A Comparison of Systems of Care in Two Rural Communities

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*The Indiana University evaluation team thanks you for your interest in this work and always welcomes your questions and suggestions.*

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EXECUTIVE SUMMARY

In order to understand how systems of care (SOCs) function, how they evolve, and how they are similar and different, this study examined two rural systems of care in terms of how they function and who they serve. In addition, the research team identified and compared changes in the behavioral health of participants over time. The two SOCs involved in this study are the One Community One Family (OCOF) SOC in southeastern Indiana and the Madison CARES (MC) SOC in southeastern Idaho. This study, conducted by the Families, Communities, and Schools (FoCuS) team in the School of Education at Indiana University in Bloomington, IN, compared and contrasted the services of each SOC with the intended outcome of better understanding the similarities and differences of each SOC within two very different rural settings.

The report findings are based primarily on qualitative and quantitative data gathered from each case to contribute to an understanding of each system of care. Qualitative data included information from OCOF and MC’s websites along with information requested from each SOC’s board members. Quantitative data were collected as part of a federally required child and family Longitudinal Outcome Study (LOS) of systems of care. A content analysis approach was used to understand the documents for each case. Next, within each individual case, quantitative data drawn from the national LOS study were analyzed to gain an understanding of the population served and improvements made over time. After individual case analysis, a cross-case analysis was conducted in which similarities and differences were examined.

First, the report presents a rich description of each case gleaned from the analysis of qualitative data. Next, the cross-case findings of the qualitative data and quantitative data are presented separately. The major differences in the two SOC’s principles, goals, mission, vision, and strategic plans are as follows:

• While MC strives to maintain at least 80% fidelity to the wraparound model, OCOF’s focus has been to move from wraparound to interagency collaboration and to serve all children and youth, not just those experiencing emotional and behavioral challenges.
• MC offers several additional services (e.g., Madison County Youth group, social media campaigns, community events, supporting schools to implement PBIS).
• OCOF provides advocacy and support to families and partners with family connected groups, such as Parent Coaching, Project LAUNCH, Transition to Independence Process (TIP), United Families, Finding Improvement by Reaching Empowerment (FIRE), and The Incredible Years.
• OCOF provides a statewide systems of care conference.
• OCOF has a partnership with three states: Kentucky, Ohio, and Indiana.
• OCOF includes “Trauma-Informed” in its core principles and applies this principle throughout its activities and supports the development of the Tristate Trauma Network organization.
• OCOF places great emphasis on evaluation as a part of its commitment to quality.
Who Participates in One Community One Family and Madison CARES SOCs?

- From 2008 to 2015, 718 families enrolled in the OCOF system of care, with the majority of youth enrolled being male (60%). From 2010 to 2015, 891 families entered MC: 476 (53%) were male and 415 (47%) were female.
- The majority of the youth in OCOF were identified as Caucasian (98%). The mean age of the respondents was 12.03 years old, and age ranged from 1 to 25 years. In MC, 93% participants have identified themselves as Caucasian. The average age of young people who participated in MC was five years of age, and the age range was 1 year to 21 years.
- For OCOF, 178 families participated in the National Longitudinal Outcomes Study (LOS) and have been assessed every six months during the service period. A total of 177 families in MC have participated in the LOS and were assessed every six months since enrollment.

Caregiver Profiles

- For OCOF, 10% male and 90% female caregivers participated in the LOS. For MC, female caregivers (90%) are also the majority of participants.
- At the time of enrollment in OCOF, 50% of the caregivers reported being in the 25–40 age group and 36% reported being in the 40–60 age group. For MC, 63% of caregivers were in the 25–40 age group, and 31% of caregivers were in the 40–60 age group. More than 90% caregivers in these two sites identified as being Caucasian.
- For OCOF, approximately 62% of caregivers reported that their highest education level was high school. For MC, 67% of caregivers had a bachelor’s degree while 28% of caregivers’ highest education level was high school.
- In OCOF, 81% families reported a household income below $35,000. However, for MC, 48% of families reported household incomes above $35,000 a year.

Satisfaction with Services

- Overall, for OCOF and MC, both youth and caregivers reported at enrollment and over time that they were generally satisfied (satisfaction score larger than 4.0) with the services they were receiving.
- For OCOF, youth tended to have a higher level of satisfaction than their caregivers at all time points. For MC, caregivers tended to report a higher level of satisfaction than their children.

Behavioral Improvements Overtime

- For OCOF and MC, average behavioral change scores on the CBCL (internalizing, externalizing, total) for youth from age 1.5 to 5 years and 6 to 18 years of age, decreased between enrollment and 18 months, suggesting improved behavior after enrollment in these two systems of care.
- Similarly, CIS scores also decreased from enrollment to 18 months for these two SOCs.
- On average, participants in OCOF are considered to have more emotional and behavioral challenges than MC participants, likely due to the older age of the participants.
Comparing Youth and Caregiver Perceptions of Strengths

- For OCOF and MC, young people consistently rate their own strengths higher than their caregivers in all four domains measured by the BERS-2: interpersonal strengths, family involvement, intrapersonal strengths, and school functioning. For OCOF and MC, caregiver ratings were more likely to fall under the low-average score of 8, while youth are in the average and above average ranges.
- For OCOF and MC, both caregiver and youth ratings of all four domains measured by the BERS-2 improved over time.

Depression and Anxiety

- The average scores of RADS-2 for OCOF and MC at all time points are below 61, which indicates that depression did not reach a clinically significant level in either SOC.
- The average score of RADS-2 for OCOF was consistently higher at each time point than for MC, which indicates higher depressive symptoms among youth served in OCOF than those in MC.
- For both OCOF and MC, youths’ average anxiety scale scores (RCMAS) decreased at each time point from enrollment to 12 months, which indicates improvement of anxiety status in MC and OCOF. Also, levels of anxiety in these two SOCs were not in the clinically significant range at any time point.

Even though the context of services and needs are different, both SOCs appear to be having positive effects on their respective communities. The hard work of OCOF and MC also highlight what can be accomplished when communities work together, and, more importantly, collaborate with families and the systems that support them. A comprehensive understanding of how to best implement rural SOCs will likely be most clear in hindsight, emerging over time, as multiple local site-specific studies are published and examined (Anderson, 2000; Foster, Stephens, Krivelyova, & Gamfi, 2007; Knapp, 1995).
**INTRODUCTION**

In the children’s mental health and social services arena, interagency collaboration vis-à-vis systems of care (SOCs) has more than 30 years of practical support. An emerging evidence base highlights that when systems, agencies and families work together to coordinate services, outcomes can be expected to improve (Anderson & Mohr, 2003; Kutash, Duchnowski, & Friedman, 2005; Stroul & Friedman, 1986). From its inception, the SOC concept has focused on creating partnerships. Success has been noted in the collaborative relationships across child-serving agencies to improve outcomes, particularly for children and adolescents with serious emotional and behavioral challenges, but also in empowering families to lead programmatic decision making (Stroul, Blau, & Friedman, 2010). Even with this rich history, SOCs are in many ways a relatively recent phenomenon. They are highly context-specific and therefore require unique evaluative approaches that can account for differences both within and across specific sites. Moreover, some researchers are suggesting that sustaining and expanding SOCs will require incorporating a broad-based public health model that includes both prevention and intervention efforts (Anderson & Cornell, 2015; Miller, Blau, Christopher, & Jordan, 2012). Thus, it is important to continue studying how SOCs function, how they evolve, and how they are similar and different.

The purpose of this study was to examine two rural systems of care in terms of how they function and who they serve, as well as to identify and compare changes in the behavioral health of participants over time. Specifically, this study compared and contrasted the One Community One Family (OCOF) SOC in southeastern Indiana and the Madison CARES (MC) SOC in southeastern Idaho. By comparing these two systems of care, this study will help those involved to better understand and evaluate their service quality and make improvements in order to provide better service.

**METHOD**

**Study Design**

This study employed a multiple case study design utilizing mixed methods. Yin (2014) defined case study research as an “empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context” (p. 17). In addition, Yin (2014) indicates that a multiple case study design could help draw a single set of “cross-case” conclusions.

Consistent with multiple case study methods, the purpose of this study was not to generalize but to generate hypotheses and propositions for further inquiry (Yin, 1994). For this study, a case is defined as a SOC site. The first case is the One Community One Family (OCOF) SOC in southeastern Indiana. The second case is the Madison CARES (MC) SOC in southeastern Idaho. Qualitative and quantitative data from each case was first analyzed individually, and then a cross-case analysis was conducted to make comparisons in terms of key similarities and differences (Yin, 2014).

**Data Collection**

Both qualitative and quantitative data were collected within each case to contribute to an understanding of each system of care in terms of how it functions, whom it serves, and what changes occur in the behavioral health of participants over time.

Qualitative data for this study were collected primarily from two sources: OCOF and MC’s websites, and information requested from each SOC’s board members. The documents in this review included MC and OCOF’s strategic plans, mission, vision, goals, programs, and information on their websites. The purpose of the document review was to provide a rich
Quantitative data were collected as part of a federally required child and family Longitudinal Outcome Study (LOS) of systems of care. Every system of care that received federal funding was required to participate in the National LOS. Quantitative data were collected in a similar way at each SOC site to assure they were comparable and analyzable. The LOS was designed to longitudinally investigate the extent to which clinical changes in participating youths and their caregivers were observed over time in the program. Young people and their families who received services in the system of care community were informed about and invited to participate in this study. All data collected as part of the national LOS study were acquired through face-to-face interviews. During the interviews, participant responses were entered directly into a database and identified only by a participant number, utilizing a password-protected laptop used only by evaluation staff. The principal caregiver/parent and child interviews were conducted separately, and acquired information was kept confidential to the parent and the child. Youth, 11 or older, were eligible to complete the evaluation interview.

For MC, the SOC grant was funded from 2009-2015, while OCOF was funded from 2008-2014. Both SOCs began conducting interviews approximately 12 months after grants were awarded. Interview data were typically collected from participants (i.e., caregivers and youth of 11 years of age and older) at enrollment and every 6 months up to and including the 24-month mark. The protocol for the LOS is fairly extensive as demonstrated by the data derived from the instruments below. These instruments, provided by the federal evaluator, were used to offer individual/family level information about demographics and child and family functioning. The instruments (Center for Mental Health Services, 2010) utilized in this study are listed below; see Appendix D for more detailed information on each.

- Enrollment and Demographic Information Form (EDIF) Caregiver Information Questionnaire, Revised (CIQ-R) Caregiver strain questionnaire (CGSQ)
- Youth Services Survey (YSS)

**Data Analysis**

Each system of care was treated as an individual case. Both cases were analyzed such that both qualitative and quantitative data were examined. Qualitative document analysis was first conducted for each case, using a content analysis approach. Consistent with the content analysis approach, two researchers coded and organized qualitative documents into categories related to the study’s purpose (Bowen, 2009). The researchers met on a regular basis to pool judgment related to the construction of the categories used to answer the study’s questions. More specifically, the qualitative document analysis contributed to creating a detailed description of each system of care in terms of its mission, vision, how it functions, whom it serves, and its
various programs and services.

Next, within each individual case, quantitative data drawn from the national LOS study were analyzed to gain an understanding of the population served and improvements made over time. First, descriptive analyses were conducted in the following broad areas: 1) youth and caregiver demographic and enrollment information, 2) parent and caregiver profiles, and 3) child and youth clinical functioning at enrollment and at 6, 12, 18, and 24 months. After the preliminary descriptive analyses were completed, Chi-square tests were conducted to compare whether there were significant differences between each time point.

After analyzing the qualitative and quantitative data for each individual case, a cross-case analysis was conducted in which similarities and differences were examined across each case. First, qualitative similarities and differences were examined between cases. Then, Chi-square tests were conducted among the quantitative data to compare and contrast whether there were significant differences between cases.

**FINDINGS**

To reduce redundancy, this report first presents a rich description of each case yielded from the analysis of qualitative data. Next, the cross-case findings of the qualitative data are presented, which highlights key similarities and differences between each case in terms of vision, mission, principles, programs, and strategic plans. Last, the cross-case findings of the quantitative data are shared, which highlights similarities and differences in terms of the populations served and child and family functioning during the time in which the system of care was awarded the national system of care grant.

I. Madison CARES

Madison CARES (MC) is a community system of care designed to develop a mental healthcare system that works to improve services for families and their children. Similar to other systems of care, MC works to benefit all families in its community. The SOC is part of the Madison School District in Rexburg, Idaho. One of its goals is to encourage communication throughout different agencies. Figure 1 below presents its logic model.

**SOC definition.** MC defines “system of care” as “an organization whose goal is to maximize resources available, and employ those resources, in order to provide for the many needs of the families that live in the community” (Madison CARES, 2012).

In the definition, MC does not specify that its organization focuses only on children and youth with emotional, behavioral, and mental health needs. Its definition is broader, stating that it tries to meet “the many needs of the families that live in the community.” However, the vision and mission clearly show that MC indeed has a more focused interest in working to support the needs of youth and their families who experience mental health challenges.

**Vision and mission.** The MC system of care has a clearly stated vision and mission: “To strengthen our community by supporting youth and their families who experience mental health challenges to be successful at home, school, and in the community” (Madison CARES, 2012). The MC mission statement reads: “Through systems transformation, we will develop a comprehensive system of care that improves outcomes for Madison County’s youth and their families who experience mental health challenges” (Madison CARES, 2012). (Note: the researchers utilized the mission statement that was in use at the time of this study. Since that time, the MC mission statement has been updated).

**Goals, values, and motto.**

- “We are family-driven youth guided culturally & linguistically competent and
strength-based.”

- “We are respectful, responsible and ready.”
- “Through systems transformation, we will develop a comprehensive system of care that improves outcomes for Madison County’s youth and their families who experience mental health challenges.”
- “To strengthen our community by supporting youth and their families who experience mental health challenges to be successful at home, school, and in the community” (Madison CARES, 2012).

**Principles.** With the SOCs Individualized and Strength-Based Care principles in mind, Madison School District System of Care makes an effort to understand each family’s individual strengths and needs, and to incorporate them into its goals, in order to establish a proper network of care for the families and children it serves.

As a system of care, MC intends to expand its interagency collaboration. The MC staff value working together as a community because they believe it creates synergy, “the idea that together we can create something better than we ever could by ourselves” (Madison CARES, 2012). For example, the staff has a strong connection with Madison School District, which enables them to create programs, services, and address local issues together. One of their goals is to involve family and youth in as many aspects of the system of care as possible, because “Child and Family Services Reviews have experienced that families have had much more success when parents and youth were involved in the goal setting and planning process” (Madison CARES, 2012). In addition, they state that as they work “to explore options for people with different backgrounds, we increase our sense of respect for one another and feel a stronger sense of belonging” (Madison CARES, 2012). Staff work to find ways to utilize and promote the community’s resources and improve their programs and services to meet specific goals. They care about families in Madison County and have confidence that those in Madison County who need services will be able to find the help they need.

**Evaluation.** MC states its evaluation goal under its strategic plan and logic model (see Figure 1), which is relevant throughout the process and is continuum-based. Since receiving the grant in 2009, Dr. Eric Gee of Brigham Young University—Idaho, has served as the lead evaluator. The following is the stated goal for evaluation in Madison CARES:

**Goal 7:** Madison CARES will follow high-quality evaluation processes.

- **Outcome Objective 7.1.** Establish evaluation practices to ensure fidelity, ethical procedures, and family and youth involvement.
  - 7.1.1. Establish community and family-approved evaluations.
  - 7.1.2. Develop a local survey utilizing family and youth feedback.
  - 7.1.3. Train evaluators in quality assurance, confidentiality, cultural competence, and retention.
  - 7.1.4. Recruit local family and multilingual evaluators.
  - 7.1.5. Retain 50% of referred wraparound participants.
  - 7.1.6. Assist in evaluating and administering all survey material (Madison CARES, 2012).

**II. One Community One Family**

One Community One Family (OCOF) is southeastern Indiana’s local system of care partnership. In 2005, the One Community One Family partnership was established to provide a coordinated system of care to serve children and youth with emotional and behavioral health needs, along with their families. In the beginning of its formation, OCOF became a system of
care under the umbrella of the local community mental health center. However, since 2014, OCOF has been operating as its own nonprofit organization and as a system of care situated above other child-serving organizations. This was an important shift, as OCOF believed that separating itself from the community mental health center would better position it to serve the community.

SOC definition. OCOF defines a system of care as “a partnership of child-serving providers, families, youth and community members. This partnership comes together to meet the challenges of children and youth with emotional, behavioral and mental health needs along with the needs of their families. A system of care strives to help children, youth and families function better at home, in school, in the community and throughout life” (OCOF, 2016).

Vision and mission. OCOF has a clearly stated vision and mission. Its vision statement is: “All youth are happy, healthy and successful.” Its mission is: “A community partnership promoting an evidence supported System of Care approach that enhances the wellness of families and children” (OCOF, 2016).

Goals. Through a broad variety of activities, OCOF works to improve the community in order to positively impact all children and families in southeastern Indiana. The goals of the OCOF partnership have moved beyond a focus on wraparound to a broader focus, which includes the following:

- Family and youth empowerment, advocacy, and support throughout the lifespan;
- Facilitating and expanding interagency collaboration within and among communities in the region;
- Improving practices in K–12 and early childhood education;
- Disseminating information about trauma and trauma-informed care;
- Supporting the region to better address substance abuse;
- Providing training and consultation to providers and caregivers;
- Supporting partner agencies in system change and organization improvement efforts through grant writing, evaluation, and strategic planning;
- Inclusion of family voice in local, state, and national-level policymaking.
Core Principles and Values. The organization’s core principles are family-driven, youth-guided, community-based, culturally responsive, and trauma-informed. These core principles are defined on its website:

- **Family-Driven.** The services we provide are specialized to meet each family’s unique needs, and families are the experts in regards to their children. The family voice is evident in how services and policies are designed.
- **Youth-Guided.** The youth we serve have an important voice in their care as well as in how services and policies are designed.
- **Community-Based.** We believe in the importance of incorporating community
into a family’s care. Children experience better long-term outcomes if they are a part of their communities.

- **Culturally Responsive.** We strive to meet the needs of our diverse community and the importance of each family’s individual culture.
- **Trauma-Informed.** We understand the role that trauma plays in the lives of families and how this affects their lives.

**Evaluation.** OCOF places great emphasis on evaluation as a part of its commitment to quality. In its SOC goals, OCOF has a separate goal for evaluation, which reads, to “ensure quality evaluation and continuous quality improvement in order to truly improve and meet the goals of a system of care.” Its website also includes a separate page about evaluation, which provides past and current evaluation data as well as the results of national and local evaluations. OCOF’s efforts are evaluated by external evaluators, which are the Collaborative Research Initiative (CRI) at Indiana University led by Drs. Jeff Anderson and Allison Howland, and the FoCuS team that is also led by Dr. Jeff Anderson.

**III. Qualitative Cross-Case Comparison**

In general, MC and OCOF’s principles, goals, mission, and vision are similar. One difference is that OCOF includes “Trauma-Informed” in its core principles and applies this principle throughout its activities, such as conferences, meetings, trainings, and webinars, while MC does not.

In terms of how “system of care” is defined, OCOF and MC use similar definitions that share the same intent. Although OCOF’s description of SOC is more comprehensive, including its partnerships in the definition, both organizations’ definitions convey the same purpose. In addition, their purposes are similar to the SOC definition originally articulated by Stroul and her colleagues in 1986.

In these descriptions, MC does not specify that it focuses only on children and youth with emotional, behavioral, and mental health issues. Rather, its definition is broader, stating that it strives to meet “the many needs of the families that live in our community.” However, its vision and mission clearly show that MC is working with youth and their families who experience mental health challenges.

**Strategic plans.** The strategic plans (see Appendix A and B) of MC and OCOF were found to have similar goals and outcome objectives. The major differences in their strategic plans are as follows:

1. While MC tries to maintain at least 80% fidelity to the wraparound model, OCOF’s focus has been to move from wraparound to interagency collaboration and to serve all children and youth, not just those experiencing emotional and behavioral challenges.
2. While its focus is on children with emotional/behavioral challenges, MC also offers several services that go further (e.g., Madison County Youth group, social media campaigns, community events, supporting schools to implement PBIS).
3. OCOF provides a statewide systems of care conference, which has been awarded a contract by Division of Mental Health and Addiction (DMHA).
4. OCOF supports the efforts of United Families in providing education and support to families.
5. OCOF provides trainings and has certified trainers in Bridges Out of Poverty, Crisis Prevention Interventions, Trauma-Informed Approaches, and Mental Health First Aid. OCOF supports the development of the Tristate Trauma Network organization through consultation, fiscal management, and other supports.

6. MC has the following programs and events: Madison County Welcome Baby Packet, English as a Second Language Classes, Madison County Latino Parent Meetings, Madison County Block Parties, and Mental Health Regional Summit (see Appendix C for definitions).

7. OCOF has a partnership with three states, which are Kentucky, Ohio, and Indiana.

8. MC has the following goal: “Using system of care core values and principles, implant a unified social and emotional support system through Response to Intervention (RTI), Positive Behavioral Interventions and Supports (PBIS) and other models.”

Programs. OCOF does not provide detailed information about its programs on its website, but MC states all of its programs’ purposes, descriptions, and schedules (see Appendix C under “Programs,” “Events,” and “Campaigns”). However, OCOF does provide detailed information about its programs related to Parent Coaching and Project LAUNCH. OCOF states that it offers a Parent Coaching program, which is under Incredible Years. The parent coaches help families find needed resources and offer free group workshops based on the Incredible Years curriculum to all caregivers with children between the ages of 0 months and 6 years.

OCOF also has a Baby Group for the prenatal population. Further, OCOF partners with Project LAUNCH, which is “intended to improve the overall wellness of young children birth–8 years old and is administered by the Indiana State Department of Health in partnership with the Indiana Division of Mental Health and Addiction.”

OCOF’s implemented practices include:
- Wraparound
- TIP
- United Families
- FIRE
- Incredible Years

The Transition to Independence Process (TIP). TIP model was developed for working with youth and young adults (17-25 years) with emotional/behavioral difficulties (EBD) to:

- Engage youth in their future planning process.
- Provide youth with developmentally appropriate, non-stigmatizing, culturally competent, and appealing services and supports.
- Involve youth and their families and other key players in a process that prepares and facilitates them toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains.
  1. Employment/career
  2. Educational opportunities
  3. Living situation
  4. Personal effectiveness and wellbeing
  5. Community-life functioning transition
Finding Improvement by Reaching Empowerment (FIRE). FIRE was initiated by OCOF but is now housed under the Community Mental Health Center. It has been dedicated to empowering at-risk youth to self-advocate in their community for social change involving mental health awareness and service provision since 2010. FIRE employs several young adult staff members trained as peer support specialists who provide one-on-one peer support to youth. These support services are open to youth receiving services at CMHC, with a target age range of 13 to 25 years.

Table 1
Madison CARES program and events

<table>
<thead>
<tr>
<th>Programs</th>
<th>Events</th>
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<tbody>
<tr>
<td>● Parents As Teachers Program (PAT)</td>
<td>● Celebrate Youth</td>
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<tr>
<td>● Wraparound</td>
<td>● Madison County Block Parties</td>
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<tr>
<td>● Parenting Classes</td>
<td>● Mental Health Regional Summit</td>
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<tr>
<td>● Madison County Welcome Baby Packet</td>
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<tr>
<td>● Governance Board</td>
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<tr>
<td>● English as a Second Language Classes</td>
<td></td>
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<tr>
<td>● Madison County Latino Parent Meetings</td>
<td></td>
</tr>
</tbody>
</table>

IV. Quantitative Cross-Case Comparison
A. Demographic and enrollment information.

Age, gender, and race. Table 2 highlights findings related to age, gender, and race for both OCOF and MC. From October 2008 to May 2015, 718 families enrolled in the OCOF system of care. The majority of youth enrolled in OCOF were male (60.3%, n = 433).

Additionally, the majority of the youth were identified as Caucasian (98.2%). The mean age of the respondents was 12.03 years old (SD = 5.49), and age ranged from 1 to 25 years. This table includes all of the families that were ever in contact with OCOF, even if they never officially enrolled in the National Longitudinal Outcomes Study (LOS). Of these 718 families, 178 participated in the study and had been assessed every six months during the service period.

From November 2010 to February 2015, 891 families had entered MC. There were 476 (53.4%) males and 415 (46.6%) females in MC. Similar to OCOF, 92.7% participants in MC identified themselves as Caucasian. The average age of young people who participated in MC was 5 years, and the age range was 1 year to 21 years (see Figure 3). A total of 177 families participated in the LOS and were assessed every six months since enrollment.

Thus, race and gender distributions were similar across both SOCs. In contrast, the age distribution differed between the SOCs. Almost all of the participants were Caucasian in both SOCs. Although the male proportion in OCOF was higher than in MC, male participants accounted for the majority of participants in both SOCs. MC serves younger children, as most of its clients (72.4%) were in the aged 0–5 age group. These clients (0-5 years of age) were served
by the Parents As Teachers (PAT) program, and do not necessarily have a diagnosable Mental Health (MH) disorder. Although families completed the EDIF, most did not participant in the LOS. However, the PAT program is a subdivision of MC—PAT; employees generally report only to the head of PAT program, who is an employee of MC.

On the other hand, the majority of OCOF participants (80.6%) were 6–18 years old. As expected, at the time of enrollment, the mean age of participants in MC was 5 years, substantially lower than the average age of participants in OCOF, which was approximately 12 years (see Figure 3).

Diagnostic categories. With regard to mental health diagnosis, at enrollment in OCOF, the majority of young people (29.4%) had been diagnosed with a Conduct Disorder, followed by Mood Disorder (20.2%), ADHD (18.4%), and Anxiety Disorder (14.1%). In MC, the majority of young people (25.8%) have a primary diagnosis of Mood Disorder, followed by Anxiety Disorder (21.2%), ADHD (20.3%), and Conduct Disorder (13.8%).

Family structure. At the time of enrollment in OCOF, 66% of youth were living with a biological parent or parents; 17% of youth were living with a grandparent(s); and 11% of youth were living with other caregivers. For MC, more youth (86.0%) were living with a biological parent or parents, only 2.9% of youth were living with a grandparent(s), and 0.6% of youth were living with other caregivers. Thus, in contrast, a higher percentage of children in MC lived with their biological parent(s) than the children in OCOF.

Caregiver substance dependence or abuse. In OCOF, 20.3% (n = 144) of the youth had mothers who were dependent on substances, were abusing substances, or had a history of substance dependence or abuse, and 14.2% (n = 101) of youth had fathers with similar problems. In MC, these two proportions were significantly lower than in OCOF (4.4% and 6.3%), ($\chi^2=54.29$, $p < .001$; $\chi^2=16.60$, $p < .01$). This result indicates that at enrollment, caregivers in
OCOF have more significant needs than those in MC, in terms of substance dependence or abuse.

**Maternal depression.** In OCOF, 17.2% (n = 122) of youth had mothers who indicated they were experiencing depression at enrollment. This is significantly lower ($\chi^2 = 12.79, p < .001$) than the percentage of mothers who indicated experiencing depression at enrollment into MC (26%, n = 111)

### Table 2
**Frequencies, percentages, and Chi square comparisons of OCOF and MC participants on demographic information**

<table>
<thead>
<tr>
<th></th>
<th>OCOF</th>
<th>MC</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>$\chi^2=563.13$ (p &lt; .01)</td>
</tr>
<tr>
<td>0-5</td>
<td>89 (12.4%)</td>
<td>627 (70.4%)</td>
<td></td>
</tr>
<tr>
<td>6-18</td>
<td>543 (75.6%)</td>
<td>258 (29.0%)</td>
<td></td>
</tr>
<tr>
<td>19-25</td>
<td>86 (12.0%)</td>
<td>6 (0.7%)</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td>$\chi^2=7.67$ (p &lt; .01)</td>
</tr>
<tr>
<td>Male</td>
<td>433 (60.3%)</td>
<td>476 (53.4%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>285 (39.7%)</td>
<td>415 (46.6%)</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td>$\chi^2=31.16$ (p &lt; .05)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>705 (98.2%)</td>
<td>826 (92.7%)</td>
<td></td>
</tr>
<tr>
<td>Black or African American</td>
<td>3 (0.4%)</td>
<td>15 (1.7%)</td>
<td></td>
</tr>
<tr>
<td>American Indian or Alaska</td>
<td>0 (0%)</td>
<td>2 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>Native</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>0 (0%)</td>
<td>2 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>Japanese</td>
<td>0 (0%)</td>
<td>3 (0.3%)</td>
<td></td>
</tr>
<tr>
<td>Korean</td>
<td>0 (0%)</td>
<td>1 (0.1%)</td>
<td></td>
</tr>
<tr>
<td>Multi-race</td>
<td>2 (0.3%)</td>
<td>22 (2.5%)</td>
<td></td>
</tr>
<tr>
<td>High-risk environment for mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maltreatment</td>
<td>163 (22.9%)</td>
<td>15 (3.5%)</td>
<td>$\chi^2=76.19$ (p &lt; .01)</td>
</tr>
<tr>
<td>Maternal substance abuse/use</td>
<td>144 (20.3%)</td>
<td>19 (4.4%)</td>
<td>$\chi^2=54.29$ (p &lt; .01)</td>
</tr>
<tr>
<td>Paternal substance abuse/use</td>
<td>101 (14.2%)</td>
<td>27 (6.3%)</td>
<td>$\chi^2=16.60$ (p &lt; .01)</td>
</tr>
<tr>
<td>Homelessness</td>
<td>60 (8.4%)</td>
<td>10 (2.3%)</td>
<td>$\chi^2=17.18$ (p &lt; .01)</td>
</tr>
</tbody>
</table>

*Note. For OCOF, N=718; For MC, N=891.*
**Maltreatment and homelessness.** At enrollment, nearly a quarter (22.9%) of youth from OCOF had experienced maltreatment (defined as child abuse or neglect), but the proportion in MC (3.5%) was significantly lower ($\chi^2 = 76.19, p < .01$). In addition, 8.4% (n = 60) families were at risk for homelessness in OCOF, while only 2.3% (10) families had the similar issues in MC ($\chi^2=17.18, p < .01$). This information, in combination with the above information related to substance dependence and abuse, indicates that youth enrolled in OCOF are living in environments that are known to put youth at risk for mental health-related challenges.

**B. Parent and Caregiver Profiles.**

This section summarizes the demographic information for caregivers of youth enrolled in each SOC that participated in the National Longitudinal Outcomes Study (LOS). The caregivers’ information was taken from the Caregiver Information Questionnaire, Revised (CIQ–R). In addition, caregiver strain was analyzed over time, and this data was collected using the Caregiver Strain Questionnaire (CGSQ) at enrollment and at 6, 12, 18, and 24 months.

**Caregiver gender, age, and race.** For OCOF, 13 (10.2%) male and 114 (89.8%) female caregivers participated in the LOS. At the time of enrollment in OCOF, most caregivers reported being in the 25–40 (50.4%) and 40–60 (35.5%) age categories, respectively (see Figure 4). Fewer than 5% of caregivers reported being younger than 25, and 9.4% of caregivers reported being older than 60. For the MC, 18 (10.5%) male and 154 (89.5%) female caregivers participated in this study. A total of 62.7% of caregivers were in the 25–40 age group, and 31.4% of caregivers were in the 40–60 age group (see Figure 4). Only .6% of caregivers were older than 60. Most caregivers in these two sites identified as being from a Caucasian background (98.2% for OCOF; 92.7% for MC).

**Education level.** For OCOF, approximately 62% of caregivers reported that their highest education level was high school, 9% had associate degrees, 24% went to college but did not have degrees, 5% held bachelor’s degrees, and only 1% had master’s degrees. For MC, 67.4% of...
caregivers had a bachelor’s degree and 27.9% of caregivers selected high school as their highest education level. According to Figure 5, the highest education level for the majority of caregivers from OCOF was secondary school while most caregivers from MC had received bachelor’s degrees.

Figure 5. Caregiver education level of two SOCs. For OCOF, N=127; For MC, N=172.

**Income.** In OCOF, most families (80.6%) reported a household income below $35,000. Approximately 16% of caregivers reported earning less than $5,000 annually, while slightly less than 10% reported earning more than $50,000. However, for MC, most families (47.6%) reported household incomes above $35,000 a year. Approximately 8.4% of caregivers reported earning less than $5,000 annually, while 34.3% reported earning more than $50,000 each year (see Figure 6).

Figure 6. Caregiver income level of two SOCs. For OCOF, N=124; For MC, N=166.

**Caregiver strain.** Caregiver strain refers to the special demands associated with caring for a child with emotional and behavioral challenges. This information was taken from the Caregiver Strain Questionnaire (CGSQ), which was administered at enrollment and every 6 months until the participant’s exit from the program. The average strain scores for both OCOF
and MC decreased at each time point. Additionally, at each time point, the level of strain experienced by caregivers in MC was lower on average than the strain experienced by caregivers in OCOF (see Table 3).

<table>
<thead>
<tr>
<th>Table 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Strain for MC and OCOF</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Objective</strong></td>
</tr>
<tr>
<td>OCOF</td>
</tr>
<tr>
<td>MC</td>
</tr>
<tr>
<td><strong>Subjective-externalizing</strong></td>
</tr>
<tr>
<td>OCOF</td>
</tr>
<tr>
<td>MC</td>
</tr>
<tr>
<td><strong>Subjective-internalizing</strong></td>
</tr>
<tr>
<td>OCOF</td>
</tr>
<tr>
<td>MC</td>
</tr>
<tr>
<td><strong>Global</strong></td>
</tr>
<tr>
<td>OCOF</td>
</tr>
<tr>
<td>MC</td>
</tr>
</tbody>
</table>

*Note.* Sample sizes became smaller over time. For OCOF: Enrollment (N=133); 6 months (N=66); 12 months (N=43); 18 months (N=36); 24 months (N=29). For MC: Enrollment (N=173); 6 months (N=128); 12 months (N=87); 18 months (N=51); 24 months (N=35).

**Satisfaction with services.** The Youth Services Survey (YSS) was administered to youth and their caregivers at 6, 12, 18, and 24 months to assess their perceptions of system of care service experiences. Satisfaction with service is one of the most important components measured by this instrument. A score of equal to or greater than 4 indicates that the respondent is satisfied with the service. Table 4 highlights satisfaction scores for both MC and OCOF, indicating that on average at each time point, participants were satisfied with their services. The only time point with a score under 4.0 was that of 6 months for OCOF’s caregivers. For OCOF, youths tended to have a higher level of satisfaction than their caregivers at all time points. For MC, caregivers tended to report a higher level of satisfaction than their children. When comparing the satisfaction trends between these two sites, youths in OCOF always reported higher satisfaction than MC’s participants, but caregivers in OCOF tended to reported lower satisfaction than caregivers in MC at all time points. Potentially, this can be due to the fact the youth in the OCOF case were older and had a higher level of difficult behaviors which could lead to a more challenging environment for the caregiver.
Table 4
Service Satisfaction for MC and OCOF

<table>
<thead>
<tr>
<th></th>
<th>6 Months</th>
<th>12 Months</th>
<th>18 Months</th>
<th>24 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>4.19</td>
<td>4.23</td>
<td>4.39</td>
<td>4.54</td>
</tr>
<tr>
<td>MC</td>
<td>4.11</td>
<td>4.09</td>
<td>4.30</td>
<td>4.37</td>
</tr>
<tr>
<td><strong>Caregiver</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>3.88</td>
<td>4.23</td>
<td>4.08</td>
<td>4.04</td>
</tr>
<tr>
<td>MC</td>
<td>4.22</td>
<td>4.22</td>
<td>4.19</td>
<td>4.40</td>
</tr>
</tbody>
</table>

Note. This figure does not include information at enrollment. It is not reasonable to report satisfaction data at baseline since respondents would not have been previously involved with system of care services. For OCOF, Sample sizes for youth: 6 months n=31; 12 months n=27; 18 months n=22; 24 months n=17. Sample sizes for caregivers: 6 months n=65; 12 months n=41; 18 months n=34; 24 months n=25. For MC, Sample sizes for youth: 6 months n=41; 12 months n=32; 18 months n=18; 24 months n=12. Sample sizes for caregivers: 6 months n=120; 12 months n=77; 18 months n=40; 24 months n=30.

C. Child and Youth Clinical Functioning.

Child Behavior Checklist (CBCL). Tables 5 and 6 summarize children’s symptomology from enrollment to 12 months for both OCOF and MC. Lower values indicated better clinical functioning. Scores below 60 are considered to be within the normal range, scores between 60 and 65 are considered “borderline,” and scores above 65 are considered to be clinical in that they signal problematic behaviors that require intervention. The average score for both OCOF and MC decreases at each time point. For children between 1.5 and 5 years old, the only scores in the clinical range are scores at enrollment for OCOF. In addition, OCOF participants consistently have higher scores than youth enrolled in MC. This indicates that, on average, participants in OCOF are considered to have more emotional and behavioral challenges than MC participants.

Table 5
CBCL scores for OCOF and MC (1.5-5 age group)

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Internalizing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>68.81</td>
<td>62.93</td>
<td>n&lt;10</td>
</tr>
<tr>
<td>MC</td>
<td>60.70</td>
<td>59.90</td>
<td>59.29</td>
</tr>
<tr>
<td><strong>Externalizing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>70.93</td>
<td>61.71</td>
<td>n&lt;10</td>
</tr>
<tr>
<td>MC</td>
<td>64.51</td>
<td>62.83</td>
<td>61.08</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>71.30</td>
<td>63.79</td>
<td>n&lt;10</td>
</tr>
<tr>
<td>MC</td>
<td>63.81</td>
<td>62.66</td>
<td>61.25</td>
</tr>
</tbody>
</table>


21
Table 6  
CBCL scores (6-18 age group)

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>6 months</th>
<th>12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internalizing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>67.52</td>
<td>67.21</td>
<td>64.79</td>
</tr>
<tr>
<td>MC</td>
<td>64.50</td>
<td>62.43</td>
<td>59.70</td>
</tr>
<tr>
<td>Externalizing</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>70.44</td>
<td>69.27</td>
<td>68.54</td>
</tr>
<tr>
<td>MC</td>
<td>62.22</td>
<td>60.56</td>
<td>55.91</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>71.35</td>
<td>70.81</td>
<td>69.79</td>
</tr>
<tr>
<td>MC</td>
<td>65.37</td>
<td>63.62</td>
<td>59.33</td>
</tr>
</tbody>
</table>

Note. For OCOF, Enrollment: N=104; 6 Months: N=52; 12 Months: N=39; For MC, Enrollment: N=137; 6 Months: N=100; 12 Months: N=64.

Behavioral and Emotional Rating Scale (BERS). The BERS measures the emotional and behavioral strengths of children and youth. Table 7 highlights the perceptions parents have about their children’s strengths. Table 8 highlights the perceptions youth have about their own emotional and behavioral strengths. A score between 8 and 12 is considered to be within the average range, with lower scores indicating lower strengths. Parents in MC consistently rated their child’s strengths higher than caregivers in OCOF. However, for the youth-rated scores, there is no clear difference between OCOF and MC.

Table 7  
Comparison of BERS-Parent Scores

<table>
<thead>
<tr>
<th></th>
<th>Enrollment</th>
<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Strength</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>6.00</td>
<td>6.40</td>
<td>6.63</td>
<td>7.46</td>
</tr>
<tr>
<td>MC</td>
<td>7.51</td>
<td>8.13</td>
<td>8.87</td>
<td>9.45</td>
</tr>
<tr>
<td>Family Involvement</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>6.65</td>
<td>7.04</td>
<td>8.05</td>
<td>7.54</td>
</tr>
<tr>
<td>MC</td>
<td>7.89</td>
<td>8.32</td>
<td>8.89</td>
<td>9.21</td>
</tr>
<tr>
<td>Intrapersonal Strength</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>6.89</td>
<td>7.12</td>
<td>8.02</td>
<td>7.83</td>
</tr>
<tr>
<td>MC</td>
<td>7.56</td>
<td>7.69</td>
<td>8.73</td>
<td>9.06</td>
</tr>
<tr>
<td>School Functioning</td>
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<td></td>
</tr>
<tr>
<td>OCOF</td>
<td>6.58</td>
<td>7.31</td>
<td>6.76</td>
<td>7.16</td>
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<tr>
<td>Strength</td>
<td></td>
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<tr>
<td>MC</td>
<td>7.38</td>
<td>7.44</td>
<td>7.87</td>
<td>8.15</td>
</tr>
</tbody>
</table>

Table 8
Comparison of BERS-Youth Scores

<table>
<thead>
<tr>
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<th>6 months</th>
<th>12 months</th>
<th>18 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Strength</td>
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<td>9.57</td>
<td>10.66</td>
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</tr>
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<td></td>
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<td>10.22</td>
<td>10.67</td>
<td>10.97</td>
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<td>Family Involvement</td>
<td>OCOF</td>
<td>8.79</td>
<td>9.77</td>
<td>9.75</td>
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<td></td>
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<td>9.56</td>
<td>10.56</td>
<td>10.20</td>
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<tr>
<td>Intrapersonal Strength</td>
<td>OCOF</td>
<td>9.46</td>
<td>10.31</td>
<td>10.48</td>
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<td></td>
<td>MC</td>
<td>8.82</td>
<td>9.53</td>
<td>9.83</td>
</tr>
<tr>
<td>School Functioning Strength</td>
<td>OCOF</td>
<td>8.26</td>
<td>9.14</td>
<td>9.52</td>
</tr>
<tr>
<td></td>
<td>MC</td>
<td>8.48</td>
<td>9.58</td>
<td>9.66</td>
</tr>
</tbody>
</table>


Columbia Impairment Scale (CIS). The Columbia Impairment Scale (CIS) measures behavioral functioning. Scores above 15 are generally considered as indicating clinical levels of concern. The average scores on the CIS decreased at each time point. The CIS total average score for MC was consistently lower than the score for OCOF, indicating that OCOF participants have higher levels of impairment than MC participants. In addition, it is important to note that the average scores at each time for both MC and OCOF were still within the range that indicates clinical levels of concern.

Figure 7. Comparing CIS total score. For OCOF, Enrollment: N=131; 6 Months: N=62; 12 Months: N=44; For MC, Enrollment: N=167; 6 Months: N=127; 12 Months: N=88.
**Reynolds Adolescent Depression Scale (RADS-2).** The RADS-2 is used to screen for the presence and severity of depressive symptoms in young people between 11 and 20 years of age. Scores below 61 are considered average, and scores over 61 indicate depression. The average scores for OCOF and MC at all time points are below 61, which indicates that depression is not a clinical area of need in either SOC. Nonetheless, the average score for OCOF was consistently higher at each time point than for MC, which indicates a higher level of depressive symptoms among youth served in OCOF than those in MC (see Figure 8).

![Figure 8](image)

*Figure 8. Comparing RADS-2 score. For OCOF, Enrollment, n = 85, 6 months, n = 35, 12 months, n = 29, 18 months, n = 26, 24 months, n = 18; For MC, Enrollment, n = 71, 6 months, n = 46, 12 months, n = 36, 18 months, n = 21, 24 months, n = 16.*

**Revised Children’s Manifest Anxiety Scale, second edition (RCMAS-2).** Data about levels of anxiety were also collected using the Revised Children’s Manifest Anxiety Scale (RCMAS-2), a brief self-reporting inventory measuring anxiety in 6- to 19-year-olds. A score of 50 is considered average, and scores above 60 suggest that anxiety may be clinically significant. For both OCOF and MC, youths’ average anxiety scale scores decreased at each time point from enrollment to 12 months post-enrollment. Again, levels of measured anxiety in both MC and OCOF were not in the clinically significant range at any time point (see Figure 9).
DISCUSSION

A higher percentage of children in MC lived with their biological parent(s) as compared to children in OCOF. This may be a function of the average age of participants, as MC appeared to serve younger children. Additionally, as compared to MC, families in OCOF experienced greater numbers of risk factors and fewer protective factors. Indeed, analyses indicated that a greater percentage of children in OCOF were living in high-risk environments (e.g., maltreatment, parental substance abuse, homelessness) as compared to MC. As might be expected, caregivers in MC presented with lower levels of caregiver strains. Moreover, children in OCOF tended to have more problems with behavior and emotional functioning, as measured by the CBCL, BERS, CIS, as compared to children in MC. This is not surprising given that more externalizing behavior problems in children have been shown to be a strong predictor of caregiver strain (Wang & Anderson, 2016).

In this study, although there were some differences in symptomology, participants in both SOCs tended to improve over time. Moreover, other findings appear to make sense when the specific context of each SOC is considered. For example, the higher caregiver strain observed in OCOF as compared to MC, becomes clear given the increased number of risk factors (substance abuse, lower income, etc.); this could also explain higher prevalence of behavioral challenges as noted in the CBCL and BERS. On the other hand, the higher RADS scores observed in MC is compatible with the data given that more youth participants have been diagnosed with mood disorders at baseline.

Limitations

For several reasons, readers are encouraged to interpret the findings from this preliminary comparison study of two rural SOCs with some caution. First, this study did not necessarily examine the many possible variables that might have contributed to these findings. Second, the
data used in this study came from the LOS and examination of public documents. Thus, it is possible that important information was missed which might have added contextual clarity to the similarities and differences between the two SOCs that have been highlighted in this study.

**Conclusion**

Still, in spite of these limitations, the study offers a number of interesting and potentially important insights about these two communities as well as for the national SOC movement. Even though the context of services and needs are different, both SOCs appear to be having positive effects on their respective communities. Both have similar visions of supporting youth and families across home, school, and community, reminding us of the importance of the maxim that it takes a village to fully support and raise children to become healthy adults. The hard work of MC and OCOF also highlight what can be accomplished when communities work together and more importantly, collaborate with families and the systems that support them. Findings suggest that earlier intervention is important and reinforce how potentially devastating poverty can be for families, particularly when children are experiencing serious mental challenges. We also are reminded that, although internalizing behaviors can be difficult to detect, MC appears to be successfully identifying children with these “invisible” behaviors. In closing, we note that although poverty, as well as average age at enrollment, might explain at least some of the differences identified between MC and OCOF, we also acknowledge that overall, this study has not examined the critically important “why questions.” Thus, we end this document, as do all good social scientists, indicating the need for more and better research to fully tease out the important causes for the similarities and differences in functioning and outcomes of two well developed rural systems of care. Comprehensive understandings of how to best implement rural SOCs will likely be most clear in hindsight, emerging over time, as evidence from multiple local site-specific studies are published and examined (Anderson, 2000; Foster, et al., 2007; Knapp, 1995).

We end with a set of questions for the SOC field:

- How do we spur all of the necessary child-serving systems and agencies to commit to operating within an SOC network at the community level? And how can such partnerships be sustained over time once created?
- What are the specific steps and activities that SOCs are taking to systematically identify gaps and needs in the community?
- How is the mental wellness of an overall community enhanced, measured, and monitored over time?
- How are data-driven action plans created and implemented at the community/systems level and across agencies?
- How might SOCs be supported to learn from each other and how can such learning to be used to more quickly inform policymakers?
REFERENCES


457. http://dx.doi.org/10.1016/S0887-6185(01)00075-5
APPENDIX A
OCOF Strategic Plan (From 2012)

Purpose
The Community Mental Health Center (CMHC), on behalf of the Governance Board of the One Community, One Family Partnership (OCOF), has requested a statement of work that describes what it would look like to continue strategic planning with the assistance of Sightlines Group (SLG).

The work we have done over the past ten months has taken an inside-out approach. When we started, the concepts of Wraparound care, Systems of Care, and OCOF were indistinct although they were already starting to become clearer. As we separated them out and the role of OCOF became clearer, the pathway to sustainability became apparent. OCOF would act as a forum for the community of providers and as an agent to continuously move the system of care forward toward our ideals. OCOF had formed a strategic planning committee which, in its commitment and level of engagement, is now moving closer to being an executive committee of the board of OCOF. OCOF staff have begun to craft clear descriptions of what they will be able offer, on a contract or fee-for-service basis, to the community and the state.

If the first phase of our work was about identifying and clarifying the value we have created, the second phase of our work is about formalizing it and moving that value out into the community to ensure we are in a position to not only sustain, but to lead.

Over the next few years, this region and the state will work through several challenges. The Affordable Care Act will roll-out in some fashion; the state will decide high level priorities in how it spends the Block Grant; there may be a new administration with new guidance to state agencies; and new, potentially large institutions may move into our region with their own sets of priorities and approaches to mental and behavioral health.

We are fortunate to be this far ahead. If we continue on the path we are on, we can use the final few years of the grant to emerge in a position to provide leadership locally and statewide in how these scenarios unfold. And we can do so in a way that not only sustains the value we have created for our youth and families here, but sustains each of us as providers.

This point in any strategic planning process can feel a bit overwhelming. Because we’ve made progress, we’ve opened up insight into how much more we can do and how different the future may look. My promise as a steward of this process is to ensure we remain focused and vigilant with regard to our long-term aspirations, and to ensure we take meaningful steps each month.
OCOF Partners have described where they want to be by the end of the grant, September 30, 2014.

As the graphic on the left shows, these goals fit into 4 broad categories:

- **Our house is in order**
  These goals relate to the structure and operations of the OCOF Partnership.

- **The SOC realizes outstanding results**
  These goals relate to the quality and costs of our system of care.

- **Our stakeholders understand our impact**
  These goals relate to telling our story and demonstrating our relevance.

- **The partnership provides leadership**
  These goals relate to our partners providing leadership in decision making about mental and behavioral health, and wellness generally.

In the chart that follows, each goal is listed along with its present status and possible next steps. We can ask the committee to help rank order goals and use that to form our work plan for the
remainder of the year. This statement of work assumes roughly the same level of support as last year in terms of trips and work between trips.

**Our house is in order**

These goals relate to the structure and operations of the OCOF Partnership.

<table>
<thead>
<tr>
<th>Our goal by the end of the grant</th>
<th>Present status</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 OCOF Partnership has assumed an organizational form and legal structure that is consistent with its long-term goals and values</td>
<td>Created a 2-pager to share with the attorney that includes our mission, objectives, and questions we have.</td>
<td>Work with Attorney to identify a list of the questions she thinks we need to have answers to in order for her to help us select an appropriate organizational form and to have what we need for a successful application to the IRS and other institutions. Then, explore those questions with the committee</td>
</tr>
<tr>
<td>2 United Families and FIRE have clarified their role and assumed an organizational form and legal structure that ensures authentic family and youth involvement in the system of care</td>
<td>Brenda and I have culled the top questions regarding UF and FIRE and can use it as we begin strategic planning.</td>
<td>Tom and Julia would like to put a call out to form another committee for UF/FIRE strategic planning. The process can begin with a focused set of questions based on work done to date.</td>
</tr>
<tr>
<td>3 OCOF Partnership’s governance and staffing structures are clear, including the role of the board, committees, and leadership</td>
<td>We have had several staff retreats; working on envisioning staff roles going forward and helping them communicate their changing roles to the community</td>
<td>Working in bringing staff into the strategic planning process and communicating more with them about our work</td>
</tr>
<tr>
<td>4 OCOF has marketing materials and internal manuals and guidelines describing the array of services it can offer the community, state, and beyond</td>
<td>Based on the two staff retreats in Nov. and Dec. we got a good start on OCOF’s <em>Technical Assistance and Change Initiatives Handbook</em> (In Google Docs).</td>
<td>Brenda and Chris are continuing here.</td>
</tr>
</tbody>
</table>
5 Partners’ relationships to OCOF are clear, including opportunities for or requirements of general or specific financial support and what that support buys them

6 Individual partners are strong and secure; and are contributing to the SOC in a way that best utilizes their unique capacities

We began partner presentations and this seemed to generate new information for partners about how they could help one another, and a lot of good will.

Brenda and Chris are taking what came up in these presentations and adding it to the list of what OCOF can do for its partners (e.g. one thing that came up a lot is how

7 Additional partners are involved from systems such as Justice and Education; we have settled on our geographic scope

Move forward with meetings with these partners (e.g. how is it going meeting with Judges we identified?)

The system of care realizes outstanding results at low costs

These goals relate to the quality and costs of our system of care.

<table>
<thead>
<tr>
<th>Our goal by the end of the grant</th>
<th>Present status</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 Improvement in access to services</td>
<td>Early on in strategic planning we identified our vision for the continuum of care we want to see in the SOC (this is in the Mind Map). We can come back to it as OCOF chooses where to deploy staff in change initiatives that build out and improve the SOC.</td>
<td>Goal for 2012 is to get Governance more involved in change initiatives. The Technical Assistance and Change Initiatives Handbook suggests ways to do this.</td>
</tr>
<tr>
<td>9 Improvement in service quality (more alignment with SOC values and principles), the continuity of care, and lowering of costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Improvements in authentic family and youth involvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The partnership provides leadership in decisions affecting our region
These goals relate to our partners providing leadership in decision-making about mental and behavioral health, and wellness generally.

<table>
<thead>
<tr>
<th>Our goal by the end of the grant</th>
<th>Present status</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 We have several presentation tools including: graphical (e.g., Prezi); chart/tables with data; and a narrative</td>
<td>We created the FAQs and ‘circle diagram’ which were a success; we are working on an update which includes more information.</td>
<td>Stay in touch with the EAB to ensure the study will meet our needs.</td>
</tr>
<tr>
<td>These tools enable our partners to demonstrate: *Our outcomes and costs as compared with other models of care *Key values and concepts we use *The expertise, value, and role of each of the OCOF partners</td>
<td>Brenda would like to keep this diagram as a branding and marketing item unique to OCOF – to be shared widely, but always credited to OCOF.</td>
<td></td>
</tr>
<tr>
<td>14 Partners have formal roles in decision-making committees from the local to state level</td>
<td>How can we secure greater participation in regional and state committees? Which decision-making bodies are most important?</td>
<td></td>
</tr>
<tr>
<td>15 Partners have informal relationships of trust and dynamic exchange of ideas with key decision makers</td>
<td>We began asking partners to list relationships they can continue to build. We can pick this up again.</td>
<td>For example, how do we form relationships with St. E’s decision makers?</td>
</tr>
</tbody>
</table>
In their Strategic Plan Document, they have 7 goals listed, each has outcome objectives.

**Goal 1**: Transform fragmented services into a high quality, sustainable system of care in Madison County.

- **Outcome Objective 1.1**: Enhance cross-agency communication, cooperation, and collaboration.
  - 1.1.1. Hold monthly inter-agency meetings in Madison County.
  - 1.1.2. Recruit 5 new, or reactivated community and agency partners per year.
  - 1.1.3. Develop system performance and accountability measures during first year.
  - 1.1.4. Develop a collaborative referral and intake process during first year.
  - 1.1.5. Develop a secure, cross-agency web site to act as a central data warehouse.

- **Outcome Objective 1.2**: Ensure provider knowledge of system-of-care principles and maintain at least 80% fidelity to the wraparound model.
  - 1.2.1. Develop a certification process for wraparound facilitators.
  - 1.2.2. Provide monthly wraparound skills training/coaching.
  - 1.2.3. Conduct case reviews of all open cases monthly.
  - 1.2.4. Observe, for each facilitator, 1 wraparound team meeting per month and measure fidelity to wrap.
  - 1.2.5. Assess supervisor performance semiannually.

- **Outcome Objective 1.3**: Create a self-sustaining system-of-care for mental health by the final grant year.
  - 1.3.1. Ensure that key stakeholders (families, youth, providers, and community members) are active participants in at least 90% of meetings involving planning, governing, and evaluating the system.
  - 1.3.2. Include sustainability on the agenda at each inter-agency meeting, to develop and revise a long-term plan for sustainability.
  - 1.3.3. Key stakeholders will plan or conduct at least 1 fund raising campaign, social market campaign, and public forum/town hall meeting annually.

**Goal 2**: Ensure children with Social Emotional Disorders are identified early and offered age-appropriate and evidence-based treatment that is culturally and linguistically competent, child centered, and family driven.

- **Outcome Objective 2.1**: Increase the number of service providers each year that utilize a community-approved screening tool to identify children with SED.
  - 2.1.1. Form an Advisory Committee inclusive of key stakeholders to establish a single screening instrument and process to be used system-wide.
  - 2.1.2. Distribute the screening tool and related information to at least 20 day
care and service providers annually.

- **Outcome Objective 2.2.** Reduce stigma associated with mental illness and increase community knowledge of warning signs and early detection of SED.
  - 2.2.1. Conduct social marketing campaigns reaching at least 2 key audiences per year (e.g. Primary care physicians, cultural minorities, child care providers.)
  - 2.2.2. Provide community outreach to at least 1000 community members per year, with an emphasis on underserved populations (e.g. cultural minorities).
  - 2.2.3. Maintain an online resource with bilingual educational material, information about local resources and services, and a message board for families.

- **Outcome Objective 2.3.** Provide home visitation program that outreaches to at risk SED children and families providing support and social emotional development.
  - 2.3.1. Provide home visitation to 150 families through Parents as Teachers program including social-emotional screening to identify and serve SED children.
  - 2.3.2. Conduct monthly family support group meetings for parents of children and their families.
  - 2.3.3. Provide training and implementation of positive behavior intervention and supports in the home.

- **Outcome Objective 2.4.** Using system of care core values and principles, implant a unified social and emotional support system through RTI, PBIS and other models.
  - 2.4.1. Create a committee for PBIS/RTI initiatives.
  - 2.4.2. Ongoing training key staff, stakeholders and Administrators in PBIS/RTI.
  - 2.4.3. Ongoing implement School Wide PBIS/RTI plan developed by committee.
  - 2.4.4. Improve school climate through school wide initiative and or curriculum.

**Goal 3:** Keep Children with SED (age 0-21) with their families and in community settings by improving their mental health, academic achievement and school readiness.

- **Outcome Objective 3.1.** (Short Term): Increase families’ knowledge, skills, and resources to address their children’s strengths and needs. (Intermediate): Improve children’s strengths. Reduce problem behaviors. Improve family functioning. Decrease caregiver strain. Increase family empowerment. (Long-term): Reduce the number of children removed from their homes due to behavioral or emotional problems.
  - 3.1.1. Provide wraparound of a total of 125 families during the grant period.
  - 3.1.2. All families, youth and their teams will have an individualized, strengths-based service plan with measurable goals that will be revisited at each team meeting and revised as needed.
  - 3.1.3. Provide feedback of evaluation data to youth, families and teams to guide service planning and to track progress over time.
3.1.4. Provide biweekly family support groups and youth teams in Madison County.
3.1.5. Recruit 10% of family participants to serve on wraparound teams for other families receiving services.

- Outcome Objective 3.2. Reduce the number of children expelled/suspended from school/programs due to their behavioral or emotional problems.
  - 3.2.1. Provide school staff with at least 6 on-site trainings on working with children with SED.
  - 3.2.2. Include Madison Cares staff and school staff on wraparound and child assistance teams for at least 80% of children served.

- Outcome Objective 3.3. Increase school readiness and academic achievement.
  - 3.3.1. All wraparound families completing services will have a transition plan that includes education.
  - 3.3.2. At least 80% of identified children and youth will be enrolled in preschool program, after school program or other appropriate intervention/prevention.
  - 3.3.3 At least 75% of families will have an adult who reads to the child at least twice a week

**Goal 4:** Empower families to provide leadership in all aspects of the system of care.

- Outcome Objective 4.1. (Short-term): Increase family empowerment to control their own services (Intermediate): Ensure that family members will be active participants in at least 90% of meetings involving planning, governance, and evaluation of the system-of-care. (Long-term): Ensure that family members will chair or co-chair the Governance Council and majority of advisory groups and committees within the system-of-care by final grant year.
  - 4.1.1 100% of identified family members will be included in all aspects of systems of care including training, educational activities and support groups.
  - 4.1.2 Recruit and train at least two family representatives who will meet with new families to introduce wraparound and system of care concepts.
  - 4.1.3 Ensure that 100% of families have access to a list of local resources, services, and contact information
  - 4.1.4 Recruit at least five family members annually to serve on advisory groups, boards & committees and to facilitate support groups.
  - 4.1.5 Distribute two family produced newsletters annually and provide access to online message board for families for communication and dissemination purposes

**Goal 5:** Provide culturally & linguistically competent, community-based services.

- Outcome Objective 5.1. Increase cultural competence of services in target areas.
  - 5.1.1. Provide 2 trainings in cultural competence annually for service providers.
  - 5.1.2. Provide clinical services in parents preferred language.
  - 5.1.3. Develop a Spanish language social marketing campaign during the first year.
  - 5.1.4. Ensure that all service plans take into account family traditions, beliefs,
and culture.
  • 5.1.5. Governance board will be trained in personal cultural development.

**Goal 6:** Empower Madison County youth who have mental health challenges.
  • Outcome Objective 6.1. Create a youth guided advocacy program providing education and resources for youth and their families, and the community.
    • 6.1.1. Create a Youth Group that meets semi-monthly.
    • 6.1.2. Recruit Youth to serve on councils in the community and/or participate in council meetings monthly.
    • 6.1.3. Provide support groups monthly for youth who are in transition.
    • 6.1.4. Work with BYU-Idaho to get youth up to 21 years old involved in the youth group or in their own youth group.
    • 6.1.5. During deployment, provide a monthly support group for military youth.
  • Objective 6.2. Provide opportunities for the youth to express themselves and have their voice heard in a community setting.
    • 6.2.1. Take youth to attend at least 10 community councils per year and encourage them to participate.
    • 6.2.2. Youth initiated development of a Madison Youth MOVE Chapter within the first 3 years.
    • 6.2.3. Create and implement an annual sustainable youth initiated anti-stigma campaign.

**Goal 7:** Madison cares will follow high quality evaluation processes
  • Outcome Objective 7.1. Establish evaluation practices to ensure fidelity, ethical procedures and family and youth involvement.
    • 7.1.1. Establish community and family approved evaluations.
    • 7.1.2. Develop local survey utilizing family and youth feedback.
    • 7.1.3. Train evaluators in quality assurance, confidentiality, cultural competence and retention.
    • 7.1.4. Recruit local family and multilingual evaluators.
    • 7.1.5. Retain 50% of referred wraparound participants.
    • 7.1.6. Assist in evaluating and administering all survey material.
**APPENDIX C**

Madison Care Programs  
(copied directly from the website)

- **Parents As Teachers Program (PAT):** This program provides the information, support and encouragement parents need to help their children develop optimally during the crucial early years of life (0-5). Our educators are in the home working with the families once each month. We provide screenings and work toward early identification of SED and services for children with SED as well as train their parents to watch for warning signs. We are currently serving about 300 families each month.

- **Wraparound:** Madison CARES helps your family build a Wraparound team to help in the goal setting process. A trained facilitator will work with you to develop goals, and then help you develop a plan to meet those goals based on your family’s strengths and culture. This facilitator works with multiple agencies and incorporates your ideas and concerns, as they are very important to this process. No plan can work unless it truly meets your family’s specific needs.

- **Parenting Classes:** We offer free parenting classes for any parent in Madison County. In these classes, you will learn important concepts you need to know to help your child develop into someone that you will be proud of. There is also free childcare during the class. We also offer these classes in Spanish. To learn more about when these classes are, please visit our events calendar [here](https://ax.d321.k12.id.us/apex/f?p=WEB:CONTENT:15690745034510::NO::P2_PAGE_ID:1903).

- **Madison County Welcome Baby Packet:** The welcome baby packets are a free collection of tips, tools, community resources and information that we distribute to new parents. We hope these items will ease the transition of bringing life into this world. Also included in the packet is information on how to get involved and stay connected with our many programs available for your family. Learn more about this program on our Early Childhood Page [here](https://ax.d321.k12.id.us/apex/f?p=WEB:CONTENT:::P2_PAGE_ID:1262).

- **Governance Board:** The Governance board is a chance for the families and youth of Madison County to get involved in the decision-making process on matters that concern our families. The board meets on the last Tuesday of every month. Contact our Lead Family Contact for more information about these meetings.

- **English as a Second Language Classes:** Every Tuesday and Thursday, we hold classes at a local school for anyone who would like to learn or improve their English. For more information on this, contact our specialist.

- **Madison County Latino Parent Meetings:** We have a quarterly parent meeting open to all Latino parents in the area. A different mental health topic is discussed each time as well as other school related questions. For more information on this, contact our specialist.

**Events**

- **Celebrate Youth:** Madison CARES looks forward to our big party in the park. This event is scheduled to occur right before school starts back up in the fall. Community
organizations join together each year to provide this event for the community. The theme is “Children’s Mental Health Matters”. There are booths all around the park where parents and teens can pick up information about SED and sign up to get more info or to be involved. There are also 12 carnival booths as well as free cotton candy, popcorn, train rides, blow up toys and face painting.

- **Madison County Block Parties:** (Seasonal: June - September) In the summer, we work in conjunction with the Rexburg Police Department and the Madison County Sheriff’s Office to hold block parties, which are meant to promote unity and education in our community. All who apply by means of the Rexburg Police Dept. or County Sherriff’s office and qualify to host a party are given a $100 gift card to subsidize costs of the party and we are given the dates and times of their event. The day of the party, one of our staff members and a law enforcement officer collaborate and speak to these neighborhood groups about mental health warning signs, stigma and neighborhood safety. Please visit our For Families page to learn more about these events.

- **Mental Health Regional Summit:** As the days progress, what we know about mental health is changing all the time. One of our goals as an organization is to keep ourselves and our community as updated and informed as possible. For this purpose, we have a regional Mental Health Summit annually in the fall season to provide training in the latest trends, interests and concerns in the mental health field. We will have a track for parents, providers, educators and youth. Please check the For Families page for more information.

**Campaigns**

- **37 Acts Of Kindness (from 2012):** This campaign is an opportunity we gave to the kids to get in the habit of doing nice things for one another. So as the main invitation for this campaign, we are encouraging students to participate in 37 acts of kindness before the end of the school year. It’s the little things that count sometimes, even something as little as a thank you note or even just a smile.

- **Gotch’er Back Campaign:** There are two key components to the Gotch’er Back campaign. The first component includes a teacher-led classroom exercise followed by a classroom discussion. Second, the students were given stickers to place on the back of their student body cards. This sticker includes information about how to help a friend in need. Our Goals with this campaign are mental health promotion and stigma reduction, suicide awareness and prevention, youth and community involvement, and enlarge circle of support. This campaign was held countywide for all students that are in school. Our plan is to do this in March/April of every year.

- **100% Original Campaign:** In this anti-labeling campaign, we encouraged kids in schools to be positive toward one another. Labels leave a lasting impression, and it can have a significant impact on how that child acts and views themselves and how others act towards and view them. Because of this, 1 out of every 10 kids will drop out or change schools. 3 million kids each month will stay home from school. That’s 160,000 kids per day. Thirteen million kids will become targets of labels and bullying. According to our local school climate survey, more than half of our students witness this, sometimes daily. It is time to make a change and we are starting locally. This campaign
was designed to turn these numbers around. Learn more and view the campaign materials here.

- **I Am, We Are Campaign:** This is a campaign was designed to run in the High Schools. Each student was asked to write a positive quality or characteristic on a piece of multi-colored paper. Each student did this in a classroom setting. The teacher gathered the papers and explained to the class that who we are as individuals, makes up who we are as a class. They also explained that all the papers would be utilized to make a giant mural which the youth group would create. This symbolized that each of us contributes to the bigger picture in class/school/home/community/team/etc. (note: the last two sentences were lightly edited by the FoCuS team and therefore not directly copied from the site).
**APPENDIX D**

Primary Instrument Descriptions

**Enrollment and Demographic Information Form (EDIF).** The EDIF is designed to collect enrollment and demographic information on all children and youth who are receiving SOC services from a Center for Mental Health Services (CMHS)-funded SOC. The information for completing this form was obtained from record reviews and was completed at enrollment. The EDIF contains 26 items that describe each youth’s demographic information, diagnostic information, and enrollment into the system of care program. Conventional assessments of reliability and validity are not appropriate for the EDIF (Center for Mental Health Services, 2007).

**Caregiver Information Questionnaire, Revised (CIQ-R).** The CIQ-R was developed to collect uniform demographic information about caregivers to whom the national evaluation instruments are being administered. The CIQ-R was completed at enrollment and every 6 months until the 24-month mark. This questionnaire has four related versions, including the CIQ-RC-I (Caregiver), the CIQ-RS-I (Staff as Caregiver), the CIQ-RC-F (Caregiver), and the CIQ-RS-F (Staff as Caregiver). Although the versions are highly similar, not all of the items are listed in the Staff as Caregiver versions. The topics covered in the measure include demographic information, risk factors, family composition, physical custody of the child or youth, the child or youth’s mental and physical health, service use history, caregiver employment status, attitudes about coercion in receiving services, problems the child or youth presents, and the caregiver’s job changes in relation to the services provided (only on the CIQ-RC). Conventional assessments of reliability and validity are not appropriate for the CIQ-R (Center for Mental Health Services, 2007).

**Caregiver Strain Questionnaire (CGSQ).** The CGSQ is administered to caregivers to assess difficulties, strains, and other negative effects related to caring for a child experiencing emotional and behavioral problems. The CGSQ was completed at enrollment and every six months until the 24-month mark. The CGSQ contains 21 items, and caregivers respond to each item on a 5-point scale: “Not at all” (1), “A little” (2), “Somewhat” (3), “Quite a bit” (4), or “Very much” (5). The CGSQ evaluates three main dimensions of caregiver strain: objective strain, subjective internalizing strain, and subjective externalizing strain. Subscale scores are the mean score of the items corresponding to each subscale, and the global strain score is the sum of the mean scores of the subscales (Brannan, Heflinger, & Bickman, 1997). The CGSQ demonstrated strong reliability and validity in previous studies (Brannan et al., 1997; Brannan & Heflinger, 2001; Heflinger, Northrup, Sonnichsen, & Brannan, 1998; Kang, Brannan, & Heflinger, 2005; Taylor-Richardson, Heflinger, & Brown, 2006).

**Youth Services Survey (YSS).** The Youth Services Survey (YSS) was administered to youth and their caregivers at 6, 12, 18, and 24 months to assess perceptions of system of care service experiences. Satisfaction with service is one of the most important constructs that was measured by the YSS. Respondents are asked to rate satisfaction on a Likert-type scale, with 1 being “Strongly disagree” and 5 being “Strongly agree.” Thus, higher scores indicate higher levels of
satisfaction (Center for Mental Health Services, 2007).

**Behavioral and Emotional Rating Scale — Second Edition, Parent Rating Scale (BERS-2C).** The BERS-2C was administered to caregivers at enrollment, and at 6, 12, 18, and 24 months, to measure the emotional and behavioral strengths of their youth. It includes 57 items, and parents are given four response options for each item, which include: “Not at all like your child” (0), “Not much like your child” (1), “Like your child” (2), and “Very much like your child” (3). The BERS-2C measures each youth’s behavioral and emotional strengths in six subscales: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, Affective Strength, and Career Strength. The raw scores for each subscale are converted to scaled scores and percentiles, and an overall strength index can be calculated by adding the scaled scores for all of the subscales (Epstein & Cullinan, 1998). Several analyses reported in the BERS-2C Examiner’s Manual indicate that the BERS-2C demonstrates adequate reliability and validity (Buckley, Ryser, Reid, & Epstein, 2006; Epstein & Cullinan, 1998; Epstein, 1999; Epstein, Cullinan, Harniss, & Ryser, 1999; Epstein, Cullinan, Ryser, & Pearson, 2002; Mooney, Epstein, Ryser, & Pierce, 2005).

**Behavioral and Emotional Rating Scale — Second Edition, Youth Rating Scale (BERS-2Y).** The BERS-2Y was administered to youths between the ages of 11 and 20 at enrollment, and at 6, 12, 18, and 24 months, to assess their emotional and behavioral strengths. It includes 57 items, and youth respond based on a four-point scale that includes the following options: “Not at all like you” (0), “Not much like you” (1), “Like you” (2), and “Very much like you” (3). The BERS-2Y contains six subscales: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, Affective Strength, and Career Strength. The raw scores for each subscale are converted to scaled scores and percentiles, and an overall strength index can be calculated by adding the scaled scores for all of the subscales (Epstein & Cullinan, 1998). Several analyses reported in the BERS-2Y Examiner’s Manual indicate that the BERS-2Y demonstrates adequate reliability and validity (Buckley, Ryser, Reid, & Epstein, 2006; Epstein & Cullinan, 1998; Epstein, 1999; Epstein, Cullinan, Harniss, & Ryser, 1999; Epstein, Cullinan, Ryser, & Pearson, 2002; Epstein, Mooney, Ryser, & Pierce, 2004).

**Child Behavior Checklist (CBCL 1½–5).** The CBCL 1½–5 is a caregiver reporting measure intended to provide a standardized measure of emotional and behavioral problems for children between 1½ and 5 years old. It was administered to caregivers at enrollment and at 6, 12, 18, and 24 months. This measure includes 99 items, and caregivers respond to all items on a three-point scale: “Not true” (0), “Somewhat or sometimes true” (1), and “Very true or often true” (2). The checklist includes two broad syndrome scores (“internalizing,” “externalizing”), seven more narrowly defined syndrome scores (“emotionally reactive,” “anxious/depressed,” “somatic complaints,” “withdrawn,” “sleep problems,” “attention problems,” and “aggressive behaviors”), and a total problems score. The raw scores for each subscale are converted into T scores. The CBCL 1½–5 demonstrates adequate validity and reliability (Achenbach & Rescorla, 2001).

**Child Behavior Checklist (CBCL 6–18).** CBCL 6–18 is a caregiver report of social competence, behavior problems, and emotional problems among youths between the ages of 6 and 18. It was administered to caregivers at enrollment and at 6, 12, 18, and 24 months. The
checklist provides a detailed description of behaviors, symptoms, and competence. It has been widely used in children’s mental health services. The CBCL 6–18 provides a total problems score, two broad syndrome scores (“internalizing,” “externalizing”), eight narrow syndrome scores (“anxious/depressed,” “withdrawn/depressed,” “somatic complaints,” “social problems,” “thought problems,” “attention problems,” “rule-breaking behavior,” and “aggressive behavior”), and a total competence score. It also provides competence scores for the following categories: “Activities,” “Social Situations,” and “School.” Raw scores for each subscale are calculated by summing the items within each subscale, and all raw scores are converted into T scores. Several previous studies indicate that CBCL 6–18 demonstrates strong reliability and validity (Achenbach, 1991; Achenbach & Rescorla, 2001).

**Columbia Impairment Scale (CIS).** The CIS evaluates level of impairment in (a) interpersonal relations, (b) functioning in a job or school, (c) use of leisure time, and (d) certain broad psychopathological domains. It was administered to caregivers at enrollment and at 6, 12, 18, and 24 months. Scores above 15 are generally considered as indicating clinical levels of concern (Bird, Shaffer, & Fisher, 1993).

**Reynolds Adolescent Depression Scale, Second Edition (RADS-2).** The RADS-2 is a self-reporting measure of the presence and severity of depression, and it is intended for use with youth ages 11 through 20. It was administered to youth at enrollment and at 6, 12, 18, and 24 months. The RADS-2 measures four basic areas of adolescent depression, including dysphoric mood, anhedonia/negative affect, negative self-evaluation, and somatic complaints. It includes 30 items, and youth are given four response options for every item: “Almost never” (1), “Hardly ever” (2), “Sometimes” (3), and “Most of the time” (4). Items corresponding to each subscale are summed and converted to a standardized score, and an adolescent’s score on all of the items is summed to determine his or her total depression score. Scores below 61 are considered average; 61–64 indicates mild clinical depression; 65–69 is moderate; and 70 is the threshold for severe clinical depression (Reynolds, 1987; 2002). The RADS was standardized using a sample of 3,300 adolescents ages 11 to 20, and it demonstrated strong reliability and validity (Reynolds, 1987; 2002; 2003).

**Revised Children’s Manifest Anxiety Scale, Second Edition (RCMAS-2).** RCMAS-2 is a self-reporting measure of the level and nature of anxiety experienced by youth ages 6 to 19 years old. It was administered to youth at enrollment, and at 6, 12, 18, and 24 months. It has 49 items, and youth respond to each item with either “Yes” (1) or “No” (0). The measure contains six scales: Worry, Physiological Anxiety, Social Anxiety, Total Anxiety, Defensiveness, and Inconsistent Responding. The first four scales are anxiety-related, and high scores on the subscales represent the different aspects of anxiety. The last two scales are validity scores. Raw scores for each subscale are calculated by summing the items that make up each subscale, and the raw scores can be converted into standardized scores (Reynolds & Richmond, 2008). The RCMAS-2 has been found to demonstrate a high level of reliability and validity (Pina, Silverman, Saavedra, & Weems, 2001; Reynolds & Richmond, 2008; Stark & Laurent, 2001; Valera & Biggs, 2006).