
<u>Risk Behavior Scale (12 Items)**</u>	(n=853)	(n=268)	(n=1,121)
• Percentage Actionable	(82.5)	(85.1)	(83.1)
<u>Transition to Adult (8 Items)³</u>	(n=288)	(n=71)	(n=359)
• Percentage Actionable	(65.6)	(69.0)	(66.3)
<u>Child Strengths Scale (10 Items)</u>	(n=853)	(n=268)	(n=1,121)
• Percentage Actionable	(85.7)	(89.2)	(86.5)
<u>Caregiver Strengths Scale (13 Items)⁴</u>	(n=783)	(n=145)	(n=928)
• Percentage Actionable	(54.5)	(46.2)	(53.2)

¹ Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

² Traumatic Experiences and Traumatic Symptoms were calculated separately.

³ Youth under age 17 were excluded from analysis.

⁴ Youth who were identified as not having Caregivers were excluded from analysis.

Table D-25: Demographic and History Characteristics of Youth at Admission by Funding Authority
 (Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Age at Admission**</u>	(n=682)	(n=213)	(n=91)	(n=187)	(n=1,176)
• 5-11 Years	19.1%	--	13.2%	6.4%	13.2%
• 12-14 Years	29.0%	7.0%	37.4%	28.3%	25.5%
• 15-17 Years	49.1%	56.3%	49.5%	63.1%	52.7%
• 18 or Older	2.8%	36.6%	—	2.1%	8.6%
<u>Gender**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Male	60.8%	72.1%	49.5%	40.8%	58.7%
• Female	39.2%	27.9%	50.5%	59.2%	41.3%
<u>Hispanic Ethnicity</u>	(n=676)	(n=212)	(n=90)	(n=192)	(n=1,173)
• Yes	33.3%	33.5%	38.9%	28.6%	32.9%
• No	66.7%	66.5%	61.1%	71.4%	67.1%
<u>Race/Ethnicity⁴</u>	(n=591)	(n=187)	(n=77)	(n=163)	(n=1,021)
• Caucasian	72.4%	64.7%	67.5%	67.5%	69.7%
• African American	19.6%	26.2%	24.7%	22.1%	21.7%
• Asian	0.7%	1.6%	1.3%	1.8%	1.1%
• American Indian/Alaskan	6.3%	7.0%	6.5%	8.0%	6.7%
• Hawaiian/Pacific Islander	1.0%	0.5%	—	0.6%	0.8%
<u>Dependency/Neglect at Admit^{2**}</u>	(n=639)	(n=186)	(n=87)	(n=182)	(n=1,097)
• Yes	63.1%	9.1%	6.9%	15.9%	41.6%
• No	36.9%	90.9%	93.1%	84.1%	58.4%
<u>Type of Dep./Neglect Involvement²</u>	(n=368)	(n=21)	(n=6)	(n=29)	(n=425)
• Involuntary Placement	75.3%	85.7%	50.0%	82.8%	76.0%
• Court Action Pending	10.9%	4.8%	16.7%	6.9%	10.4%
• Voluntary Placement	13.9%	9.5%	33.3%	10.3%	13.6%
<u>Special Education Approved^{2**}</u>	(n=637)	(n=204)	(n=86)	(n=164)	(n=1,094)
• Yes	55.9%	46.1%	79.1%	75.0%	58.9%
• No	44.1%	53.9%	20.9%	25.0%	41.1%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

⁴ Race/ethnic information is adjusted for Hispanic ethnicity, which was coded separately.

Table D-26: Selected Placement Characteristics and History of Youth at Admission by Funding Authority
(Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS/County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Expected LOS in Placement**³</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• < 3 months	67.3%	46.5%	85.7%	33.2%	59.4%
• 4-6 months	4.1%	2.8%	3.3%	1.0%	3.3%
• 7-12 months	25.7%	43.3%	9.9%	64.8%	34.1%
• 13-24 months	2.6%	6.5%	—	1.0%	2.8%
• ≥ 24 months	0.3%	0.9%	1.1%	—	0.4%
• Mean ⁴	(6.3 mo.)	(9.1 mo.)	(4.4 mo.)	(8.3 mo.)	(7.0 mo.)
<u>Prior OOH Placement History?***</u>	(n=682)	(n=215)	(n=91)	(n=190)	(n=1,181)
• Yes	72.9%	80.9%	71.4%	58.9%	72.1%
• No	27.1%	19.1%	28.6%	41.1%	27.9%
<u>Setting Immediately Before Placement**</u>	(n=639)	(n=211)	(n=75)	(n=158)	(n=1,086)
• Home with Primary Caregiver	14.1%	1.4%	37.3%	28.5%	15.4%
• Kinship-Relative Care	5.3%	—	2.7%	1.9%	3.6%
• Foster Home-Therapeutic	1.9%	0.9%	—	1.9%	1.6%
• Foster Home-Regular	13.8%	—	1.3%	1.9%	8.5%
• Independent Living	0.3%	0.5%	—	—	0.3%
• Group-CPA Home	4.1%	0.5%	—	2.5%	2.9%
• RCCF (Includes PRTF)	13.6%	8.1%	16.0%	17.7%	13.3%
• Psychiatric Hospital	13.0%	0.5%	40.0%	19.6%	13.4%
• Detention	32.6%	50.2%	2.7%	25.9%	33.0%
• DYC Commitment	1.4%	37.9%	—	—	8.2%
<u>Number of Past Runs from Facility**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• None	71.1%	55.8%	85.7%	78.1%	70.7%
• 1	8.7%	12.1%	4.4%	4.6%	8.3%
• 2 or more	20.2%	32.1%	9.9%	17.3%	21.0%
<u>Number of Past Runs from Home**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• None	63.4%	51.6%	71.4%	65.8%	62.3%
• 1	6.1%	6.5%	6.6%	2.0%	5.5%
• 2 or more	30.5%	41.9%	22.0%	32.1%	32.2%
<u>Number of Past Admissions to Psychiatric Hospital</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• None	57.3%	67.4%	19.8%	44.4%	54.2%
• 1	15.5%	14.9%	23.1%	15.8%	16.0%
• 2 or more	27.1%	17.7%	57.1%	39.8%	29.8%
<u>History of Past Homicidal Threats**</u>	(n=588)	(n=177)	(n=82)	(n=142)	(n=992)
• Yes	28.2%	20.9%	45.1%	50.0%	31.5%
• No	71.8%	79.1%	54.9%	50.0%	68.5%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

⁴ Only computed on youth whose expected length of stay was greater than “0” months.

Table D-27: Caretaker Characteristics of Youth at Admission by Funding Authority
 (Percent of Youth)¹

CANS Dimensions ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Status of Parental Rights**</u>	(n=639)	(n=201)	(n=90)	(n=184)	(n=1,117)
• Intact	67.9%	84.1%	88.9%	89.1%	76.1%
• Pending or Terminated	32.1%	15.9%	11.1%	10.9%	23.9%
<u>Youth Currently Adopted</u>	(n=675)	(n=214)	(n=88)	(n=187)	(n=1,167)
• Yes	16.7%	9.8%	30.7%	20.3%	17.1%
• No	83.3%	90.2%	69.3%	79.7%	82.9%
<u>Caregiver Agree with Placement?</u>	(n=531)	(n=173)	(n=83)	(n=145)	(n=934)
• Yes	91.9%	95.4%	98.8%	98.6%	94.2%
• No	8.1%	4.6%	1.2%	1.4%	5.8%
<u>Caregiver Supports Placement?</u>	(n=505)	(n=167)	(n=85)	(n=137)	(n=897)
• Yes	92.7%	95.2%	98.8%	98.5%	94.5%
• No	7.3%	4.8%	1.2%	1.5%	5.5%
<u>Caregiver Want Child Home?***</u>	(n=495)	(n=165)	(n=74)	(n=133)	(n=870)
• Yes	76.2%	60.0%	87.8%	91.0%	76.3%
• No	23.8%	40.0%	12.2%	9.0%	23.7%
<u>Caregiver has Reliable Transportation?</u>	(n=457)	(n=162)	(n=85)	(n=107)	(n=812)
• Yes	84.7%	90.1%	94.1%	87.9%	87.2%
• No	15.3%	9.9%	5.9%	12.1%	12.8%
<u>Distance from RCCF*</u>	(n=528)	(n=174)	(n=85)	(n=147)	(n=937)
• 20 miles or less	32.4%	48.3%	52.9%	10.2%	33.6%
• 21-50 miles	29.4%	35.6%	25.9%	2.7%	26.0%
• 51-100 miles	21.6%	10.9%	9.4%	3.4%	15.7%
• ≥ 100 miles	16.7%	5.2%	11.8%	83.7%	24.7%
<u>How Long to Facility?</u>	(n=524)	(n=169)	(n=84)	(n=137)	(n=917)
• 30 minutes or less	30.2%	47.9%	50.0%	7.3%	31.8%
• 31 minutes to 1 hour	31.9%	36.7%	28.6%	4.4%	28.4%
• > 1 hour, < 2 hours	19.7%	10.7%	8.3%	5.1%	14.7%
• 2 hours or more	18.3%	4.7%	13.1%	83.2%	25.1%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

Table D-28: Diagnostic Characteristics of Youth at Admission by Funding Authority
(Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>3 Most Frequent Diagnoses: Axis I</u>	(n=680) Mood D/O (29.3%) PTSD (23.5%) Conduct/Antisocial (19.6%)	(n=214) Conduct/Antisocial (45.3%) Mood D/O (27.1%) PTSD (11.7%)	(n=91) Mood D/O (52.7%) PTSD (20.9%) Psychotic D/O (13.2%)	(n=191) Mood D/O (45.5%) Conduct/Antisocial (15.7%) Psychotic D/O (10.5%)	(n=1,183) Mood D/O (33.3%) Conduct/Antisocial (22.8%) PTSD (18.9%)
<u>Axis II Disorders</u>	(n=45) Dev Delay/MR (77.8%) Personality D/O (22.2%)	(n=1) Personality D/O (100%)	(n=7) Personality D/O (71.4%) Dev Delay/MR (28.6%)	(n=20) Personality D/O (95.0%) Dev Delay/MR (5.0%)	(n=74) Dev Delay/MR (51.4%) Personality D/O (48.6%)
<u>Number of Diagnoses**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• 1	24.1%	12.1%	12.1%	10.2%	18.7%
• 2	36.1%	33.5%	40.7%	29.1%	34.8%
• 3	34.3%	51.6%	40.7%	48.5%	40.3%
• 4 or more	4.2%	2.3%	6.6%	9.7%	4.9%
<u>Axis V (GAF score)^{4**}</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• 30 or less	9.7%	21.9%	17.6%	11.2%	12.7%
• 31-40	28.2%	11.6%	47.3%	57.1%	31.3%
• 41-50	40.6%	30.2%	28.6%	28.1%	35.8%
• 51-60	16.4%	26.0%	5.5%	3.6%	15.2%
• 61-70	4.6%	9.3%	1.1%	—	4.4%
• ≥ 70	0.4%	0.9%	—	—	0.4%
• Mean	(45.8)	(51.2)	(40.3)	(39.5)	(45.1)

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

⁴ The GAF (Global Assessment of Functioning) is a numeric scale (1-100) that rates social, occupational and psychological functioning. The highest score of any youth at admission was 75. Scores of “0” are not included in the proportions or the mean score.

Table D-29: CANS Special Modules: Percent of Youth with Actionable Scores at Admission by Funding Authority (i.e., scores of 2 or 3 on items that trigger each of 7 Special Modules) (Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Developmental Disabilities</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Yes	12.6%	5.6%	12.9%	7.8%	10.8%
• No	87.4%	94.4%	87.1%	92.2%	89.2%
<u>Substance Abuse**</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Yes	19.9%	48.7%	8.2%	32.7%	26.0%
• No	80.1%	51.3%	91.8%	67.3%	74.0%
<u>Danger to Others**</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Yes	32.4%	16.4%	43.5%	36.6%	31.0%
• No	67.6%	83.6%	56.5%	63.4%	69.0%
<u>Sexual Aggression**</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Yes	12.6%	10.8%	3.5%	4.6%	10.5%
• No	87.4%	89.2%	96.5%	95.4%	89.5%
<u>Runaway**</u>	(n=647)	(n=194)	(n=85)	(n=151)	(n=1,080)
• Yes	25.3%	32.0%	16.5%	25.8%	25.9%
• No	74.7%	68.0%	83.5%	74.2%	74.1%
<u>Delinquency**</u>	(n=648)	(n=195)	(n=85)	(n=153)	(n=1,084)
• Yes	14.4%	27.2%	3.5%	11.1%	15.3%
• No	85.6%	72.8%	96.5%	88.9%	84.7%
<u>Fire Setting</u>	(n=648)	(n=193)	(n=85)	(n=153)	(n=1,082)
• Yes	4.0%	2.1%	2.4%	2.6%	3.3%
• No	96.0%	97.9%	97.6%	97.4%	96.7%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

Table D-30: Juvenile Justice History of Youth at Admission by Funding Authority (Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Delinquency at Admission?***</u>	(n=675)	(n=209)	(n=90)	(n=193)	(n=1,170)
• Yes	49.3%	95.2%	22.2%	28.5%	52.0%
• No	50.7%	4.8%	77.8%	71.5%	48.0%
<u>Type of Delinquency Involvement?***</u>	(n=316)	(n=195)	(n=17)	(n=52)	(n=581)
• Adjudicated	57.3%	95.9%	29.4%	88.5%	72.3%
• Court Action Pending	42.7%	4.1%	70.6%	11.5%	27.7%
<u>Ever Adjudicated for a Crime?***</u>	(n=645)	(n=211)	(n=86)	(n=157)	(n=1,102)
• Yes	41.7%	99.1%	20.9%	35.0%	50.1%
• No	58.3%	0.9%	79.1%	65.0%	49.9%

Table D-30: Juvenile Justice History of Youth at Admission by Funding Authority
(Percent of Youth)¹

Characteristic ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>If Yes, Number of Different Types of Crimes**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• None	57.9%	0.9%	80.2%	70.4%	51.4%
• 1	20.3%	37.2%	13.2%	17.9%	22.4%
• 2	10.2%	31.6%	4.4%	5.1%	12.8%
• 3 or more	11.6%	30.2%	2.2%	6.6%	13.4%
<u>If Yes, Types of Crimes</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Crimes against persons**	26.0%	60.9%	7.7%	16.3%	29.3%
• Crimes against property**	23.1%	56.3%	12.1%	15.8%	27.0%
• Substance use related**	6.8%	25.1%	1.1%	7.1%	9.7%
• Crimes against public order*	5.1%	11.2%	--	1.5%	5.2%
• Violations of court proceedings**	10.2%	29.8%	3.3%	4.6%	12.3%
• Status offenses**	11.5%	23.7%	4.4%	5.1%	12.1%

¹ Percentages may not equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information. The number in *parenthesis* equals the number of youth for whom we had valid data.

² Characteristics with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

Table D-31: CANS Scale Scores of Youth at Admission by Funding Authority¹
(Mean score)

CANS Dimensions ²	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ³	Private/ Out of State	
<u>Trauma Scale</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Mean	(9.2)	(8.1)	(7.8)	(6.0)	(8.4)
<u>Behavioral Emotional Needs*</u>	(n=650)	(n=195)	(n=85)	(n=153)	(n=1,086)
• Mean	(11.6)	(11.0)	(12.4)	(10.5)	(11.4)
<u>Life Domain Scale**</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Mean	(10.2)	(9.8)	(9.0)	(10.0)	(10.0)
<u>Risk Behavior Scale**</u>	(n=649)	(n=195)	(n=85)	(n=153)	(n=1,085)
• Mean	(8.6)	(8.4)	(8.2)	(8.6)	(8.5)
<u>Child Strengths Scale*</u>	(n=649)	(n=194)	(n=85)	(n=153)	(n=1,084)
• Mean	(14.9)	(14.2)	(13.4)	(16.7)	(14.9)
<u>Caregiver Strengths Scale⁴</u>	(n=484)	(n=161)	(n=81)	(n=139)	(n=867)
• Mean	(7.8)	(6.7)	(4.6)	(4.7)	(6.8)

¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that goes from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths; 0 or 1 on individual items.) Lyons, JS (2009) *Communimetrics. A communication theory of measurement for human services.* New York: Springer.

² Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

³ Child Mental Health Treatment Act

⁴ Youth who were identified as not having caregivers were excluded from the analysis.

Table D-32: ROCRS CANS Scale Scores:
Percent of Actionable Items in each Domain for Youth at Admission by Funding Authority
(Percent of Items scored as Actionable, i.e., rated as 2 or 3)

ROCRS CANS Dimensions ¹	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ²	Private/Out of State	
<u>Trauma Experiences (13 Items)**³</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percent Actionable	(83.0)	(77.7)	(78.0)	(58.7)	(77.6)
<u>Trauma Symptoms (Max=5 Items)**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percent Actionable	(66.0)	(48.8)	(67.0)	(37.2)	(58.2)
<u>Behavioral/Emotional Needs (13 Items)**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percentage Actionable	(91.4)	(85.6)	(92.3)	(75.0)	(87.8)
<u>Life Domain Scale (17 Items)**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percentage Actionable	(91.7)	(87.0)	(90.1)	(75.5)	(88.1)
<u>Risk Behavior Scale (12 Items)**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percentage Actionable	(86.1)	(80.9)	(86.8)	(71.9)	(82.9)
<u>Transition to Adult (8 Items)⁴</u>	(n=154)	(n=147)	(n=16)	(n=76)	(n=393)
• Percentage Actionable	(64.9)	(72.1)	(56.3)	(59.2)	(66.2)

Table D-32: ROCRS CANS Scale Scores:
Percent of Actionable Items in each Domain for Youth at Admission by Funding Authority
(Percent of Items scored as Actionable, i.e., rated as 2 or 3)

ROCRS CANS Dimensions ¹	Funding Authority				Total
	CDHS /County	CDYC	BHO/ CMHTA ²	Private/Out of State	
<u>Child Strengths Scale (10 Items)**</u>	(n=689)	(n=215)	(n=91)	(n=196)	(n=1,194)
• Percentage Actionable	(90.3)	(81.4)	(90.1)	(75.0)	(86.2)
<u>Caregiver Strengths Scale (13 Items)⁵</u>	(n=525)	(n=182)	(n=87)	(n=182)	(n=978)
• Percentage Actionable	(61.7)	(50.0)	(48.3)	(33.5)	(53.2)

¹ Dimensions with statistically significant differences are noted by * $p \leq .05$ or ** $p \leq .01$.

² Child Mental Health Treatment Act

³ Traumatic Experiences and Traumatic Symptoms were calculated separately.

⁴ Youth under age 17 were excluded from analysis.

⁵ Youth who were identified as not having Caregivers were excluded from analysis.

APPENDIX E

PROFILE OF YOUTH AT DISCHARGE: SELECTED CHARACTERISTICS FOR CASES WITH BOTH ADMISSION AND DISCHARGE INFORMATION (N=474)

Table E-1: Distribution of Study Cases by RCCF Provider*		
Agency	Frequency (n=)	Proportion ¹ (%)
• Denver Children’s Home	39	8.2%
• Devereux Cleo Wallace Centers	70	14.8%
• Excelsior Youth Center	42	8.9%
• Griffith Centers for Children	21	4.4%
• Jefferson Hills	69	14.6%
• Kidz Ark, Inc.	31	6.5%
• Lost and Found	9	1.9%
• Mt. St. Vincent Home	27	5.7%
• Shiloh Home	78	16.5%
• Tennyson Center for Children	57	12.0%
• Third Way Center	31	6.5%
• TOTAL	474	100%

*Only cases that have completed forms at both admission and discharge. One RCCF dropped off from the admission RCCF list because no discharge forms were completed.

¹ Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-2: Distribution of ROCRS Study Cases by Placing County at Admission *		
Ten Counties with Highest Number of Admissions	Frequency (n=)	Proportion ¹ (%)
• Adams County	54	17.3%
• Denver County	45	14.4%
• El Paso County	33	10.5%
• Arapahoe County	32	10.2%
• Jefferson County	32	10.2%
• Weld County	18	5.8%
• Morgan County	15	4.8%
• Douglas County	13	4.2%
• Larimer County	10	3.2%
• Boulder County	7	2.2%
• Ten Counties Subtotal	259	82.7% of 313
• Remaining Counties Subtotal	54	17.3% of 313
• SAMPLE TOTAL	313	100%

*Only cases that have completed forms at both admission and discharge.

¹Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-3: Placement Characteristics of Youth at Discharge
(Percent of Youth)¹

Characteristic	Frequency (n=)	Proportion (%)
<u>Placement/Setting Recommended</u>		(n=473)
• Ready for Less Restrictive	303	64.1%
• Same/Other RCCF – Lateral	44	9.3%
• Return to this RCCF	42	8.9%
• Needs More Restrictive	84	17.8%
<u>Less Restrictive Placement Type</u>		(n=298)
• Home	182	61.1%
• Foster Care - Therapeutic	28	9.4%
• Foster Care – Regular (includes Kinship)	44	14.8%
• Group/CPA Home	44	14.8%
<u>More Restrictive Placement Type</u>		(n=85)
• Secure/Locked Facility (includes Detention)	48	56.5%
• Division of Youth Corrections (DYC) Commitment	18	21.2%
• Psychiatric Hospital	9	10.6%
• PRTF (Psychiatric Residential Treatment Center)	10	11.8%
<u>Were RCCF Discharge Recommendations Followed by Referring Agency?</u>		(n=360)
• Yes	318	88.3%
• No	42	11.7
<u>If Recommendations were not followed, why not?</u>		(n=32)
• Alternate Placement	10	23.3%
• Funding	1	2.3%
• Client Age	2	4.7%
• AWOL/On Run	4	9.3%
• Case Closed/Discharge before Adequate Transition	2	4.7
• Disagreement with Placement/Noncompliant	7	16.3%
• Lack of Services Available /Could Not Find Appropriate Setting	2	4.7%
• Policy Required Discharge	1	2.3%
• Caseworker/GAL Not Approved	1	2.3%
• Unknown	2	4.7%
<u>Actual Placement</u>		(n=451)
• Home with Primary Caregiver	182	40.4%
• Detention	44	9.8%
• Group/CPA Home	43	9.5%
• Foster Home – Regular	38	8.4%
• RCCF (includes PRTF)	28	6.2%
• Foster Home – Therapeutic	24	5.3%
• Kinship/Relative Care	23	5.1%
• Independent Living	14	3.1%
• DYC Commitment	13	2.9%
• Psychiatric Hospital	12	2.7%
• Other	30	6.7%

Table E-3: Placement Characteristics of Youth at Discharge
(Percent of Youth)¹

Characteristic	Frequency (n=)	Proportion (%)
<u>How often did Caseworker Visit</u>		(n=41)
• Less than 1X Months	1	2.4%
• Monthly	9	22.0%
• 2X per Month	28	68.3%
• Weekly	3	7.3%
<u>Number of Past Runs from Facility</u>		(n=474)
• None	383	80.8%
• 1	51	10.8%
• 2 or More	40	8.4%
<u>Number of Past Admissions to Psychiatric Hospital</u>		(n=474)
• None	440	92.8%
• 1	23	4.9%
• 2 or More	11	2.3%
<u>Number of Past Suicide Attempts</u>		(n=474)
• None	441	93.0%
• 1	14	3.0%
• 2 or More	19	4.0%
<u>Number of Past Homicidal Threats</u>		(n=455)
• Yes	93	20.4%
• No	362	79.6%
<u>Number of Psychotropic Medications Prescribed</u>		(n=474)
• None	168	35.4
• 1	100	21.1
• 2 or More	206	43.5
<u>Guilty of Crime</u>		(n=462)
• Yes	136	29.4
• No	326	70.6

¹ Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-4: Treatment Goals Met at Discharge (Percent of Youth) ¹		
Characteristic	Total (n=474)*	(%)
<u>Percent of Treatment Goals Met by Youth</u>		
• 0-40%	128	(n=471) 27.2%
• 41-70%	106	22.5%
• 71-90%	174	36.9%
• 91-100%	63	13.4%
<u>Percent of Treatment Goals Met by Parent/Caregiver</u>		
• 0-40%	131	(n=390) 33.6%
• 41-70%	80	20.5%
• 71-90%	125	32.1%
• 91-100%	54	13.8%

¹ Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-5: Placement Setting Recommendations at Discharge (Percent of Youth) ¹		
Characteristic	Frequency (n=)	Proportion (%)
<u>Placement/Setting Recommended</u>		
• Ready for Less Restrictive	303	(n=473) 64.1%
• Same/Other RCCF – Lateral	44	9.3%
• Return to this RCCF	42	8.9%
• Needs More Restrictive	84	17.8%
<u>Less Restrictive Placement Type</u>		
• Home	182	(n=298) 61.1%
• Foster Care - Therapeutic	28	9.4%
• Foster Care – Regular (includes Kinship)	44	14.8%
• Group/CPA Home	44	14.8%
<u>More Restrictive Placement Type</u>		
• Secure/Locked Facility (includes Detention)	48	(n=85) 56.5%
• Division of Youth Corrections (DYC) Commitment	18	21.2%
• Psychiatric Hospital	9	10.6%
• PRTF (Psychiatric Residential Treatment Center)	10	11.8%
<u>Were RCCF Discharge Recommendations Followed by Referring Agency?</u>		
• Yes	318	(n=360) 88.3%
• No	42	11.7%

Table E-5: Placement Setting Recommendations at Discharge
(Percent of Youth)¹

Characteristic	Frequency (n=)	Proportion (%)
<u>If Recommendations were not followed, why not?</u>		(n=32)
• Alternate Placement	10	23.3%
• Funding	1	2.3%
• Client Age	2	4.7%
• AWOL/On Run	4	9.3%
• Case Closed/Discharge before Adequate Transition	2	4.7%
• Disagreement with Placement/Noncompliant	7	16.3%
• Lack of Services Available /Could Not Find Appropriate Setting	2	4.7%
• Policy Required Discharge	1	2.3%
• Caseworker/GAL Not Approved	1	2.3%
• Unknown	2	4.7%

¹ Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-6: Estimated Amount of Service Youth Received during Placement
(Percent of Youth)*

Type of Service	n=474*	None	I -2 Times/ week	3-4 Times/ week	Daily or More
Assessment, including psychological testing	452	91%	8%	1%	< 1%
Individual therapy/counseling	473	4%	89%	7%	1%
Group therapy	472	5%	36%	50%	9%
Family Therapy	470	38%	62%	<1%	—
Educational groups	468	42%	35%	18%	6%
Psychiatric services and medication management	470	91%	9%	—	—
Expressive therapy	458	75%	24%	1%	<1%
Special services (physical, occupational, speech)	458	95%	5%	<1%	—
Recreational therapy (sports, equine, animal)	466	36%	23%	9%	31%
Vocational therapy	456	75%	12%	11%	2%
Mentoring	459	89%	7%	1%	3%

Table E-6: Estimated Amount of Service Youth Received during Placement
(Percent of Youth)*

Type of Service	n=474*	None	1-2 Times/ week	3-4 Times/ week	Daily or More
Community service/restorative justice services	459	81%	17%	2%	<1%
Faith/spirituality services	443	67%	33%	—	<1%
Milieu therapy	470	5%	8%	11%	76%
Services delivered in client's home	467	96%	3%	1%	<1%
Community activities	470	49%	35%	7%	9%
Urinalysis	456	82%	16%	1%	<1%
Evidence-based services	421	43%	21%	11%	25%

Table E-7: Estimated Participation by Family during Placement
(Percent of Youth)¹

Type of Family Participation	n=474*	None	Placing Agency Requested No Contact	1-2 Times/ Month	Monthly	2 Times/ Week	Weekly
Family Therapy	421	11%	1%	8%	7%	9%	65%
Telephone Calls	422	4%	1%	2%	5%	14%	74%
Visiting On-Site	398	14%	2%	15%	13%	9%	49%

¹ Percentages may not exactly equal 100 percent because of rounding. Total number of youth varies from question to question because of missing information.

Table E-8: CANS Domain Mean Scale Scores at Admission and Discharge¹ and Reliable Change²

Traditional (Lyons') CANS Dimensions ³ Scale Scores (0-30 range) ⁴	Overall n=474***	Admission Range (Min-Max)	Percent of Youth with Reliable Change	Percent of Youth with Reliable Change reported by Lyons' Indiana Study	Percent of Youth with ANY Reliable Change
<u>Trauma Symptoms Scale**</u>	(n=466)				
• Admission Mean	9.24	0 - 30	14.8%		
• Discharge Mean	8.29				
<u>Child Strengths Scale**</u>	(n=466)				
• Admission Mean	14.98	0 – 28	28.3%	28%	
• Discharge Mean	11.85				
<u>Life Domain Scale**</u>	(n=467)				
• Admission Mean	9.22	0 – 21.9	25.7%	8%	
• Discharge Mean	7.15				
<u>Behavioral Emotional Needs**</u>	(n=467)				
• Admission Mean	10.75	0 – 23.9	20.8%	36%	
• Discharge Mean	9.29				
<u>Risk Behavior Scale**</u>	(n=467)				
• Admission Mean	8.19	0 - 20	16.9%	22%	
• Discharge Mean	6.36				
<u>Caregiver Strengths Scale**⁵</u>	(n=376)				
• Admission Mean	5.83	0 - 30	17.7%		
• Discharge Mean	4.90				54.8%

¹ Dimension scores are calculated by averaging items within a dimension and multiplying these averages by 10 resulting in a scale that ranges from 0 (all '0's no identified needs or all centerpiece strengths) to 30 (all '3's indicate all dangerous or disabling needs or no strengths identified). Dimension scores are best thought of as complexity indicators as they reflect the number of actionable needs (2 or 3 on individual items or useful strengths (0 or 1 on individual items. Lyons, JS (2009) *Communimetrics. A communication theory of measurement for human services.* (New York: Springer.)

² Reliable Change is a more rigorous indicator of change than statistical significance in that it requires that the difference between the two measures, in this case admission and discharge, exceed the Reliable Change Index (which is calculated based on the reliability of the measure).

³ Dimensions with statistically significant differences are noted by *p <.05 or **p < .01.

⁴ Higher scale scores indicate more needs and lower strengths.

⁵ Youth who were identified as not having Caregivers were excluded from the analysis.



Table E-9. ROCR CANs Dimensions Percent of Items that are Actionable	
<u>Trauma Experiences (13 Items)**¹</u>	(n=467)
• Percent Actionable at Admission	24%
• Percent Actionable at Discharge	20%
<u>Trauma Symptoms (Max=5 Items)**</u>	(n=428)
• Percent Actionable at Admission	23%
• Percent Actionable at Discharge	18%
<u>Behavioral Emotional Needs (13 Items)**</u>	(n=466)
• Percent Actionable at Admission	36%
• Percent Actionable at Discharge	26%
<u>Life Domain Scale (17 Items)**</u>	(n=467)
• Percent Actionable at Admission	21%
• Percent Actionable at Discharge	15%
<u>Risk Behavior Scale (12 Items)**</u>	(n=467)
• Percent Actionable at Admission	30%
• Percent Actionable at Discharge	19%
<u>Transition to Adult (8 Items)**²</u>	(n=115)
• Percent Actionable at Admission	29%
• Percent Actionable at Discharge	23%
<u>Child Strengths Scale (10 Items)**</u>	(n=437)
• Percent Actionable at Admission	50%
• Percent Actionable at Discharge	32%
<u>Caregiver Strengths (13 Items)**³</u>	(n=372)
• Percent Actionable at Admission	15%
• Percent Actionable at Discharge	10%

¹ Traumatic Experiences and Traumatic Symptoms were calculated separately.

² Youth under age 17 were excluded from analysis.

³ Youth without caregivers were excluded from the analysis



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