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Evaluation of Specialized Treatment Programs for Dually Served Youth

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Executive Summary

Dually served youth refers to minors who are involved, or at risk of involvement, with both the child welfare and juvenile justice systems (Wright, Spohn, Chenane, & Juliano, 2017). These youth are considered a vulnerable population because they have a greater number of risk factors, fewer protective factors, and a wider range of unmet needs than youth involved in only one system (Wright et al., 2017). Dually served youth also are more likely to have poor outcomes, such as an earlier onset of delinquent behavior, more juvenile detention stays, higher out-of-home placement rates, and more frequent placement disruptions (Halemba & Siegel, 2011; Ryan, 2006). These findings have raised concerns about how to best address the unique needs of this population.

The Florida Department of Children and Families (DCF) issued awards to three service providers to implement specialized treatment programs for dually served youth beginning in December 2017. Each program provides a wide range of intensive short-term services that includes individualized treatment plans, counseling, case management, parenting skills training, mobile crisis support, and follow-up services. The goal of the programs is to ensure permanency and a successful transition from juvenile justice facilities.

In February 2018, DCF contracted with the University of South Florida to conduct an independent evaluation of the specialized treatment programs. The evaluation team utilized a mixed methods approach consisting of focus groups with administrators and front-line staff, case file reviews of completed or nearly completed cases, collection of administrative data from each agency, and longitudinal surveys administered to caregivers and youth at two time points. This report presents results by these analytic approaches and offers recommendations for consideration by DCF and the providers.

Study 1: Focus group participants indicated that youth served by the programs have complex needs, including serious behavioral health problems. Additionally, many families reside in impoverished and unsafe neighborhoods and have multigenerational involvement with the child welfare system. Although programs had similar goals and core services, there were important differences in terms of eligibility, referral criteria, assessments, and program models. The most common challenge, according to participants, was lack of family engagement, but agency staff successfully implemented a variety of strategies to encourage program participation.

Study 2: At intake, most youth were living with their biological family, and a majority were referred for problems with mental health, substance use, and/or anger/aggression. Fewer than half of referrals were contacted by the providers within 24 hours, but nearly all had an intake assessment completed within 30 days. In most cases, the youth and their family were actively engaged in the assessment and treatment process, but treatment teams did not always include important stakeholders. The most frequent services provided were family counseling, case management, parental skill building, and individual therapy. Fewer than 10% of cases had three weekly in-person contacts within the first two months as required. Among cases discharged, about half successfully completed treatment.

Study 3: Youth and caregiver surveys were administered to five families participating in each specialized treatment program. The surveys were completed at intake and three months after intake in order to assess changes in satisfaction with services, parenting skills, behavioral and

emotional health of the youth, the youth's attitudes toward school, and the youth's likelihood of engaging in high-risk behaviors. Results are preliminary due to the small sample size, but youth report fewer problems on a variety of measures than their caregivers. In addition, caregiver satisfaction with the program was high, but there was little improvement in their self-reported parenting skills.

Study 4: Youth referred to the specialized programs had a wide range of presenting problems, but conduct disorder and substance abuse were common. A greater proportion of youth were referred by DCF or community providers than the Department of Juvenile Justice (DJJ). Based on the analysis of the administrative data, approximately 41% of discharged youth successfully completed treatment.

Overall Conclusions: The specialized treatment programs serve youth and families with numerous risk factors for continued involvement with the child welfare and juvenile justice system. In spite of some challenges with family engagement and adherence to timelines as specified in their contracts, the specialized treatment programs demonstrated success on a variety of outcomes. For example, youth and families who remained in treatment showed significant improvement, and the majority of youth were not discharged to higher level of care, which is a primary goal of the programs.

Recommendations: The evaluation team recommends that the treatment programs (a) allow greater flexibility in the required number of weekly contacts, (b) provide additional cultural sensitivity and trauma-informed training to staff, (c) consider incorporating a parent peer mentor, (d) administer a brief survey to families that choose not to participate or discontinue the program, (e) develop a standard protocol for collecting information, (f) use electronic records to facilitate information sharing, (g) agree on a common set of assessment tools and administration schedule, and (h) collaborate with DCF to define and establish appropriate outcome goals.

Introduction

Dually served youth is a term used to describe minors who are involved, or at risk of involvement, with both the child welfare and juvenile justice systems (Wright, Spohn, Chenane, & Juliano, 2017). These youth have a greater number of risk factors, fewer protective factors, and a wider range of unmet needs than youth involved in only one system (Wright et al., 2017). Dually served youth also are more likely to have poor outcomes, including further system involvement such as incarceration and out-of-home placements (Halemba & Siegel, 2011). At the same time, they are more likely to receive harsher punishments than their non-maltreated counterparts in the juvenile justice system (Herz & Ryan, 2008). These findings have raised concerns about how to best address the unique needs of this population in order to prevent deeper involvement with both systems. In particular, services are needed to improve the ability of caregivers to manage the youth's behaviors, improve family relations and functioning, and facilitate positive behavior changes in the youth.

In December 2017, the Department of Children and Families (DCF) issued awards to three service providers (Children's Home Society [CHS], Devereux Advanced Behavioral Health [Devereux], and National Youth Advocate Program [NYAP]) to implement specialized treatment programs for 20 dually served youth each month. These providers are located in the Suncoast (Tampa), Central (Orlando), and Northeast (Jacksonville) regions of the state, respectively. Each program must provide an array of individualized treatment services to the youth and their family. Although each provider offers a unique set of services to meet the needs of the population, the goal for all of the programs is a successful transition from juvenile justice facilities as well as permanency for youth and their families.

In February 2018, DCF contracted with the University of South Florida to conduct an independent evaluation of the specialized treatment programs. The evaluation team utilized a mixed methods approach consisting of focus groups with administrators and front-line staff, case file reviews of completed or nearly completed cases, collection of administrative data from each agency, and longitudinal surveys administered to caregivers and youth at two time points. Results of the evaluation are presented by these analytic approaches. The report concludes with a summary of findings and recommendations.

Background

In order to meet the needs of dually served youth and improve their long-term outcomes, it is important to have a clear understanding of the population. One challenge is that the extent and timing of a youth's contact with each system can vary, which has resulted in different subgroups. For example, youth may have concurrent involvement, a history of involvement, or simply be at risk for involvement with both systems. As such, researchers have used various terms (e.g., dual status, dually identified, dually adjudicated, crossover, and multisystem youth) to distinguish between these groups. However, according to Huang, Ryan, and Herz (2012), most dually served or crossover youth (92%) are first involved in the child welfare system and then the juvenile justice system. For the purpose of this evaluation, we use the term dually served to refer to youth who are involved, or at risk of involvement, with both systems. Regardless of the extent and timing of system involvement, research suggests that this population is at high risk for poor long-term outcomes.

Several research studies have reported that involvement in the child welfare system can place youth at risk for behavioral, educational, and vocational problems (Dworsky & Courtney, 2010; Goerge et al., 2002; Halemba, Siegel, Lord, & Zawacki, 2004). Not only are youth who experience maltreatment more likely to engage in delinquent and criminal behavior, they are more likely to reoffend and receive harsher treatment in juvenile justice settings (Haight, Bidwell, Choi, & Cho, 2016; Herz et al., 2010; Huang et al., 2012; Ryan et al., 2007; Ryan & Testa, 2005; Widom & Maxfield, 2001). This is concerning because dually served youth often have a history of traumatic experiences and possess fewer protective factors than youth involved in only one system (Grisso & Vincent, 2014; Lee & Villagrana, 2015). Of particular concern is the greater likelihood that these youth will experience deeper system involvement, including jail time and long-term out-of-home placements. Specifically, dually involved youth are "younger at the time of their first arrest, have higher rates of recidivism, are detained more often and for longer periods of time, experience more frequent placement changes, are more likely to experience school failure, and generally have more extensive mental health needs than youth who do not touch both systems" (Robert F. Kennedy National Resource Center for Juvenile Justice, 2014, p. 3). These findings have raised concerns about how best to address the unique needs of this population.

In 2010, Center for Juvenile Justice Reform developed the Crossover Youth Practice Model (CYPM) in order to help multiple systems improve outcomes for dually served youth. The model includes four recommended practices. First, the CYPM encourages communities to establish processes to identify dually served youth and ensure all agencies that are involved with these youth are notified. These processes allow for new practices to be developed and for data collection procedures to include relevant information. Second, the model recommends using validated screening and assessment tools, particularly risk screening tools. These tools can be used to develop individualized case plans in order to refer youth to appropriate services. Third, the model recommends coordination in case planning and management across systems as well as sharing of appropriate information. As others have noted, collaborative service delivery models that include professionals from child welfare, juvenile justice, law enforcement, education, behavioral health, and the courts are viewed as best practice when working with these youth (Haight et al., 2016; Hirsch, Dierkhising, & Herz, 2018). This allows for the needs of the youth and their families to be addressed through coordinated case planning and supervision. Finally, the CYPM recommends engaging youth and families in decision-making processes in order to create interpersonal trust, enhance the family's sense of competence, and improve safety and stability.

As previously described, DCF issued awards to three service providers in December 2017 to implement specialized treatment programs for dually served youth (see Figure 1). Using the CYPM as a foundation, each program must provide individualized treatment services to the youth and their family, including a screening and intake assessment, an individualized treatment plan, family counseling, youth group sessions, parenting skills training, therapeutic mentorship, case management, school engagement support or vocational training, independent living services, 24/7 mobile crisis support, a discharge plan, and follow-up services. Each provider offers a unique set of services to meet the needs of the population, yet the goal for all of the programs is a successful transition from juvenile justice facilities as well as permanency for youth and their families.

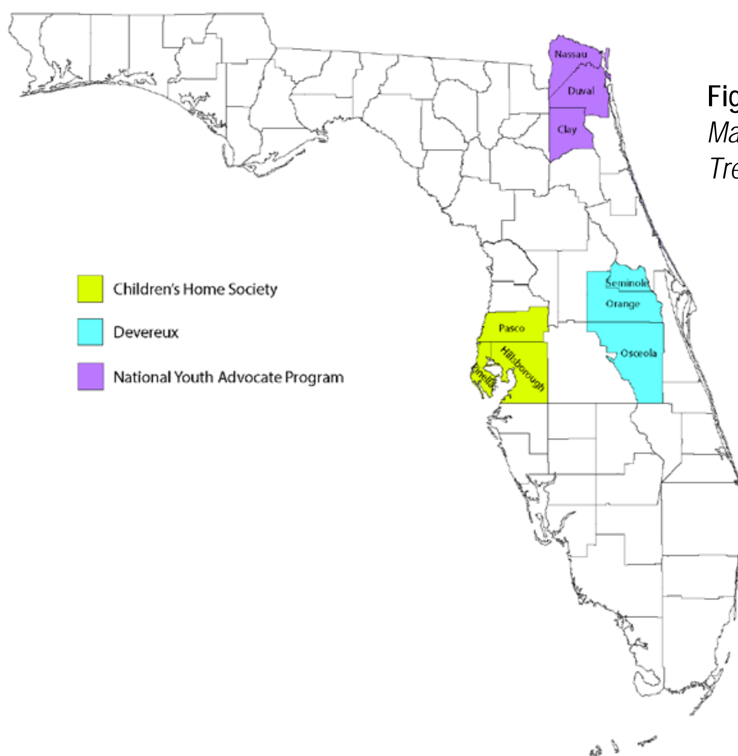

Figure 1
Map of Providers Offering Specialized Treatment Services for Dually Served Youth

Purpose of the Evaluation

The purpose of the proposed evaluation is to assess the impact of specialized treatment programs for dually served youth and their families that are being implemented by the providers. These pilot programs offer individualized treatment services for youth who are being served by the juvenile justice and child welfare systems with the goal of preventing deeper involvement with these systems. The evaluation will address the following research questions:

1. How are youth identified as dually involved (or at risk for dual involvement)?
2. What is the selection process for participating in the programs?
3. Do the services provided prevent further involvement with the dependency/delinquency systems?
4. What EBPs were selected and are they being implemented with fidelity?
5. Are caregivers/youth engaged and satisfied with the quality of services?
6. What are the implementation strengths and challenges according to key stakeholders?
7. What are the characteristics of youth served (demographics, diagnoses, prior services, living situation)?

Method

The evaluation utilized a mixed method approach consisting of four studies. The team conducted focus groups with administrators and front-line staff (Study 1), an in-depth review of case files (Study 2), an exploratory analysis of administrative data maintained by the programs

(Study 3), and a longitudinal analysis of responses to youth and caregiver surveys (Study 4). The remainder of this section describes the methodology corresponding to each study, including data sources, procedures, and analytic approaches. The remaining sections describe results of each study.

Study 1

In May 2018, the evaluation team contacted each organization to inform them about the evaluation and schedule a conference call to discuss the procedures and answer any questions. The team also developed a flyer that was distributed via email to the organizations (see Appendix A). Subsequently, each organization and the evaluation team worked together to schedule the focus groups and case file reviews.

To conduct focus groups with staff, the evaluation team developed a consent form describing the purpose, procedures, and risks/benefits of participating in the evaluation (Appendix B-1), a brief questionnaire about the background and demographics of the participants (Appendix B-2), and a semi-structured focus group guide consisting of 14 questions. The focus group guide asked participants to describe the structure of their specialized program, the characteristics and involvement of families and youth in treatment, strengths and challenges to service provision, and anecdotal and concrete evidence of effectiveness. The evaluation team conducted one focus group session at each agency and invited all front-line staff, such as counselors, case workers, and supervisors, to participate. Sessions lasted from one to two hours and were audio recorded with permission from all participants. Recordings were professionally transcribed by an external agency. Three team members established a list of codes, applied these codes to one transcript chosen at random, discussed results, compared interrater reliability statistics, and developed a final list of codes. Each team member was assigned one of the transcripts to code using Atlas.ti 6.2, a software program developed specifically for qualitative data analysis.

Study 2

The evaluation team developed a case file review protocol (Appendix C) to standardize data collection among 31 completed, or nearly completed, cases. The protocol collected information about referral, screening and intake, treatment plan development, treatment team meetings, discharge, and follow up, when available. Cases were assigned by agency supervisors at each site. The evaluation team reviewed 10 cases from NYAP, 10 cases from CHS, and 11 from Devereux. Five members of the evaluation team conducted case file reviews, though only two to three completed each site at a time. The evaluation team consulted with agency staff for clarification on case file notes. Data were analyzed in two ways (1) quantitative data were entered into SPSS for descriptive analysis, and (2) narrative data were reviewed and summarized by members of the evaluation team.

Study 3

The evaluation team consulted with DCF to develop two surveys to be administered to youth in the specialized treatment programs and their caregivers. The caregiver survey (see Appendix D-2) consisted of 46 items about satisfaction with services, behavioral and emotional health of the youth, and parenting. The youth survey (see Appendix E-2) consisted of 38 items measuring attitudes toward school, risk behaviors, and behavioral and emotional health. An informed consent letter also was created to be distributed along with the surveys (see Appendices D-1

and E-1). The surveys were administered at two time points to the same individuals. The first administration (pretest) occurred in late February 2019 to newly enrolled families. The evaluation team distributed five youth packets and five caregiver packets to administrators at each agency. (Packets were mailed to Devereux and hand-delivered to NYAP and CHS). Each packet contained a copy of the survey, a cover letter, a stamped envelope, and a $10 Walmart gift card. Administrators distributed the packets to treatment coordinators or therapists, who in turn gave them to families. The completed surveys were mailed to the evaluation team. The second administration (posttest) occurred in late May 2019 and early June 2019, and the same procedures were used for distribution. SPSS was used to enter the data and conduct a descriptive analysis.

Study 4

The data source for this analysis included administrative records for 254 youth who were referred to the specialized treatment programs beginning in December 2017. The evaluation team received copies of electronic records for 123 youth from Devereux, a spreadsheet containing data on 74 youth from CHS, and reviewed paper files and entered data into a spreadsheet for 57 youth served by NYAP's Constant and Never Ending Improvement Program (CANEI). (The number of youth served by NYAP is lower than the other programs because the evaluation team omitted records for youth who did not engage in services.)

Each treatment program uses different data collection procedures and protocols; therefore, most of the information in this report is presented by program. A few indicators can be compared across programs, such as the number of youth enrolled and discharged, demographic characteristics, referral source, average length of treatment, and completion rate.

Study 1: Staff Focus Groups

As shown in Tables 1 and 2, focus group participants consisted of 21 individuals employed by three agencies that provide specialized treatment programs for dually served youth. These individuals included program supervisors, treatment coordinators or case managers, clinical counselors or therapists, and an office assistant. The majority of participants reported that they had been employed in their current position for about a year (range = 2 to 18 months), with the exception of the Clinical Director, who had held the position for five years. Caseload size among frontline staff ranged from 5 to 25 families, but participants most commonly reported average caseload sizes of around 10 families. Participants were predominantly female (86%), and the overall sample was racially and ethnically diverse.

Table 1. Focus Group Participant Affiliations

	N	%
Agency		
National Youth Advocate Program	8	38.1
Children's Home Society of Florida	4	19.0
Devereux Advanced Behavioral Health	9	42.9
TOTAL	21	100.0

Table 2. Demographics of Focus Group Participants

	N	%
Position Title		
Program Supervisor or Clinical Director	3	14.3
Treatment Coordinator or Case Manager	5	23.8
Clinical Counselor/Therapist	12	57.1
Office Assistant	1	3.6
Gender		
Male	3	14.3
Female	18	85.7
Race/Ethnicity		
Black/African American	11	52.4
Hispanic/Latino	2	9.5
White/Caucasian	7	33.3
Multiracial	1	3.6
Highest Degree		
Bachelor's	3	14.3
Master's	17	81.0
Missing	1	3.6

Thematic Analysis

A grounded theory approach was used to analyze the focus group transcripts, in which open coding was performed to identify themes and concepts that emerged from the data. Three members of the evaluation team reviewed the focus group transcripts independently and generated a list of emergent codes. The team then met to discuss the codes they had each identified, and agreed upon a set of codes and code definitions. The identified themes were further analyzed in terms of their relation to other themes, resulting in families of codes that are related in terms of topic.

Next, the three team members selected a transcript to code independently, and then compared the coded transcript to assess the degree of inter-rater reliability among them. During this process, the team members further clarified code definitions and refined the code list (Appendix B-4). Once the code list was finalized and sufficient agreement and consistency were established among the coders, they independently coded the remaining transcripts using Atlas.ti, a qualitative analysis computer software program.

Results

Eight overarching thematic categories were identified through the analysis. These are: (1) Purpose of Dually Served Youth programs, (2) Characteristics of families served, (3) Program models, (4) Family engagement, (5) Service array and gaps, (6) Assessment processes, (7) Program evaluation, and (8) Structural barriers to service provision. Within each category, several themes are identified and described in the following sections. Strengths and challenges to service provision, as well as commonalities and differences across program providers are discussed.

Purpose of Dually Served Youth Programs

The themes within this domain concern staff perspectives regarding the overall purpose and goals of dually served youth programs. Key themes that emerged in relation to this topic included preventing further involvement with child welfare and juvenile justice systems, preventing escalation to higher levels of care, parenting skills development, stabilizing youth and families in crisis, identifying and addressing the underlying issues affecting youth and families, and helping families to set and achieve realistic goals.

Unanimously, the main ethos of the programs was to provide assistance to families, both parents and youth, to navigate their crises. The motivation expressed by respondents was to prevent future contact with the juvenile justice and child welfare systems and deescalate the current cases of youth that are in DJJ or experiencing frequent Baker Acts. Respondents also emphasized a need to prevent further child maltreatment while examining the root causes of harm within a given family dynamic, as the following quotes illustrate:

> *The primary goal is to stabilize the family, so that children we're serving, as well as the family unit, don't come into a system of care.*
>
> *And so we often come in, and sort of help them to gather themselves, get through the crisis of the moment, connect with those community services, as well as to…discover new parenting strategies.*
>
> *We go out and seek to find other resources that we can link the family to that are community-based, and that means also looking outside the box, thinking how we can advocate for the family in a different way.*

Finding creative ways to meet the needs of families while also being flexible in the way in which those needs are met was crucial to the agencies attempting to meet these goals. Often this meant reevaluating what progress means for a given family unit and helping families to set realistic goals. The end goal shared by the agencies was for families to apply the tools provided, build upon their strengths, and become self-sufficient in how they solve their problems while preventing cyclical patterns of crisis, child maltreatment, and justice system involvement.

Family Characteristics

This domain explores participants' understandings and perceptions of the families that they serve through the dually served youth programs. Included within this domain are themes pertaining to the types of allegations or family needs involved in these cases as well as socio-demographic characteristics of the families that these programs typically serve. Another theme that emerged was families who have a prior history of child welfare involvement or generational system involvement. Indicators of worker biases towards families who receive these services, such as the use of stereotypes or stigmatizing language, are also documented under this domain.

The dominant themes of family characteristics were a history of sexual abuse, trauma, generational involvement with the child welfare system, (mostly undiagnosed) mental health issues, family conflict contributing to the behavior of the child(ren), bouts of homelessness or housing instability, poverty, and residing in unsafe neighborhoods. Single parents and young parents were highlighted in regard to those families struggling with the aforementioned characteristics. Some respondents also noted that most of their referrals were for DJJ-involved youth, and those that came from DCF were largely diversion cases rather than dependency

cases. One agency, for example, highlighted that the courts in their area would transfer cases to DCF so as not to place the youth in the criminal justice system and thereby prevented giving them a record. This approach was praised by staff as a way to provide necessary resources to youth that hail from vulnerable neighborhoods and must navigate various degrees of abuse.

Not surprisingly, the most prominent theme across programs regarding the characteristics of the clients they serve was youth with mental or behavioral health issues. Respondents provided a rich and in-depth look into the many struggles the youth face that may lead them down a path towards dual system involvement. They described many of the youth they served as having serious mental health disorders that were often not being actively managed (i.e., through therapy and/or medication), in some cases resulting in multiple Baker Acts, and lack of parent involvement in their mental health treatment. These untreated mental health conditions increased the likelihood of youth acting out and potentially engaging in criminal activity.

Despite valid connections being made on the causes and patterns witnessed in their cases, there were also varying degrees of worker bias displayed in the language respondents used and their general outlook on the plight of families they served. While some agencies notated the diverse racial, ethnic, and gendered demographics of the youth they served, highlighting their ability to maximize efforts and reach a broad audience, others reduced the complexities within family dynamics to coded stereotypical tropes. The following quotes provide examples of the kinds of stigmatizing and biased language that emerged during the focus groups:

> *The entire family typically is dysfunctional, and so everybody within the family typically needs help.*
>
> *That goes back to the parent not being educated, or the parent being used to dysfunction, and so them not realizing that the mom and dad being in an abusive relationship is traumatic.*
>
> *The parents who are unstable, who have mental illness and who are not educated, or who are not medicated. Parents who don't want to participate in the process, who want us to magically fix their child, or to take over parenting roles.*

These statements certainly do not reflect the perspectives of all participants or program staff, and the pervasiveness of biased language did vary across programs. Nonetheless, the presence of speech that demonized and blamed families was disconcerting and illustrated a lack of empathy and respect. While some respondents recognized the importance of cultural competence and demonstrated sensitivity towards the struggles that families face, others were in need of greater training in this area.

Program Models

This domain concerns characteristics of the program models that have been implemented by the various Dually Served Youth program providers. Included under this domain are themes related to program eligibility criteria, how referrals are received, whether there is a specified evidence-based program model, the frequency of contact with families, duration of services, and other key characteristics of service provision identified by respondents such as flexibility and individualization of services.

While all three programs focused on youth who were considered at-risk of dual system involvement, there were some distinctions among the three programs in terms of their eligibility

criteria. Two programs indicated that youth did not need to be formally involved with either system to be eligible for services, as long as they were at high risk of entering one or both systems. These programs both served youth between the ages of 11 and 17 and their families. The other program, however, served youth between the ages of 12 and 17 and required that youth be formally involved with either DCF or DJJ and at risk of crossing over into both systems. Thus, this program had much stricter and specific eligibility criteria compared to the other two programs, who were able to serve a broader array of at-risk families.

These differences in program criteria were also reflected in responses regarding referral sources and processes. All three programs reported that they accept referrals from DCF, DJJ, or the local CBC. The program that required formal child welfare or juvenile justice involvement stated that their referrals were limited to these three sources, and that this restriction was specified in their program contract. The other two programs also received referrals from other community partners, such as schools and mental health providers, and one program even reported that they receive some self-referrals from families who learn about the program through other community resources.

The programs were similar in terms of their duration and core service components. All three reported an average duration of about four months, but had flexibility to keep cases open up to six months as needed. Two programs delivered services through teams that included a therapist and case manager or treatment coordinator, while one program used therapists who performed both treatment and care coordination roles. Per the contract terms, each program was responsible for delivering a comprehensive package of services, which included individual therapy, family therapy, group therapy, parenting, vocational and/or life skills development, and each program reported using an in-home services delivery model.

Each program also indicated that they had face-to-face contact with enrolled youth a minimum of three times per week, at least initially, although it could be more frequent, depending on the particular needs of the youth. One program described much more intensive involvement, reporting that on average they saw youth a minimum of five hours per week, which included at least one hour of individual therapy and two hours of group therapy. The intensity of these programs was viewed as both a strength and a challenge, as one respondent stated, “We start out three times a week, which is a lot of service for families who are struggling, but it's also a lot of support for families who are struggling.” One recommendation that staff across programs made was to allow more flexibility in the frequency of contacts, as the three-times-per-week requirement was at times a burden for families and a barrier to obtaining their buy-in.

Where programs differed most substantially was in terms of the extent to which a prescribed overarching program model had been formally implemented. Only one program had a clearly identified program model, which was the National Youth Advocacy Program’s Constant and Never Ending Improvement (CANEI) model, which was described as an evidence-based model for working with youth who have histories of aggressive, violent, or defiant behavior problems. The other programs each identified evidence-based practices that various staff had been trained in and might incorporate within their service provision, such as Cognitive Behavioral Therapy, the Wraparound Model, and Solution Focused Casework, but they did not serve as a formal model that guided the overall program delivery. Respondents from one focus group explained that part of the challenge was the diverse scope of referrals that they received, which made it difficult to identify a single approach to services that would meet the varying needs of families, but did express an interest in more formally implementing the Wraparound Model, which they

felt provided the right combination of structure and flexibility. Lack of time to properly train and implement the model had been the primary impediment for this program.

Another common theme that emerged across programs was the incorporation, and perceived value, of family team meetings. Two of the programs included such meetings as part of their program model, in which they pulled together as many of the family's natural supports (relatives, friends, neighbors, etc.) as possible to be a part of the family's treatment process, in addition to the professionals who were a part of their treatment team. Respondents identified this as a critical component to ensuring the family's success. As one respondent explained, "It's been proven that the more natural supports the better chances they have as they continue. So we try to pull as many of those as we can." A respondent from a different program added, "Our youth and family feel more heard when they have a village and a team behind them." Program staff felt that the use of a family team meeting approach helped families to feel better supported and more comfortable with receiving services. Participants from the program that had not implemented family team meetings expressed similarly favorable views, and acknowledged that they would have preferred to have taken such an approach:

> *Facilitating that process from the onset, ideally it would have been wonderful to have family team conference where we could bring all the providers together and be able to allow the family to tell their story, and for us to identify who is doing what. The fast pace in which this grant sort of came about, as well as sort of the nuances of well we need you to do this now, instead of this now, sort of helped define how we went about doing things.*

The overall consensus across programs and participants was that using a family team meeting approach was highly effective and recommended for working with this target population. Furthermore, teamwork and taking a team-based approach were described as key components and strengths across all three programs.

Other common components described by participants across the three programs were individualized treatment plans and having a flexible approach to service delivery. Respondents stated that they tailor services to each family's particular strengths and needs, and emphasized the importance of adaptability and flexibility to change course in response to new and changing needs. "We need to be able to meet that family where they're at, at that moment," one respondent explained. Another added that, "The individual service plan is a living document. It can be adapted to whatever needs we encounter as we encounter them." Respondents also noted that they were encouraged to get creative and "think outside the box" in order to best meet the needs of clients. An example that was provided in one focus group was combining court-ordered community service with group therapy. Respondents also reported that they would engage in a variety of activities with clients, like going for a walk or playing a game, and incorporate therapy into these activities, rather than using a more traditional "sitting in an office" approach to therapy. Additional examples of program flexibility included the ability to provide services in a variety of community locations for the family's convenience (e.g., meeting with youth at school, at their home, or other places of their choice), being available outside normal business hours, working around the family's schedule, and having the ability to serve clients with varying or no insurance coverage.

Family Engagement

This domain includes themes relating to the strategies program staff use to engage families in services, the extent to which families have a voice and are active participants in their services, and the factors that may present barriers to family engagement. Major themes that emerged within this domain include emphasizing the benefits of services to families, taking a strength-based approach, using accessible language, demonstrating empathy and respect, soliciting the family's input, giving families the power to design their service plan versus dictating services to the family, the use of coercive or manipulative tactics to get families to engage in services, distancing the provider agency from DCF, and the roles that fear and stigma (e.g., concern over the intrusiveness of services, fear of state intervention, not wanting others to know about their situation, etc.) play in creating hesitancy or resistance among families.

Respondents reported that families were often hesitant or resistant to enrolling in services for a variety of reasons. Many families felt overwhelmed by the demands of the programs, which included allowing a multitude of providers inside the home and scheduling services in addition to work or other daily obligations. Several workers agreed that the demands of the program were often needlessly intense and may have interfered with progress, as it strained their own abilities to coordinate care and asked too much of families. For example, a respondent expressed,

> *Like I had one family, they already had like six providers coming in. So coordinating… it was a lot. It was a lot for the kids. So I think three times a week is excessive. I could see two times a week. Because also you see them three times, you get to the third visit, you're kind of like, 'What do we talk about?' because nothing has happened.*

Other families felt fearful or resentful of system involvement, believing it would make them vulnerable to further state intervention and to being labeled as 'bad' families. These feelings were not unfounded, as several workers suggested that the use of more coercive practices, such as mandating service enrollment, implying negative consequences, or threatening legal action, could be useful to convincing families to enroll in care, as exemplified in the following quote:

> *Sometimes that Department of Children and Families worker can reach back out to them and say 'Hey, you were just complaining a month ago that you didn't want your kid anymore. And we tried to put services in place. Do you realize that if you ever try to terminate your parental rights they're going to ask you if you tried to do services? And if not, legally they can charge you with abandonment.'*

The use of coercive practices to get families to engage in services was fairly common in the focus group discussions.

Another challenge reported by participants was that many caregivers, in addition to their children, were affected by issues of mental illness, substance abuse, or past trauma. These issues made it difficult for caregivers to become engaged in services, which manifested into disagreements about accusations made against the family or disagreements about the extent of caregiver involvement. One worker expressed that engagement was difficult to maintain for parents who "have to change." Another offered an example of a conversation with a client:

> *'Hey, so. You're really hesitant to talk about the fact that your 14-year-old was raped by her dad and this is something that we really need to help this child work through and you*

> *need to be involved in that process.' And their response to us is, 'Well, no one ever helped me when I was a kid.'*

Thus, in some cases, parents were still processing their own past trauma and lacked the skills to help their children work through their trauma. It was not entirely clear from the focus groups the extent to which providers fully understood the impact of trauma on caregivers or how to engage them in trauma-informed ways.

To encourage engagement, agency workers explained the benefits of service enrollment to families, finding that they were responsive when told about the nature of the agency, the purpose of the program, and the focus on family-driven care, as well as the short- and long-term resources that would be made available to them upon enrollment. "Letting them know we're here to offer that support, we're here to link you up to providers and resources that you need, so that you and your child can thrive," one respondent explained. Agency workers also employed psychoeducation when necessary to help families understand the nature of mental illness, substance abuse, and trauma. Psychoeducation greatly reduced stigmas associated with behavioral health issues and care, increasing engagement among both youth and caregivers.

Families were also responsive to workers who were consistent in implementing care by following up on families regularly and completing meetings or progress reviews as scheduled. Additionally, families were particularly responsive to workers who expressed empathy, listened nonjudgmentally, and conducted strengths-based dialogues. This was important to families who felt confused or overwhelmed by their child's behavior, which sometimes seemed to emerge out of nowhere. A respondent described, "Then other families sort of feel like, 'Am I crazy, is this crisis crazy, and is my struggle with my team totally unusual?' And we're like, 'No, this is what we do for a living, we see this every day.'"

Encouraging caregivers and youth to share their needs, create their goals, and observe their strengths was reported to be empowering for many families. Respecting autonomy in decision making and treating families as the authority of their own lives allowed families to help craft treatment plans. It also enabled workers to individualize care according to a family's needs and abilities. However, the extent to which treatment plans were driven by families, rather than providers, varied by case. These differences were caused by the extent of engagement among caregivers and youth, worker attitudes toward families and their care, and the extent to which a goal could be completed in a limited time frame. Respondents emphasized the inclusion of family input, but also reported that at times they had to negotiate treatment goals with families both to ensure they were realistic and that they were addressing the reasons the family was referred to the program.

Service Array and Gaps

This domain examines the specific variety of services that are available and provided to families who participate in Dually Served Youth programs (including both services that are provided in-house and community services that they are able to refer families out to) as well as any identified gaps in the service array. The most prominent themes that emerged with regard to services that are provided were parenting education, mental health services/counseling, family therapy, group therapy, substance abuse treatment/counseling, vocational and life skills training, care coordination, and assistance with basic needs. Each agency generally provided

this package of services, although the specific array and service delivery varied somewhat across programs.

At Devereux, clients received targeted case management, mental health counseling, psychoeducation, and advocacy resources from the agency. Targeted Case Managers coordinated care among providers and families, advocated for families in legal, educational, and healthcare systems, assisted therapists with their treatment, and provided parenting education. Licensed mental health counselors offered mental health counseling, in which they diagnosed clients, created treatment plans, assessed behavioral health history, and conducted intake assessments. The agency offered substance use screenings and "some substance abuse full treatment, if needed." Devereux offered crisis stabilization services with the help of a mobile crisis unit and a mental health emergency line staffed by a therapist. The agency also helped families with transportation by giving families gas cards. The program did not have a central evidence-based model to guide it, but workers explained they used several evidence-based or evidence-informed practices, including cognitive behavioral therapy (CBT), ultimate goal setting, and road-mapping for targeted case management, and Gestalt therapy. The agency referred out for substance abuse treatment and mentoring services.

At NYAP, clients received individual, family, and group mental health counseling, access to a 24-hour crisis line, and substance abuse treatment. The program provided Nurturing Parenting, an evidence-based parenting course, to caregivers. Youth received psychoeducation as well as life skills education needed for independent living, such as budgeting. Clients received case management services, in which a case manager coordinated care, linked clients to mentors, conducted Child and Family Team Meetings, and advocated for families in legal, educational, and healthcare systems. Agency workers also provided transportation for clients "pretty much everywhere" and provided meals during group therapy. Multiple workers explained that this was one of the most beneficial aspects of the program, as it alleviated the burden from caregivers and encouraged youth to participate in services. NYAP referred out for basic needs, such as food, and for psychological evaluations, as the program did not have a psychologist who could perform these evaluations at the time, but was working on certifying one of its staff. NYAP reported use of multiple evidence-based practices. The agency used the Constant and Never Ending Improvement (CANEI) model, which respondents described as an evidence-informed model, to guide its program, as previously described. Additionally, it used motivational interviewing and cognitive behavioral therapy during counseling, as well as the Nurturing Parenting Program for parenting courses.

CHS provided mental health counseling, psychiatric services, psychoeducation, parent skills training, case management services, and advocacy in legal, educational, and healthcare systems. The agency also provided in-kind donations of basic necessities such as food, but would simultaneously refer families to community services for these necessities. For example, families could receive food directly from the agency while also getting help in completing an application for food stamps. CHS also referred out for specialized mental health treatment, such as treatment for those with Reactive Attachment Disorder. CHS did not use an evidence-based model to guide its program, but reported that a number of staff were trained in Wraparound and often incorporated these principles in their practice.

Interestingly, across the three focus groups, respondents did not identify any significant gaps in the service array. In fact, these programs were frequently described as the solution to such service gaps, and respondents expressed their dedication to finding resources to address

whatever needs the family may have. Respondents in one focus group, for example, explained that they often received referrals for families whose needs other community providers were unable to address. Respondents prided themselves on finding creative solutions to meet clients' needs and fill the gaps that more traditional service providers could not.

Assessment Processes

This domain contains themes related to the process of assessing family needs, strengths, and changes over time. Included within this domain are discussions of specific measures, methods, or assessment tools that providers use, ways in which families are involved in the assessment process, processes for assessing progress over time, and indicators or processes that are used to determine when a family is ready to transition out of services. The programs varied considerably in how they assessed family needs and progress, but common themes included an emphasis on family involvement in the assessment process and the importance of preparing families for case closure.

All three programs described their initial family assessment as centering on a direct conversation with the family about their history, needs, and strengths, allowing the family to identify and define their needs and goals for the program. In addition to this more qualitative assessment process, each program incorporated the use of standardized instruments, although the specific tools varied across agencies. Tools that were identified in the focus groups included the Child Behavior Checklist (CBCL; reported by 2 agencies), the Trauma Symptom Checklist (TSC), the Adverse Childhood Experiences Questionnaire (ACEs), the Child and Adolescent Needs and Strengths (CANS), the Children's Functional Assessments Rating Scale (CFARS), the Structured Assessment of Violence Risk in Youth (SAVRY), the Adult Adolescent Parenting Inventory (AAPI), the Casey Life Skills Assessment, the Self-Report Delinquency Scale, and Discovering Yourself Youth Interest Inventory. Some programs reported that they also incorporate feedback or assessments from other providers working with the family, as well as observations of the family's interactions to inform their assessment.

While there was some degree of consistency across programs in the overall process of the initial family assessment, ongoing assessment processes showed greater variability. One program had a formal review process, for which service plan updates were completed every 30 days. These updates included a review of the family's needs and goals, and documented any changes that had occurred since the last update. This and one other program also re-administered the standardized assessment tools at the end of the program to assess the degree of change achieved prior to discharge. On the other hand, one program described their ongoing assessment process as largely informal and based on ongoing conversation and "checking in" with the family throughout the life of the case. This program indicated that the family drove decisions about whether their needs had been met and when they were ready for discharge, as opposed to the program dictating criteria that families must meet. They also reported that they did not re-administer the assessment instruments because the short duration of the program (3 to 4 months on average) did not allow sufficient time for those results to be valid or meaningful. Rather, staff would review the initial assessments with families and have conversations about the extent to which things had changed since that initial assessment.

Finally, planning for the family's discharge and case closure was a significant theme that emerged during the focus groups in relation to assessment. As respondents described, decisions about when a family was ready for discharge were based not only on the extent to

which they had completed their service plan goals, but also on whether they had been connected to appropriate ongoing, long-term resources and supports. Continuity of care for families was considered extremely important by program staff, and all three programs developed aftercare plans with their families to ensure that those linkages were in place. Participants from two programs also spoke to the importance of stepping families and youth down slowly so that their transition from care was not a traumatic event for them. As one respondent explained, "We all think that going from seeing somebody three times per week down to nothing is not healthy for them. It's - if you've got kids who have abandonment issues already that's just throwing another one on top." Similarly, another respondent expressed that, "Loss means so many things to so many people. And we can define it as closure, success, or whatever, but the reality is you've had some impact in some way with a family. And for someone to leave your family means so many things to so many people." Thus, program staff were very cognizant of the ways in which closure might be experienced negatively by families, and the need to ensure that families were ready to transition. In this vein, one program reported that they begin planning for discharge with families from the onset of services, so the family feels prepared when the time comes. Additionally, across all three programs, it was generally described that staff will gradually decrease the intensity of involvement with the family, such as decreasing the frequency of contact, until the family feels ready to disengage.

Program Evaluation

This domain examines the various processes that DSY programs use to monitor and evaluate their programs, including measuring fidelity, quality assurance, and program outcomes. One of the primary findings that emerged from this analysis was that there were very few clearly defined outcomes or expectations for these programs, and staff generally found it very difficult to measure or assess the effectiveness of services. As a result, staff largely relied on anecdotal assessments of program success.

All three programs had general quality assurance processes in place, which usually entailed periodic case reviews to ensure staff were adhering to program requirements and timeframes. Only one program, however, had a formal process for measuring fidelity. This involved monthly observations completed by the program supervisor and completion of a standardized observation tool.

In terms of evaluating program effectiveness, a number of intermediate and long-term outcomes were identified by respondents that informed their assessments of clients' success. Examples of intermediate outcomes included changes in school outcomes such as grades or attendance, changes in behavioral outcomes such as substance use or acting out, reductions in youth reliance on psychotropic medications, and changes between pre- and post-assessment measures (e.g., CBCL, AAPI, etc.). Although respondents discussed the use of these various outcomes at the case level to assess an individual youth's and family's progress, for the most part there did not appear to be tracking and evaluation of these outcomes at the program level to assess effectiveness. Measurement of long-term outcomes, on the other hand, was less common across programs, and only one program appeared to measure and track such data consistently. This program identified three core program outcomes that were assessed 3 months, 6 months, and 12 months after discharge: placement stability, prevention of youth from crossing over into dual-system involvement, and youth remaining in school or employed. Another program identified one long-term outcome that they measure, but indicated that it was

not part of their formal program evaluation, which was whether the child entered into out-of-home care.

Overall, it was reported that, per the program contract with DCF, the primary outcome identified was simply completion of services. This gave programs considerable flexibility in defining success for their programs, since they could determine the criteria for successful completion. Two programs indicated that they viewed their objective primarily in terms of crisis stabilization and decreasing the level of support needed by the family, such that success did not necessarily mean the family no longer required services or did not have subsequent reports, as long as they no longer required the same intensity of services. In this way, they viewed their programs as largely effective. As one respondent described,

> *I feel it's been really effective… I think the community does, too. I think the rapid referrals we're getting, and still are getting, is a sign to the fact that we are seeing success, and the community I think acknowledges the fact that our success is not that every checkbox has been filled, but that this family is no longer in this level of crisis, doesn't need this level of support anymore.*

At the same time, respondents also rationalized unsuccessful cases or undesirable outcomes as being outside their control and not necessarily indicators of the program's effectiveness. For example, in one focus group, participants expressed that some while youth enter into SIPP, they did not view these cases as unsuccessful because they felt it was the level of care the youth really needed. Across all three programs, staff articulated a belief that their services were largely effective, but most respondents were unable to articulate clearly defined program outcomes that enabled them to evaluate program effectiveness.

Structural Barriers

Themes within this final domain concern the barriers faced by Dually Served Youth program staff in their efforts to serve families that were largely imposed by outside structures. Agencies mentioned a number of barriers that can prevent them from providing comprehensive and/or adequate care to families, most of which were beyond their control. These included limited program capacity and being understaffed, lack of collaboration from community partners, and navigating rigid boundaries with specific institutions such as schools and juvenile centers.

Family schedules also posed huge hurdles because of the weekly requirements practitioners needed to meet per the program contract guidelines. Availability and flexibility within a given family's schedule may not be conducive to the intensity demanded of the program, creating extra stress for families. Other times, lack of family buy-in and engagement posed a barrier to providing services, which was influenced by the intrusive nature of the programs and negative perceptions of DCF that were projected onto DSY programs. Mainly, the limited number of staff and high intensity of caseloads, combined with a need to accommodate both the families' and the workers' schedules created considerable tensions noted by all agencies. Limited funding, language barriers with families whose first language is not English, pressure to close cases within a limited time frame, and lack of long-term solutions to families' problems exacerbate the scope of the barriers faced by the agencies.

Moreover, the family's access to community resources and the program limitations reinforce the aforementioned themes. Across the focus groups, limited access to resources, or even a complete lack of access, was identified as a significant challenge for families, and was often one

of the reasons families were ultimately referred to these programs, as illustrated by the following quotes:

> *And the families that just haven't been given the resources, you know. They'll be Baker Acted, but then they're just referred to us, like… when in reality, they really need all of what we have to offer to be able to stabilize them.*
>
> *The type of families that we serve, understanding that they might not have the resources. They might need a psych eval, but if mom doesn't have a car, they're not coming to any psych eval.*
>
> *I think another limitation that I've encountered is I know the parents need therapy themselves a lot of times, and they – I have to make it very clear that yes, I do family sessions, yes, I do parent coaching, but I'm here for the child, and a lot of times, a lot of parents just want to take over and make the session about them.*

Lack of access was often the result of multiple factors, including lack of transportation, being uninsured or not having coverage for the types of services needed, not knowing where or how to access the types of services needed, and lacking financial resources to meet even basic needs.

These structural barriers create more problems and hurdles that both the families and practitioners have to navigate in an already terse and at times contentious environment. While DSY programs worked diligently to address these barriers and the fill the gaps in the short term, it was not always clear how families' ongoing needs would be met over the long term, after case closure. Although programs developed aftercare plans with families, as described earlier, it was not clear how larger structural barriers, such as lack of insurance coverage and economic resources, would be addressed by these plans. This speaks to the limited impact that these programs are able to have on struggling families, and the need for larger structural solutions that address economic inequality. Unfortunately, the youth feel the greatest impact and loss when a barrier prevents aid or linkage to additional, long-term resources and benefits.

Conclusions

The primary goal of the DSY programs is to prevent further involvement with the child welfare and juvenile justice systems by providing a wide range of intensive short-term services. Many of the youth served by the programs have serious behavioral health problems in addition to other challenges, such as living in poverty, residing in unsafe neighborhoods, and growing up in families that have multigenerational involvement with the child welfare system. Although the programs were similar in their goals and core services, there were important differences in terms of eligibility and referral criteria as well as the implementation of a clearly identified program model. Respondents agreed that individual treatment plans, flexible services, and family team meetings were effective components, and they did not identify any significant gaps in the service array. One of the most commonly cited challenges was lack of family engagement due to scheduling, fear of system involvement, and issues such mental illness, substance abuse, or trauma, but agency staff reported success in this regard by respecting the family's autonomy, identifying their strengths, and negotiating treatment goals. At the program level, an additional challenge is the wide variety of measures, methods, and assessments tools that are used to assess progress and for monitoring. Measurement of long-term outcomes was not common, but this may change given that the programs are relatively new. However, there is a

need to formally agree on performance measures and an assessment schedule in order to gauge program success.

Study 2: Case File Reviews

Thirty-one case files were reviewed by the evaluation team; these include ten cases each for two sites, and 11 cases for one site. A structured case file review tool was used to complete the reviews on site (see Appendix C). The tool focuses on assessing programmatic compliance with the contract criteria established by the Department, and also offers some additional contextual data to better understand factors that may affect program fidelity. Data collected through the reviews were entered into SPSS, a statistical software program, for analysis. Descriptive statistics are presented in this report.

Household and Youth Characteristics

Youth represented in the case files ranged in age from 10.8 years to 17.8 years at the time of service initiation, with a mean age of 14.84 years (SD = 2.07 years). A majority of the youth were male (58%, n = 18). Youth were in a variety of placements at intake, including in the home of their biological family (64.5%, n = 20), with a relative caregiver (19.4%, n = 6), in licensed foster care (6.5%, n = 2), or inpatient treatment, such as a SIPP or CSU (9.7%, n = 3). A slight majority of youth were living with two caregivers (54.8%, n = 17), while the remaining youth lived with one caregiver (45.2%, n = 14).

Referrals and Initiation of Services

Cases reviewed were referred to the specialized treatment programs between November of 2017 and August of 2018. A variety of reasons for requesting these services were noted in the case referrals, and most referrals included at least two or more reasons (93.5%, n = 29). Table 1 presents the various reasons for which youth were referred to the programs. The most frequently provided reasons included mental health issues (n = 14), anger or aggression issues (n = 14), substance use (n = 10), school behavior issues (n = 9), and defiance or acting out at home (n = 9). Several referrals (n = 7) also noted the youth's history of traumatic exposure as a factor contributing to their need for services.

Table 3. Reasons for Requesting Dually Involved Program Services

Referral reason	N	%
Mental health issues	14	45.2
Anger, aggression, or violent behavior	14	45.2
Substance use/abuse	10	32.3
School behavior issues	9	29.0
Defiance/ acting out at home	9	29.0
Parenting/ family relationships	8	25.8
DJJ involvement (current, pending, or history w/ recidivism concerns)	8	25.8
History of Baker Acts/CSU	6	19.4
Truancy	6	19.4
Sexually inappropriate behavior (acting out)	4	12.9
History of trauma		

Sexual abuse	4	12.9
Domestic violence exposure	3	9.7
Physical abuse	1	3.2
Runaway behaviors	3	9.7

Analysis compared the date of the referral with the date the program initially contacted the family for each case to calculate the length of time between referral and contact. The program contract criteria specify that the initial family contact should occur within 24 hours of the referral. Analysis showed that only 14 (45%) of the cases reviewed met this 24-hour criteria. The number of days between the referral and initial contact ranged from less than 1 (i.e., contact made same day as referral) to 100 (mean = 9.66 days; median = 2 days).

Intake Assessment

Of the files reviewed, 93.5% (n = 29) met the program criteria for having the intake assessment completed within 30 days of the initial contact with the family. Analysis further examined what components were included as part of the intake assessment. These findings are presented in Table 4. The components most frequently addressed in the assessments were: (1) assessment of the youth's strengths and resources (96.8%, n = 30); (2) the youth's perspective of his/her strengths and needs (90.3%, n = 28); (3) whether the child can live safely in the current home/placement (87.1%, n = 27); (4) assessment of the youth's needs and risk of dual system involvement (87.1%, n = 27); and (5) the caregivers' capacity to protect the child and manage his/her behavior (83.9%, n = 26). The components least frequently included in the assessments were: (1) observations of interactions between the youth and household members (35.5%, n = 11) and (2) the caregivers' perspective of their strengths and needs (48.4%, n = 15). Additionally, the case file reviews indicated that youth and families were engaged in the assessment process. The majority of cases reviewed (80.6%, n = 25) contained documentation that the caseworker solicited the perspectives of the focal youth and his/her caregivers regarding their needs and goals, and included statements of the clients' self-identified goals in the assessment.

Table 4. Key Components Included in Intake Assessment

Items addressed in the assessment:	N	%
An assessment of the youth's strengths and resources	30	96.8
The youth's perspective of his/her strengths and needs	28	90.3
Whether the child can live safely in the current home or placement	27	87.1
An assessment of the youth's needs and risk of dual system involvement	27	87.1
Caregivers' capacity to protect the child and manage his/her behavior	26	83.9
Assessment of caregivers' needs that hinder providing a safe/stable home	23	74.2
An assessment of the caregivers' strengths and resources	22	71.0
The caregivers' perspective of their strengths and needs	15	48.4
Observations of interactions between the child and household members	11	35.5

Treatment and Service Plan

Most of the cases reviewed met the program criteria for having the treatment plan developed within 15 days of the intake assessment (87.1%, *n* = 27). Of those that did not meet the criteria, one case file was missing a treatment plan altogether, and the other three were completed within 35 days of the intake assessment. Among the cases that had a treatment plan on file (*n* = 30), most included evidence that the treatment plan was discussed with the family and that the youth's and family's voice were considered during planning process (86.7%, *n* = 26). This evidence included the treatment plan being signed by the youth and caregivers, and the inclusion of clients' self-identified goals in the treatment plan. Analysis further indicated that the services and supports identified in the treatment plans were generally consistent with the identified needs and recommendations from the intake assessments on a majority of cases reviewed (77.4%, *n* = 24). Table 3 presents findings regarding the inclusion of various services in the treatment plans. The most frequently identified services were: (1) family counseling (80.6%, *n* = 25); (2) case management (77.4%, *n* = 24), (3) parental skill building (64.5%, *n* = 20), and (4) mental health/individual therapy (64.5%, *n* = 20). As illustrated in Table 3, a number of services that are required according to the programmatic criteria established by DCF are not consistently identified in the treatment plans (e.g. youth groups, therapeutic mentors, independent living skills development, crisis support services).

Table 5. Services Included in Treatment Plan

Services included in plan:	N	%
Family counseling*	25	80.6
Case management*	24	77.4
Mental health/therapy	20	64.5
Parental skill building*	20	64.5
Youth group sessions*	18	58.1
School or vocational engagement/ educational services*	18	58.1
Availability of 24/7 crisis support*	12	38.7
Therapeutic mentor*	10	32.3
Independent living skills development*	10	32.3
Medication management	9	29.0
Substance use monitoring/treatment	4	12.9
Financial/basic needs assistance	2	6.5
Note. *Required services per DCF contract.		

Treatment Team and Meetings

Regarding the program requirement that an initial treatment team meeting occurs within 30 days of intake, only 58.1% (*n* = 18) of the cases reviewed met this criterion. An important caveat to this finding, however, is that one of the two programs clarified that they do not convene formal team meetings. Thus, there is some variability in terms of how the programs operate their treatment teams. Documentation indicated that for all of the cases reviewed, the primary coordinator/caseworker assigned to the case met with the family within the first 30 days, and usually within the first week of case initiation. For the programs that did convene team meetings, these typically occurred weekly (*n* = 7) or at least once or more per month (*n* = 4).

Documentation for a few cases (*n* = 5) indicated that the team met seldom (e.g. only once or twice). Most files did not include documentation as to the location where team meetings were held; for those that did, the files indicated that team meetings were usually convened at the clients' home (*n* = 7).

Findings related to the composition of the treatment teams are presented in Table 6. Overall, the findings suggest that while most cases (93.5%, *n* = 29) had a clearly identified treatment coordinator, many of the other stakeholders expected to be a part of the treatment team as specified in the program contract were absent. The reason for this was not always clear from the case file documentation, but with regard to some of these stakeholders (e.g. Juvenile Probation Officer, Guardian ad Litem) a possible explanation is that they may not be applicable to all cases. For example, not all youth included in this sample had DJJ involvement, and therefore were unlikely to have a Probation Officer assigned to their case. Similarly, Guardians ad Litem are assigned by the court upon the discretion of the judge, and many system-involved youth never receive one.

Table 6. Treatment Team Composition

Stakeholders included on treatment team:	**N**	**%**
Treatment coordinator	29	93.5
Therapist/counselor	11	35.5
Juvenile Probation Officer	5	16.1
Child Protective Investigator or Dependency Case Manager	3	9.7
School or vocational program representative	3	9.7
Guardian ad Litem	2	6.5

Concerning the requirement that the program conduct three weekly contacts with the clients during the first two months of services, very few cases met this criteria (9.7%, *n* = 3). Often this was due to cancelled appointments or resistance from clients to meeting more frequently, and not a lack of effort by program staff to meet this requirement. The mean number of weekly contacts was 1.997 (*SD* = 0.924). The majority of the case files (71.0%, *n* = 22) also contained documentation indicating that appropriate follow up occurred when clients expressed concerns or identified new needs during the course of services, and that concerted efforts were made to engage the family and youth in services (77.4%, *n* = 24).

Discharge Planning

At the time of review, 20 of the 31 cases (64.5%) had been discharged. Of these cases, 19 had a discharge plan on file (95%), however, only one case had an updated family and youth assessment documented in the file. Documentation in the discharge plans indicated that half of the cases were discharged because the client had completed the program, demonstrated improvements in their behavior, or made sufficient progress towards their treatment goals (50%, *n* = 10). Several cases had unplanned discharges for a variety of reasons, including clients refusing to further engage in services, a youth's placement change, or escalation to a higher level of care. Five of the 20 cases (25%) incurred a placement change for the youth between their intake and discharge; three of these involved a move to a higher level of care. Case file documentation indicated that a majority of clients were actively engaged in services at the time

of their discharge (65.0%, *n* = 13). The mean service duration for those discharged was 5.51 months (*SD* = 2.22 months).

Conclusions and Limitations

The review of case files indicated that the specialized treatment programs primarily serve youth living at home with a variety of presenting problems, such as mental health issues; anger, aggression, or violent behavior; and/or substance use/abuse. The providers were able to meet most of the specifications outlined in their contracts, such as conducting comprehensive assessments, involving multiple stakeholders in team meetings, and providing a wide variety of treatment services. In some instances, staff experienced difficulty with conducting in-person visits three times per week. This was often due to resistance from clients or cancelled appointments. Of those youth who were discharged, approximately half of the files indicated that this was due to completing the program or making sufficient progress. Although we believe these results are representative of the programs because files were selected at random, conclusions are tentative due to the small sample size.

Study 3: Caregiver and Youth Surveys

The evaluation team received a total of 11 caregiver surveys and 11 youth surveys for the pretest and four caregiver surveys and four youth surveys for the posttest. The results of these surveys are presented in this report; however, results should be interpreted cautiously due to the small sample size. The tables below report differences in overall mean scores at Time 1 and Time 2, but we cannot determine whether the differences are statistically significant.

Demographic information for the 11 caregivers is presented in Table 7. The majority of respondents were female, and the sample was racially and ethnically diverse. The mean age of the respondents was 48 years, and a majority were not married or living with a partner. Family income varied, with over half earning $30,000 or less. Approximately 46% of the respondents had graduated from college, and many reported receiving government benefits, such as food assistance or Medicaid.

Table 7. Demographic Information of Caregivers Responding to Survey (Pretest)

	N	%
Agency		
CHS	5	45.5
Devereux	3	27.3
NYAP	2	18.2
Missing	1	9.1
Gender		
Male	1	9.1
Female	10	90.9
Race/Ethnicity		
Hispanic or Latino/a	4	36.4
Black or African American	3	27.3
White	4	36.4
Age	*M* = 48.2	*SD* = 17.5

Marital Status		
Married	2	18.2
Partnered (living together)	1	9.1
Single	3	27.3
Divorced	2	18.2
Separated	1	9.1
Widowed	2	18.2
Family Housing		
Own	4	36.4
Rent	6	54.5
Temporary (shelter, temporary with relatives/friends)	1	9.1
Total Family Income		
$0-$10,000	1	9.1
$10,001-$20,000	1	9.1
$20,001-$30,000	4	36.4
$30,001-$40,000	0	0.0
$40,001-$50,000	4	36.4
More than $50,001	1	9.1
Highest Level of Education		
Some high school	1	9.1
High school diploma or GED	1	9.1
Trade/vocational training	2	18.2
Some college	2	18.2
2-year college degree (Associate's)	3	27.3
4-year college degree (Bachelor's)	2	18.2
Benefits Received*		
Food Assistance (SNAP or WIC)	5	45.5
Medicaid (State Health Insurance)	5	45.5
Temporary Assistance for Needy Families (TANF)	1	9.1
Social Security Disability Insurance/Supplemental Security Income (SSDI/SSI)	4	36.4
Note. *More than one category may be selected. Categories with 0 responses are not reported.		

As shown in Table 8, caregiver satisfaction with the specialized treatment programs was high. For instance, caregivers strongly believed that the treatment team wanted them to succeed in treatment. Overall, mean scores improved slightly from Time 1 to Time 2, with the exception of Items 4 and 7-9. However, it should be noted that Time 2 scores are based on a very small number of respondents, and the differences over time were minimal.

Table 8. Caregiver Satisfaction Survey

Item		Time 1		Time 2		Did scores improve?
		Mean	SD	Mean	SD	
1	The treatment team encourages my family to share their point of view.	4.55	0.52	4.75	0.50	Yes
2	The treatment team spends too much time focusing on my family's weaknesses.*	2.09	1.38	1.75	0.96	Yes

3	Working with the treatment team has given me more hope about what my family life will be like in the future.	4.27	0.91	4.50	1.00	Yes
4	The treatment team values the knowledge I have of my own child.	4.64	0.51	4.50	1.00	No
5	It is hard for me to work with the treatment team.*	1.45	0.69	1.25	0.50	Yes
6	The treatment team cares whether my family succeeds in treatment.	4.73	0.47	4.75	0.50	Yes
7	I feel alone in managing my family's case.*	1.36	0.51	1.75	0.96	No
8	The treatment team is available when my family needs them.	4.55	1.16	4.50	1.00	No
9	The treatment team connects my family with the services we need.	4.36	0.67	4.25	0.96	No
10	I am involved in decisions about my family's case.	4.64	0.51	4.75	0.50	Yes
11	I realize that I need some help to make sure my family has what they need.	4.18	0.98	4.25	0.96	Yes
12	The treatment team does not understand my family's background or culture at all.*	1.82	1.17	1.25	0.50	Yes

Note. Possible responses are 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree. * Indicates a reverse scored item in which lower scores are desirable.

Table 9 shows average ratings of items on the short form of the Pediatric Symptom Checklist-17. At both time points, the most common problems with youth as reported by their caregivers were "distracted easily" and "does not listen to rules" (M = 2.55 at Time 1 and M = 2.75 at Time 2). Although mean scores improved for half of the items, the overall mean for Time 1 and Time 2 were nearly the same (M = 2.02 at Time 1 and M = 2.03 at Time 2).

Table 9. Pediatric Symptom Checklist-17

Item		Time 1		Time 2		Did scores improve?
		Mean	**SD**	**Mean**	**SD**	
1	Fidgety, unable to sit still	2.27	0.79	2.50	0.58	No
2	Feels sad, unhappy	2.09	0.30	2.00	0.00	Yes
3	Daydreams too much	1.73	0.47	1.50	0.58	Yes
4	Refuses to share	2.18	0.75	1.75	0.96	Yes
5	Does not understand other people's feelings	2.18	0.60	2.50	0.58	No
6	Feels hopeless	1.55	0.52	2.00	0.00	No
7	Has trouble concentrating	2.36	0.67	2.25	0.96	Yes
8	Fights with other children	1.91	0.83	1.50	0.58	Yes
9	Is down on him/herself	1.82	0.41	2.25	0.50	No
10	Blames others for his or her troubles	2.09	0.70	2.00	1.16	Yes
11	Seems to be having less fun	1.82	0.41	1.50	0.58	Yes
12	Does not listen to rules	2.55	0.52	2.75	0.50	No
13	Acts as if driven by a motor	1.64	0.67	1.75	0.96	No
14	Teases others	1.82	0.75	1.75	0.50	Yes
15	Worries a lot	1.64	0.51	1.50	0.58	Yes

16	Takes things that do not belong to him or her	2.18	0.75	2.25	0.96	No
17	Distracted easily	2.55	0.52	2.75	0.50	No
Note. Respondents are asked to indicate a response that best describes their child. Possible responses are 1 = never, 2 = sometimes, 3 = often. Lower scores are desirable.						

Table 10 compares the Time 1 and Time 2 results of the self-reported parenting survey. Five items had mean scores that improved over time. After three months of being in the program, caregivers were more likely to have a friendly talk with their child, play games or doing fun things with their child, and calmly explain to their child why their behavior is wrong when they misbehave. However, scores did not improve for the majority of items, and this may be due to a variety of factors, including the brief time interval and the small sample.

Table 10. Parenting Survey

Item		**Time 1**		**Time 2**		**Did scores improve?**
		Mean	**SD**	**Mean**	**SD**	
1	You have a friendly talk with your child.	3.73	0.65	4.25	0.96	Yes
2	You threaten to punish your child and then do not actually punish him/her.*	2.45	0.93	3.25	1.26	No
3	Your child fails to leave a note or let you know where he/she is going.*	3.09	1.38	2.75	2.06	Yes
4	You yell or scream at your child when he/she has done something wrong.*	2.64	0.81	3.25	1.26	No
5	You ignore your child when he/she is misbehaving.*	1.64	0.81	2.50	1.00	No
6	You play games or do other fun things with your child.	3.45	0.93	3.50	0.58	Yes
7	Your child talks you out of being punished after he/she has done something wrong.*	2.09	1.14	2.75	1.71	No
8	Your child stays out in the evening past the time he/she is supposed to be home.*	2.27	1.35	2.75	2.06	No
9	You compliment or praise your child when he/she does something well.	4.60	0.52	4.50	0.58	No
10	You take away privileges or money from your child as a punishment.	4.09	1.04	4.00	0.82	No
11	You slap or spank your child when he/she has done something wrong.*	1.91	0.83	2.25	0.96	No
12	You hit your child with a belt, switch, or other object when he/she has done something wrong.*	1.45	0.82	2.00	0.82	No
13	Your child is out with friends you don’t know.*	2.27	1.42	3.50	1.73	No
14	You let your child out of a punishment early (like lift restrictions earlier than you originally said).*	2.27	0.79	3.00	0.82	No
15	Your child helps plan family activities.	3.27	1.01	3.00	0.00	No

16	You calmly explain to your child why his/her behavior was wrong when he/she misbehaves.	4.00	0.63	4.50	0.58	Yes
17	Your child is home without adult supervision.*	2.27	1.27	1.25	0.50	Yes
Note. Respondents are asked to rate each item as to how often it typically occurs in their home. Possible responses are 1 = never, 2 = almost never, 3 = sometimes, 4 = often, 5 = always. * Indicates lower scores are desirable.						

Demographic information for the 11 youth is presented in Table 11. The majority of respondents were male, and the sample was racially and ethnically diverse. The mean age of the respondents was 14 years, and a majority were in middle school. Approximately half reported that they had been absent from school between 3 and 5 days in the past month. Most indicated that more than one adult resided in the home with them.

Table 11. Demographic Information of Youth Responding to Survey (Pretest)

	N	%
Agency		
CHS	5	45.5
Devereux	3	27.3
NYAP	2	18.2
Missing	1	9.1
Gender		
Male	8	72.7
Female	3	27.3
Race/Ethnicity*		
Hispanic or Latino/a	3	27.3
Black or African American	5	45.5
White	2	18.2
Multiracial	2	18.2
Age	*M* = 14.33	*SD* = 1.87
Grade Level		
5th	1	9.1
6th	2	18.2
7th	2	18.2
8th	3	27.3
9th	0	0.0
10th	2	18.2
11th	1	9.1
12th	0	0.0
Days Absent from School in Past Month		
0	1	9.1
1-2	1	9.1
3-5	6	54.5
6-9	2	18.2
10 or more	1	9.1
Adults in Household		

One	3	30.0
More than one	8	70.0
Note. *More than one category may be selected.		

Table 12 summarizes the information from the school survey completed by the youth. Mean scores improved for half of the items from Time 1 to Time 2. The item that demonstrated the most improvement was "I respect most of my teachers." The means for items pertaining to peer relationships, academic grades, getting in trouble, and skipping school did not improve.

Table 12. School Survey

Item		Time 1		Time 2		Did scores improve?
		Mean	**SD**	**Mean**	**SD**	
1	I get along with my peers at school.	3.82	1.08	3.75	1.50	No
2	I respect most of my teachers.	3.27	1.35	4.00	0.82	Yes
3	I care about getting good grades.	3.82	1.17	3.75	0.96	No
4	Most of my teachers care about how I'm doing.	3.40	1.17	3.75	0.96	Yes
5	I try my best at school.	3.55	1.13	3.50	1.29	No
6	It is important to me that I complete my education.	3.64	1.29	4.00	0.82	Yes
7	I check my schoolwork for mistakes.	2.73	1.62	3.25	1.26	Yes
8	I think about dropping out often.*	2.50	1.51	2.00	0.82	Yes
9	I get in trouble in school often.*	2.70	1.34	2.75	0.50	No
10	I skip class or try to stay home from school frequently.*	2.36	1.43	2.75	0.96	No
Note. Possible responses are 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree. * Indicates a reverse scored item in which lower scores are desirable.						

Table 13 provides self-reported information from the youth about their behavioral and emotional health based on responses to the Pediatric Symptom Checklist-17-Youth. At pretest, the most common problems were "fight with other children," "do not listen to rules," and "distracted easily." This is fairly consistent with the parent-reported information on the Pediatric Symptom Checklist-17 (see Table 9); however, parents rated several behaviors as more problematic than the youth. Unlike the parent version, scores for most items on the youth version improved from Time 1 to Time 2 along with the overall means ($M = 1.62$ for Time 1 and $M = 1.49$ for Time 2).

Table 13. Pediatric Symptom Checklist-17-Youth

Item		Time 1		Time 2		Did scores improve?
		Mean	**SD**	**Mean**	**SD**	
1	Fidgety, unable to sit still	1.50	0.53	1.50	1.00	Same
2	Feels sad, unhappy	1.73	0.65	1.25	0.50	Yes
3	Daydream too much	1.64	0.67	1.50	0.58	Yes
4	Refuse to share	1.73	0.79	1.75	0.96	No
5	Do not understand other people's feelings	1.55	0.69	1.50	1.00	Yes
6	Feel hopeless	1.45	0.69	1.25	0.50	Yes

7	Have trouble concentrating	1.73	0.65	1.50	1.00	Yes
8	Fight with other children	2.00	0.78	2.00	0.82	Same
9	Down on yourself	1.60	0.70	1.00	0.00	Yes
10	Blame others for your troubles	1.45	0.69	1.75	0.96	No
11	Seem to be having less fun	1.55	0.69	2.00	1.16	No
12	Do not listen to rules	2.09	0.70	1.75	0.96	Yes
13	Act as if driven by a motor	1.09	0.30	1.00	0.00	Yes
14	Tease others	1.55	0.82	1.50	1.00	Yes
15	Worry a lot	1.55	0.69	1.25	0.50	Yes
16	Take things that do not belong to you	1.36	0.67	1.25	0.50	Yes
17	Distracted easily	2.00	0.89	1.50	1.00	Yes
Note. Respondents are asked to indicate a response that best describes themselves. Possible responses are 1 = never, 2 = sometimes, 3 = often. Lower scores are desirable.						

Table 14 summarizes the responses of the youth on the risk behaviors survey. Scores for most items either improved or remained the same from Time 1 to Time 2. The exceptions were “purposely damage, destroy, or set fire to someone else’s property or belongings” and “steal something worth $50 or less.” In addition, at Time 2, some youth still would consider skipping school without an excuse.

Table 14. Risk Survey

Item		Time 1		Time 2		Did scores improve?
		Mean	**SD**	**Mean**	**SD**	
In the next year, how likely is it that you would…						
1	Skip school without an excuse?	1.91	1.04	1.50	0.58	Yes
2	Purposely damage, destroy, or set fire to someone else’s property or belongings?	1.18	0.60	1.50	1.00	No
3	Steal something worth $50 or less?	1.27	0.91	1.50	1.00	No
4	Go joyriding (i.e., to take a motor vehicle such as a car or motorcycle for a ride without the owner’s permission)?	1.27	0.91	1.00	0.00	Yes
5	Hit someone or get into a physical fight?	2.27	1.19	2.25	1.26	Yes
6	Use a weapon, force, or strong arm methods to get money or things from people?	1.00	0.00	1.00	0.00	Same
7	Use tobacco or drink alcohol?	1.27	0.91	1.00	0.00	Yes
8	Use illegal drugs (such as marijuana, LSD, ecstasy, cocaine, heroin, etc.) or prescription drugs (such as Vicodin, OxyContin, Fentanyl, Xanax, etc.) outside their intended use?	1.36	0.92	1.00	0.00	Yes
9	Pressure or force someone into having sex (including oral, vaginal, or anal sex) when they don’t want to?	1.09	0.30	1.00	0.00	Yes

10	Intentionally hurt or tease an animal to cause it pain?	1.00	0.00	1.00	0.00	Same
11	Sell drugs?	1.18	0.41	1.00	0.00	Yes
Note. Possible responses are 1 = not at all likely, 2 = somewhat likely, 3 = likely, 4 = very likely. Lower scores are desirable.						

Conclusion

Caregivers reported high levels of satisfaction with their treatment teams, and they indicated some improvement in their child's emotions and behaviors, but little change in their parenting skills. It is possible that the small sample and a brief three-month interval may not be enough time to demonstrate significant improvements, but the results are encouraging. Youth had considerable improvements on nearly all dimensions, from school satisfaction to emotional and behavioral symptoms. After three months, they also were somewhat less likely to endorse engaging in risky behaviors. Thus, it appears the programs are having a positive impact on the behaviors and opinions of the youth served.

Study 4: Outcomes

This study examines the characteristics and outcomes of dually served youth who were referred to the specialized treatment programs. Results are based on a descriptive analysis of administrative data by the evaluation team. The following research questions were addressed:

1. What are the characteristics of youth served (demographics, diagnoses, prior services, living situation)?
2. Do the services provided prevent further involvement with the dependency/delinquency systems?
3. Do youth show improvements in behavioral health outcomes, school engagement, and attitudes toward delinquency?

Results for Devereux Advanced Behavioral Health

1. *What are the characteristics of youth served (demographics, diagnoses, prior services, living situation)?*

Table 15 contains the descriptive statistics for all youth enrolled in Devereux's specialized treatment program between December 2017 and April 2019. The average age was slightly over 15 years old when entering the program. There were slightly more females than males, and 45.7% of the youth were Black. Nearly 47% of the youth had four or more adverse childhood experiences (ACEs). The Centers for Disease Control reports that only 12.5% of the general population have four or more ACEs. High ACE scores have been linked to a wide variety of mental health, substance abuse, and physical health problems in youth and adults. Twenty-nine percent were referred to the program through DCF while 23.4% were referred by a mental health provider or physician. Finally, the reason for referral was at times reported in the treatment plan and in many cases was inferred from the biopsychosocial or discharge summary. Nearly 77% were referred due to conduct disorder, oppositional defiance, and/or aggression.

Table 15. Demographic Characteristics (n = 123)

	Mean or %
Age	15.1
Gender (*n* = 92)	
Male	48.9%
Female	51.1%
Race (*n* = 35)	
Black	45.7%
White	17.1%
Hispanic	28.6%
Other	8.6%
Adverse childhood experiences (ACEs) - 4 or more	46.8%
Referral source (*n* = 94)	
DCF	28.7%
DJJ	18.1%
Mental health provider or physician	23.4%
Other	29.8%
Reason for referral (*n* = 90)	
Conduct disorder/oppositional defiance/aggression	76.7%
Depression	12.2%
Other	16.7%

Table 16 contains youth characteristics based on whether the youth successfully completed the program. Bivariate tests were completed comparing youth who completed the program with youth that did not complete the program with the resulting *p* values included in the table (a $p < .05$ would be considered statistically significant). None of the differences were determined to be statistically different. Despite not achieving statistical significance, the difference in ACE score is notable, with an average of 2.6 for completers and 4.0 for non-completers. In addition, 46.5% of non-completers have 4 or more ACEs compared to 27.3% of completers. Because bivariate comparisons were not statistically significant, we did not perform a multivariate analysis that examined the effects of completing treatment while controlling for demographics, referral source, and referral reason.

Table 16. Characteristics Associated with Treatment Completion

	Completed	Did not complete	*p*-value
Age	15.1	15.3	.766
Gender			
Male	14.8%	85.2%	.365
Female	25.0%	75.0%	
Referral Source			.958
DCF	17.6%	82.4%	
Mental Health Provider	22.2%	78.8%	
Outreach Program	50.0%	50.0%	
Probation Release Authority	50.0%	50.0%	
Referral Reason			.884
Oppositional defiance	20.9%	35.5%	

Depression	28.6%	71.4%	
Other	20.0%	80.0%	
Adverse childhood experiences (ACEs)			
ACE Score (mean)	2.6	4.0	.151
ACEs - 4 or more	27.3%	46.5%	.257

2. *Do the services provided prevent further involvement with the dependency/delinquency systems?*

Table 17 contains a description of the services used by participants. The most frequently used services were case management (69.1%), individual therapy (59.3%), family therapy (49.6%), and parental coaching (39.0%).

Table 17. Services Used by Participants (n = 123)

Services	% who used service
Case management	69.1
Individual therapy	59.3
Family therapy	49.6
Group therapy	16.2
Parental coaching	39.0
Suicide risk exam	17.0

Table 18 presents descriptive data on the number of youth successfully discharged, the length of treatment, and placement at discharge. Twenty-two percent of youth successfully discharged from the program. On average, youth were enrolled for over five months, and 44.0% were in a lower level of care upon discharge than at admission. In some cases, discharge to a lower level of care was associated with premature discharge or refusal to engage in services.

Table 18. Discharge Status (n = 56)

	Mean or %
Reason for discharge	
Completed treatment/successful	21.5%
Moved to higher level of care	17.9%
Parent/child request or non-compliance with program	44.6%
Other*	16.1%
Days enrolled	158.7
Placement at discharge	
Lower level of care	44.0%
Same level of care	30.0%
Higher level of care	26.0%
*Includes discharge due to conflicting counseling services, maximizing service time, placement disruption, being a runaway, and being discharged with no reason provided.	

3. *Do youth show improvements in behavioral health outcomes, school engagement, and attitudes toward delinquency?*

Table 19 contains descriptive data on outcomes measured at admission and follow-up. The number of responses to the measures varied. There were 94 assessments at admission and 45 follow-up assessments. A follow-up assessment may be done during treatment or at discharge. Only 29 youth with a follow-up assessment were discharged from the program. Statistics are reported for all youth that were assessed at admission, and only for those that also had follow-up assessments. The primary assessment tool was the Children's Functional Assessment Rating Scale (CFARS). For each CFARS measure, youth were assessed to have no problems, less than a slight problem, a slight problem, slight to moderate problem, moderate problem, moderate to severe problem, severe problem, severe to extreme problem, or extreme problem. We report the percentage of youth that were assessed to have moderate or higher problem for each CFARS measure. Sixty-eight percent of youth had moderate or higher needs at admission regarding home behavior. The percentage fell to 40% at follow-up. Nearly 58% of youth had moderate or higher needs regarding relationships at admission, compared to 47% of youth at follow-up. Overall, the percentage of youth having moderate or higher problem fell for most CFARS measures. Declines were statistically significant for five of the measures: depression, traumatic stress, home behavior, anxiety, and work/school behavior.

Nearly half of youth had a diagnosable conduct disorder and 24% had a stress/adjustment reaction disorder. The diagnostic profile remained similar at follow-up. Nearly three quarters of youth were dependents living with parents. The Child Behavior Checklist (CBCL) was completed for youth at admission, but very few youth had a completed CBCL at discharge.

The comparison of CFARS measures between admission and follow-up must be interpreted cautiously. One reason a youth is discharged is because they were making progress in the program. Thus, one potential condition for being selected for discharge (and hence a discharge assessment) is improvement in the CFARS measures. Simple comparisons of pre- and post-measures can overstate a program's effectiveness. However, there are reasons to believe the program was having a positive effect. As noted in Table 18, only 22% of youth (*n* = 12) were successfully discharged. Most youth with follow-up CFARS assessments did not successfully complete the program, and improvements in their outcomes do not reflect sample selection issues.

Table 19. Outcomes

	Baseline (*n* = 94)	Baseline (*n* = 45)	Follow-up (*n* = 45)	*p*-value
CFARS (Moderate needs or higher)				
Depression	45%	44%	22%	.010
Thought process	35%	37%	33%	.839
Traumatic stress	46%	44%	18%	.001
Home behavior	68%	70%	40%	.002
Danger to self	25%	19%	13%	.133
Anxiety	36%	30%	18%	.027
Cognitive performance	9%	12%	11%	.625
Substance abuse	14%	14%	13%	.937
ADL function	5%	9%	7%	.752
Danger to others	18%	19%	13%	.484
Hyperactive	20%	16%	13%	.327
Medication	3%	5%	7%	.349

Relationships	58%	61%	47%	.236
Work/school	56%	56%	31%	.005
Secure	18%	16%	9%	.159
Mental health				--
Conduct disorders	49%	44%	49%	
Stress/adjustment reaction	23%	30%	31%	
Other	28%	26%	20%	
Resident status				--
Dependent living with relatives	73%	84%	72%	
Independent living with relatives	19%	12%	9%	
DJJ facility	0%	0%	7%	
Other	7%	5%	12%	
DJJ contact last 90 days	9%	9%	13%	.208
% school days attended	76%	74%	73%	--
Child Behavior Checklist (CBCL)	**(*n* = 33)**		**(*n* = 14)**	
Internalizing problems	12	--	12	
Total score	58	--	66	

Table 20 examines how the CFARS assessments changed between baseline and follow-up comparing those that did and did not successfully complete treatment. A smaller percentage of youth had moderate or higher needs at follow-up among those completing treatment. Improvements were less consistent among youth that did not successfully complete treatment. Despite consistent improvements among youth completing treatment, the differences were not statistically significant.

Table 20. Effect of Treatment Completion on Improvement in Youth Outcomes

	Baseline		**Follow-up**		
	Completed	**Did not complete**	**Completed**	**Did not complete**	***p*-value**
CFARS (Moderate needs or higher)					
Depression	56%	38%	20%	24%	.714
Thought process	22%	46%	20%	44%	.085
Traumatic stress	33%	50%	10%	10%	.626
Home behavior	67%	71%	30%	24%	.799
Danger to self	33%	17%	10%	16%	.649
Anxiety	33%	33%	10%	24%	.491
Cognitive performance	11%	13%	20%	8%	.714
Substance abuse	22%	13%	10%	20%	.908
ADL function	11%	9%	10%	4%	.143
Danger to others	11%	25%	10%	16%	.545
Hyperactive	22%	17%	10%	20%	.626
Medication	0%	8%	0%	12%	.545
Relationships	56%	67%	20%	60%	.447
Work/school	0%	46%	10%	44%	.152
Secure	11%	21%	0%	16%	.491
Mental health					--
Conduct disorders	18%	54%	30%	56%	

Stress/adjustment reaction	27%	21%	40%	20%	
Resident status					--
Dependent living with relatives	78%	88%	80%	74%	
Independent living with relatives	22%	8%	10%	9%	
DJJ facility	0%	0%	0%	13%	
Other	0%	4%	10%	4%	
DJJ contact last 90 days	13%	11%	0%	20%	--

Results for Children's Home Society

1. *What are the characteristics of youth served (demographics, diagnoses, prior services, living situation)?*

Table 21 contains the descriptive statistics for 74 youth enrolled in the treatment program at Children's Home Society. The average age was slightly less than 15 years old when entering the program. The majority of youth were males and half were White. Forty-three percent of youth were referred from the community, while 33% were referred by DCF. Common reasons for referral included family issues (54.8%), mental health issues (26.0%), and offenses (15.1%).

Table 21. Demographic Characteristics (n = 74)

	Mean or %
Age	14.9
Gender	
Male	77.0%
Female	23.0%
Race	
Black	31.1%
White	50.0%
Hispanic	12.1%
Other	6.8%
Referral source	
DCF	32.9%
DJJ	24.7%
Community	42.5%
Referral reason	
Family issues	54.8%
Mental health	26.0%
Offenses	15.1%

Table 22 examines how youth characteristics are associated with the likelihood of competing the program. Only age was significantly associated with the probability of completing the program with younger youth more likely to complete the program.

Table 22. Characteristics Associated with Treatment Completion

	Completed	Did not complete	*p*-value
Age	14.7	15.7	0.046

Gender			
Male	60.0%	40.0%	0.724
Female	57.1%	42.9%	
Race			
White	64.5%	35.5%	0.942
Other	56.5%	44.5%	
Referral Source			0.942
DCF	60.0%	40.0%	
DJJ	58.3%	41.7%	
Community	66.7%	33.3%	
Referral Reason			0.487
Family issues	64.5%	35.5%	
Mental health	70.0%	30.0%	
Offenses	42.8%	51.2%	

2. *Do the services provided prevent further involvement with the dependency/delinquency systems?*

Table 23 contains a description of the services used by participants. Data were available for 62 youth. The most frequently used services were mental health services (74.2%), financial services (29.0%), school services (29.0%), and legal services (25.8%). Other services provided to one or a few youth included substance abuse, health care, vocational, employment and job search, and kinship services. Eleven youth received no services through the program because they either left before the initial assessment or had an unsuccessful discharge.

Table 23. Services Used by Participants (n = 62)

Services	N of users	% who used service
Mental health	46	74.2%
Finance	18	29.0%
School	18	29.0%
Legal	16	25.8%

Table 24 presents descriptive data on youth discharged from the program. Discharge data are available for 54 youth or 73% of youth referred for services. Twenty youth continued to receive services. On average, discharged youth were enrolled for over 3 months. Sixty one percent of discharged youth were discharged successfully with goals achieved, while 22.2% of youth referred to the program were discharged without having contact with the program. Sixty three percent were placed in home upon discharge.

Table 24. Discharge Status (n = 54)

	Mean or %
Days enrolled	95.6
Type of discharge	
Closed prior to assessment	22.2%
Unsuccessful	16.7%
Successful*	61.1%

Placement	
Home	63.0%
Other	13.0%
Unknown	24.1%
* Indicates that treatment goals have been met and the youth/family has supports in place to sustain improvements.	

3. *Do youth show improvements in behavioral health outcomes, school engagement, and attitudes toward delinquency?*

Table 25 contains descriptive data on pre and post CBCL scores. There were 50 pre measures and 17 post measures available. The average pre CBCL score was 70.3 and the average post score was 65.4. (Decreasing scores indicate an improvement in behavior.) When comparing youth with both pre and post measures, the average score declined 8.4 points during services ($p = .0005$). While the average score declined, 11 of 16 youth in the clinical range (> 63) at admission remained in the clinical range at discharge.

Table 25. Child Behavior Checklist Scores – Pre and Post

Clinical measures – CBCL Total Score	Mean
All youth with measures	
CBCL – pre ($n = 50$)	70.3
CBCL – post ($n = 17$)	65.4
Youth with both pre and post measures	
CBCL – pre ($n = 17$)	73.8
CBCL – post ($n = 17$)	65.4

The analysis was unable to examine whether outcomes varied depending on completion of the program. CBCL post measures were only available for youth completing the program.

Results for National Youth Advocate Program

1. *What are the characteristics of youth served (demographics, diagnoses, prior services, living situation)?*

Table 26 contains the descriptive statistics for 57 youth enrolled in the National Youth Advocate Program's CANEI program. The average age was slightly over 15 years old when entering the program. The majority of youth were Black males referred to the program by DCF.

Table 26. Demographic Characteristics (n = 57)

	Mean or %
Age	15.3
Gender	
Male	57.9%
Female	42.1%
Race	
Black	70.2%
White	24.6%
Other	5.4%
Referral source	

DCF	57.9%
DJJ	38.6%
Other	3.6%

2. *Do the services provided prevent further involvement with the dependency/delinquency systems?*

Table 27 contains a description of the "flexible services" used by participants. Data were available for 27 youth. The most frequently used flexible services were family therapy, education advocacy, and connections to services (e.g., specific community resources, substances, mental health and other specialized treatment).

Table 27. Flexible Services Used by Participants (n = 27)

Flexible Services	Users	% who used service
Family therapy	23	85.2
Education advocacy	23	82.1
Connection to services	22	81.5
Volunteer activities	20	74.1
Parental education	16	59.3
Leadership activities	14	51.9
Mindfulness	12	44.4
Parent advocates	12	44.4

Table 28 presents descriptive data on the number of youth successfully discharged, the length of treatment, and placement at discharge. Forty percent of youth successfully discharged from the program. On average, youth were enrolled for nearly five months, and 87.5% were placed in the community upon discharge.

Table 28. Discharge Status (n = 41)

	Mean or %
Reason for discharge	
Completed treatment	40.0%
Moved to higher level of care	15.0%
Parent/child request or non-compliance with program	45.0%
Days enrolled	143.6
Placement at discharge	
Community	87.5%
Other (foster care, runaway, juvenile detention)	12.5%

Table 29 examines whether youth characteristics are associated with treatment completion. None of the youth characteristics were significantly associated with the probability of program completion.

Table 29. Characteristics Associated with Treatment Completion

	Completed	Did not complete	*p*-value
Age	15.5	15.2	.617
Gender			
Male	41.7%	58.3%	.681
Female	35.3%	64.7%	
Race			
White	63.6%	36.4%	.092
Black	28.6%	71.4%	
Referral Source			
DCF	44.0%	56.0%	.239
DJJ	31.3%	68.8%	

3. *Do youth show improvements in behavioral health outcomes, school engagement, and attitudes toward delinquency?*

Table 30 contains descriptive data on outcomes measured at discharge. The number of responses to the measures varied. Thirty of 36 youth had a discharge placement at the same or a lower level than at intake. Caregivers that received parental education had an increase in their Adult Adolescent Parenting Inventory (AAPI) score suggesting that parenting can be improved when needed. There were several adverse outcomes for which improvements were measured. On average, most families demonstrated improvements in parental management, school achievement, interest in school, peer delinquency, negative attitudes, substance use, and anger management. While there only 16 responses, most youth exhibited emotional or behavioral progress, educational or vocational progress, independent living progress and family progress. The statistical significance of the improvements in outcomes could not be assessed because the only available information indicates whether there was an improvement, not the extent of the improvement.

Table 30. Outcomes

Improvements in outcomes	**%**
Is discharge placement at same or lower level than at intake? (*n* = 36)	83.3
If caregivers received parent education services, did the AAPI score improve? (*n* = 13)	92.3
% that improved negative outcome measures (*n* = 34)	
Poor parental management	65.6
Poor school achievement	58.8
Low interest or commitment to school	70.6
Peer delinquency	64.7
Negative attitudes	69.7
Substance use difficulties	73.5
Anger management problems	69.7
Was there progress?	
Emotional or behavioral progress (*n* = 16)	81.3
Educational or vocational progress (*n* = 14)	78.6
Independent living skills progress (*n* = 14)	71.4
Family progress (*n* = 12)	66.7

Table 31 contains outcomes for families that did and did not complete the treatment program. Families that completed the program had better outcomes than families that did not complete the program. Families that completed treatment were more likely to have improved parental management (*p* = .016), improved attitudes (*p* = .020), less association with delinquent peers (*p* = .015), and fewer anger management problems (*p* = .042). While not meeting criteria for statistical significance, a higher percentage of families that completed treatment had improvements in school achievement, a greater commitment to school, and fewer substance use difficulties.

Table 31. Effect of Treatment Completion on Improvement in Youth Outcomes

	Completed	Did not complete	*p*-value
Placement at discharge			
Community	93.8%	90.9%	.316
Other	6.3%	9.1%	
Placement level			
Same or below	85.7%	81.8%	.760
Higher	14.3%	18.2%	
Poor parental management			
Improvement	87.5%	43.8%	.016
No improvement	12.5%	56.3%	
Poor school achievement			
Improvement	75.0%	44.4%	.077
No improvement	25.0%	55.6%	
Low interest or commitment to school			
Improvement	87.5%	44.4%	.054
No improvement	12.5%	55.6%	
Peer delinquency			
Improvement	87.5%	44.4%	.015
No improvement	12.5%	55.6%	
Negative attitudes			
Improvement	93.3%	50.0%	.020
No improvement	7.1%	50.0%	
Substance use difficulties			
Improvement	87.5%	61.1%	.096
No improvement	12.5%	38.9%	
Anger management problems			
Improvement	87.5%	52.9%	.042
No improvement	12.5%	47.1%	

Table 32 contains the results of the follow-up survey. Results were available for only 8 youth, and thus it is unclear whether these results can be generalized to all youth discharged from the program. Of the respondents, all had at least 2 reliable adults to whom they could turn to for support, and maintained placement at the same or lower level than at discharge. Seven of the eight maintained vocational or school engagement, and a substance free lifestyle.

Table 32. Follow-up Survey Results (n = 8)

Question	%
Does youth have at least 2 reliable adults to whom they can turn for support when needed?	100.0
Has youth maintained vocational and/or school engagement success?	85.7
Has youth maintained placement at same or lower level than at the time youth was discharged from CANEI?	100.0
Does youth continue to maintain a substance free lifestyle?	85.7
Does child/youth effectively utilize coping skills to manage daily challenges in an effective manner?	100.0
Has youth been free of probation violations or new delinquency/criminal charges for 2 months prior to discharge (based on act(s) occurring after admission to CANEI program)?	100.0

Comparative Results

Table 33 provides a summary of results across the specialized treatment programs. Most youth are referred to the programs by DCF or other sources rather than DJJ. Some regions serve a greater proportion of minority youth than others. Males are slightly overrepresented in two of the programs. The average age was consistent across the programs at around 15 years. The average length of treatment was ranged from 96 days (3 months) to 159 days (5 months). Of those youth who were discharged, the proportion of successful discharges ranged from 22% to 61%.

Table 33. Summary of Results across Programs

	Devereux	CHS	NYAP[1]
Total number enrolled (since December 2017)	123	74	57
Total number discharged (as of April 2019)	56	54	41
Referral source			
DCF	28.7%	32.9%	57.9%
DJJ	18.1%	24.7%	38.6%
Other	53.2%	42.5%	3.6%
Race/ethnicity			
Black	45.7%	31.1%	70.2%
White	17.1%	50.0%	24.6%
Other	37.2%	18.9%	5.4%
Gender			
Male	48.9%	77.0%	57.9%
Female	51.1%	23.0%	42.1%
Age (mean)	15.1	14.9	15.3
Days enrolled (mean)	158.7	95.6	143.6
Completed treatment or other successful discharge	21.5%	61.1%	40.0%

[1] Youth referred to NYAP who did not engage in services are not included.

Conclusions and Limitations

Results of the administrative data analysis suggest that the youth referred to the specialized programs have a wide range of presenting problems, but conduct problems and behavioral issues (including mental health disorders and substance abuse) are common. The majority of referrals come from DCF or other sources rather than DJJ. On average, 41% of the youth referred to the programs successfully completed treatment. Additional research will be needed to determine the characteristics of youth and families that did not engage or ended services prematurely.

Overall Conclusions

The specialized treatment programs serve youth and families with numerous risk factors for continued involvement with the child welfare and juvenile justice system. In spite of some challenges with family engagement and adherence to timelines as specified in their contracts, the specialized treatment programs demonstrated success on a variety of outcomes. For example, youth and families who remained in treatment showed significant improvement, and the majority of youth were not discharged to higher level of care, which is a primary goal of the programs.

Recommendations

The evaluation team recommends the following:

- DCF may want to allow greater flexibility in the required number of weekly contacts. The intensity of the program was a common barrier to getting families engaged, and providers often had difficulty meeting the requirement due to family scheduling challenges.
- Programs should provide additional, comprehensive cultural sensitivity/competency and trauma-informed training to program staff.
- Given the difficulty respondents reported in engaging caregivers, the programs might consider incorporating a parent peer mentor or support specialist with lived experience as part of the program.
- Programs should consider administering a brief survey to families that choose not to participate as well as to families that discontinue the program to learn why they made that choice. This real-time information would be helpful for programs to determine which modifications need to be made to increase participation or adherence.
- Programs should utilize a standard protocol for collecting information on performance measures and other important indicators, such as type and frequency of specific treatment services provided to youth and their caregivers.
- All programs should be encouraged to use electronic records to facilitate information sharing.
- The programs should agree on a common set of assessment tools and schedule for administration; for example, the CBCL, CFARS, and SAVRY could be administered at assessment and discharge. Additionally, programs should be encouraged to collect outcome data using brief assessment tools for youth who leave the program before completing treatment.

- DCF should work with the providers to set appropriate outcome goals. Moreover, it is important to define what constitutes a good outcome. Preventing out-of-home placements or demonstrating improvement in functioning made not be sufficient for an intensive program.

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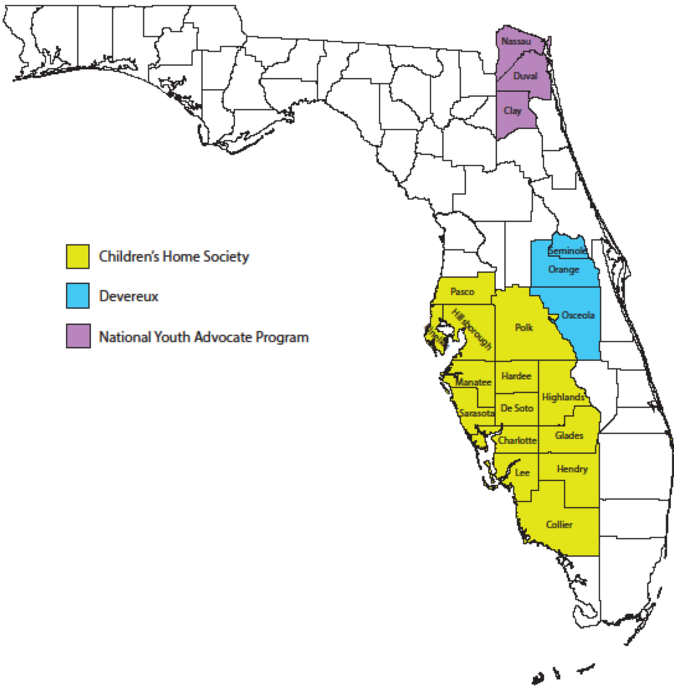
APPENDIX A

Evaluation of Specialized Treatment Programs for Dually Served Youth

The University of South Florida is collaborating with the Florida Department of Children and Families to evaluate the impact of specialized treatment programs for dually served youth and their families. We are interested in learning whether these programs successfully prevent deeper involvement with the child welfare and juvenile justice systems. We also want to learn about the impact of the programs on other youth and caregiver outcomes. The evaluation will consist of several activities, including case file reviews, focus groups with administrators and front-line staff, and longitudinal surveys of caregivers and youth.

Case file reviews of a small sample of cases from each provider will assess whether youth are receiving services as intended. Focus group discussions will explore the processes for referring families, expectations for participation, methods for ensuring quality and effectiveness, strategies for engaging families and procedures for re-engaging families that discontinue participation, and successes and challenges with achieving the specified goals of the program. We anticipate conducting two focus groups with each provider.



In addition, two surveys will be developed and administered longitudinally. The caregiver survey will assess parent engagement and satisfaction, parenting skills, and youth behavior problems. The youth survey will assess behavioral health outcomes and attitudes related to delinquency and school engagement. We will work with the providers to determine the best method for distributing the surveys.

We look forward to working with you on this important evaluation. If you have questions, please contact Melissa Johnson (mhjohns4@usf.edu; 813-974-0397) or Lodi Rohrer (llrohrer@usf.edu; 813-974-0517).

APPENDIX B-1

Evaluation of Specialized Treatment Programs for Dually Served Youth
Informed Consent Information

You are being asked to take part in an evaluation study of specialized treatment programs for dually served youth. This project is not under the oversight of the USF Institutional Review Board (IRB); however, we would like to provide you with information about the study purpose and procedures, risks and benefits, and confidentiality.

The people in charge of this study are Lodi Rohrer (813-974-0517) and Melissa Johnson (813-974-0397). Other study staff are also involved and can act on behalf of the individuals in charge.

Study Purpose: The purpose of this study is to evaluate the impact of specialized treatment programs for dually served youth and their families that are being implemented by providers in the Northeast, Central, and Suncoast regions of Florida. These programs offer individualized treatment services for youth who are being served by the juvenile justice and child welfare systems with the goal of preventing deeper involvement with these systems.

Study Procedures: You are being asked to participate in a focus group. Focus group discussions may be audiotaped for accuracy in reporting, if you agree to this. Audio recordings will be professionally transcribed, and the recordings will be erased once the transcriptions are verified for accuracy. You will only be asked to participate in one focus group; however, study staff may want to re-contact you if further information or clarification is needed. Your participation in this study is voluntary.

Benefits: While you may not receive any direct benefit by taking part in this study, the information you provide will help the evaluation team develop a comprehensive understanding and description of how these programs are being implemented. The only cost to you will be the time you take to participate in this focus group. You will not receive compensation for taking part in this study.

Risks: This is a minimal risk study which means that the risks associated with this study are the same as what you face every day. There are no known additional risks to you by taking part in this study.

Privacy and Confidentiality: We will keep study records private and confidential as allowed by law, and your name will not be included in the study report. Study findings will be summarized and reported in aggregate form. We may also publish what we learn from this study, but if we do, we will not include your name or any other personally identifiable information.

APPENDIX B-2

Evaluation of Specialized Treatment Programs for Dually Served Youth
Staff Background and Demographics

1. What is your position title? ________________________

2. How long have you worked in this position? ___________

3. What is your typical/average caseload? _____________

4. What is your gender? M F Other: __________

5. What is your race/ethnicity? Please circle all that apply.

Asian	Native American/Alaska Native
Black/African American	Pacific Islander/Native Hawaiian
Hispanic/Latino	White/Caucasian
Other: ________________	

6. What is your highest level of education attained?

___ Bachelor's Degree; Major: ________________

___ Master's Degree; Major: ________________

___ Doctorate Degree; Major: ________________

___ Other (e.g. medical, law): ______________________

APPENDIX B-3

Programs for Dually Served Youth
Focus Group Guide

1. How would you describe the purpose/objective of the [dually served youth program]?

2. Tell me about your role with this program. What are your typical tasks and responsibilities?

3. How are families referred to your agency for these services? What are the eligibility criteria for families to receive these services? What role, if any, do you have in assessing a family's eligibility?

4. Tell me about the types of cases that are typically referred for this program. (e.g. What kinds of allegations or family/youth risk factors do you typically see on these cases? Family/youth characteristics? Needs?)

5. What strategies do you use to engage youth and families in treatment planning and services? What other factors facilitate family and youth engagement?

6. What factors hinder or present barriers to family and youth engagement in the program? How do you address the barriers to family engagement? (e.g. What do you do if a family is reluctant or resistant towards engaging in services?)

7. What is the process for assessing family and youth needs and strengths? How are youth and families involved in identifying their needs and strengths? How are family and youth strengths incorporated in the family's service plan?

8. What kinds of services are provided to these families and youth? To what extent are they individualized to the particular needs of the clients? Do you provide all the services in house or do you refer families out to any other providers? On average, how many hours per week of services do families/youth receive (e.g. number and length of sessions per week)?

9. Are there particular program models or evidence based practices that you use? What steps are taken to ensure that services/programs are being implemented as intended (e.g. with fidelity to the model)?

10. What processes are used to assess a family's progress towards desired goals and outcomes? How are decisions made about when to close a case?

11. What procedures are in place for ensuring the quality of services provided and assessing the effectiveness of the program?

12. In your experience, how effective is this program in meeting the needs of families and youth with dual system involvement? Please explain and identify any gaps that you've observed.

13. What do you think are the strengths of this program? What are the challenges of this program and/or serving these particular families? What services or programs do you feel are most beneficial to families and youth with dual system involvement?

14. Do you have any recommendations about how the program might be improved to better serve these families and youth?

Thank you!

APPENDIX B-4

DSY Code List

Purpose/Goals of Services

Prevention	Prevent future child maltreatment, further involvement with DCF
Family Preservation	Keep families intact, prevent child removals
Parenting skills	Address parenting practices, develop skills/capacities of parents to care for their children
Self-sufficiency	Develop the capacities of families to be independent, e.g. able to meet their own needs and not reliant on state intervention
Linkage	Link families to resources/supports in their community
Root issues	Identify and address the underlying/root causes of child maltreatment
Realistic goals	Focus on setting up realistic goals with families

Family Characteristics

Mental health	Parents suffer from mental health problems/mental illness
Substance abuse	Parents have problems with substance abuse/misuse
Domestic violence	Issues with domestic/family violence
Physical injury	A child in the home has been physically injured
Sexual abuse	Cases involve allegations of sexual abuse of children
Hazardous conditions	Home has hazardous environmental conditions
Poverty	Families struggle with low economic status/poverty, employment instability or joblessness, trouble meeting basic needs, etc.
Homeless	Families struggle with housing instability or homelessness, unable to find/access affordable housing
Single parents	Families with a single-parent household
Young parents	Parents are young/inexperienced

Child health	Families have children with significant physical or behavioral health problems or developmental disabilities and have trouble meeting the child's special needs
Inadequate supervision	Families have issues with leaving children unsupervised, lack adequate childcare/supervision
Prior history	Parents have prior history with DCF as perpetrators of abuse/neglect
Generational	Families have been involved with DCF over multiple generations; parents were formerly in the system as children.
Unsafe neighborhoods	Families live in neighborhoods with high levels of crime and community violence (gangs, drugs, etc.)
Worker biases	Workers convey negative views/attitudes towards families, use judgmental or stigmatizing language, such as "dysfunctional," "aggressive," "ignorant," "resistant," "crazy," "addict."

Family Engagement

Benefits	Emphasize the potential benefits to the family of engaging in services, such as preventing future involvements with DCF
Strengths-based	Workers identify and build on family strengths
Accessible language	Avoid professional jargon, use language that families can easily understand
Empathy	Demonstrate empathy for the family's situation, approach things from their perspective, avoid blame/shame
Respect	Treating families with respect and dignity
Family input	Soliciting the family's perspective on their needs, strengths, and goals for services and incorporating this into the family's plan
Family driven	Giving the family the authority to choose their services and goals; the family drives the service plan, with help from professionals, as opposed to simply providing input on the plan.
Provider driven	The family's plan and services appear to be largely dictated by the provider's assessment of what the family needs.
Youth involvement	The inclusion of youth in service planning and provision is explicitly noted.

Coercion	Workers manipulate or pressure the family to engage in services, such as by failing to inform the family that services are voluntary or telling the family that participating in services is the only way to get rid of DCF.
Misinformation	Workers take advantage of a family's misinformation to get them engaged in services, such as the belief that DCF won't close their case if they don't engage or fear that their children will be removed.
Distancing	Workers actively distance/separate their agency from DCF, clarify and reinforce to families that they do not work for DCF
Stigma	Families are resistant/hesitant to engage in services because they fear stigma of DCF involvement, don't want others to know.
Disagreement	Family does not agree with the allegations or reason for intervention, does not feel there is a need for services
Intrusive	Families find services to be overly intrusive, too many people in the home, too many requirements and/or too much time commitment.
Further intervention	Families are concerned that cooperation with services will result in increased intervention by DCF and possible removal of their children
Communication	Providing clear and honest information to the family about the program, including the voluntary nature of services and what families can expect.

Program Model

Eligibility – high risk	Program only accepts/serves high/very high risk families.
Eligibility – lower risk	In addition to high risk, program also serves families with lower levels of risk (e.g. moderate or low risk).
Eligibility – in-home	Program only serves families whose child(ren) currently lives in the home (has not been removed).
Eligibility – other	Anything else concerning eligibility that does not fit into the other categories.
Referrals – CPI	Program receives/accepts referrals from CPI (including Sheriff's office).
Referrals – DJJ	Program receives/accepts referrals from DJJ/probation.

Referrals – community	Program receives/accepts referrals from other community partners, such as schools, mental/physical health providers, etc.
Specified model	The program uses a specific, formal, manualized program model.
Frequency of contact	The program has established criteria for how frequently workers must have contact with the family.
Different tracks	Program offers two or more distinct tracks to address families with differing levels of need and service intensity.
Limited duration	Services are intended to be time-limited in their duration, e.g. 3-4 months.
Family team meetings	Program convenes child/family team meetings as part of their program model, in which the family and all their formal and informal supports come together for service planning and/or progress review.
Flexible	There is flexibility in service provision to accommodate family needs, such as workers/providers going to the family's home or other community locations to deliver services, scheduling appointments in the evening or weekends, etc.
Individualized	Services are tailored to the family's particular needs and strengths.
Most beneficial	Specific services or components of the program that are identified as being the most beneficial to families.
Early initiation	Program allows for the agency to begin working with families before CPI finishes the investigation and transfers the case.

Services (in house)

IH-Parenting	Services designed to teach/develop parenting skills.
IH-Counseling	Individual counseling/therapy to address mental health needs.
IH-Family therapy	Family counseling/therapy to address family dynamics, improve communication, etc.
IH-SA counseling	Counseling to address issues with substance use/abuse
IH-Advocacy	Family is provided with an advocate who can assist with various needs (educational, legal, etc.) and help ensure the family has a voice in their services.
IH-Vocational skills	Program provides services to help in development of employment/vocational skills.

IH-Care coordination	Program provides care coordination for the family, including workers who are specifically responsible for care coordination.
IH-Support groups	Program offers support groups for parents and/or youth.
Psychoeducation	Provision of education about mental health, domestic violence, or substance misuse to help the client understand the impact of these issues on their life and functioning
Transport assistance	Provision of transportation for clients, including vouchers or passes for public transit.
Daycare assistance	Provision of daycare subsidies or help with paying for childcare.
EBPs	Program models or practices that are recognized as evidence-based.

Community Services

CS-Basic needs	Assistance for families in meeting basic needs, such as food, housing, clothing, utilities, etc.
CS-SA treatment	Services for substance abuse treatment, such as detox, counseling, etc.
CS-MH treatment	Mental health services (therapy, counseling, psychiatry, etc.) that are not provided in house.
CS-Parenting	Services designed to teach/develop parenting skills.

Service Gaps

Housing	Affordable/low-income housing and/or housing assistance programs.
Transportation	Public transportation options (buses, trolleys, etc.)
Daycare	Affordable childcare options or subsidized programs.
Flex funding	Funds to help with meeting the family's basic needs, e.g. paying an overdue utility bill, down payment for an apartment, etc.

Structural Barriers

Capacity	Insufficient staff capacity to deal with the number of referrals
Funding	Inadequate program funding to support the number of cases and/or provide the amount and quality of services that families need.

DCF assessment	Risk assessments described as "overly cautious", not an accurate assessment of a family's need for services.
Referral process	Time frame of receiving referrals from CPIs towards the end of their investigation, resulting in delay of service initiation.
Family schedules	Difficulty working around families' work and school schedules to provide the intensity of services prescribed.
Access to resources	Families don't know how or are unable to access resources in their community to meet their needs; includes poor availability, lack of flexible hours, lack of insurance coverage, etc.
Community partners	Agencies such as schools, DJJ, DCF, etc. not fully cooperating or collaborating.
Short-term solutions	Lack of long-term solutions to address family economic needs.
Pressure to close	Workers feel pressure to close out cases sooner than they feel ready in order to stick to prescribed timeframes.
Dual roles	Staff have multiple roles that sometimes create conflict, e.g. serving as both safety management and family support provider.

Program Evaluation

Recidivism data	The program uses data such as subsequent/verified reports, child removals, arrests, etc. to assess program effectiveness.
Service completion	The program uses data on service completion rates to assess program effectiveness.
Functional outcomes	The program measures changes in parental and/or child skills, capacities, well-being, functioning, etc. to assess program effectiveness.
Anecdotal	Perceptions of success without supporting data
Unsuccessful	Ways in which participants understand, rationalize, and make sense of unsuccessful cases.
Withdrawal	Procedures for family to terminate services, request case closure prior to agency decision to discharge.

Assessment

Measures	Use of validated measures/tools for assessing family needs and improvement over time
Family involvement	Assessment process includes family's input regarding their needs and how they are progressing towards their goals; family decides when they feel their needs have been met.
Progress reviews	Family's progress is periodically reviewed to re-assess where they are at in achieving their goals.
Observation-family	Use of observation to assess the family's situation and progress (e.g. observation of children, home environment, parent behavior, family dynamics, etc.)
Supports	Extent to which family has been connected to long-term providers and resources used as an indicator of readiness for case closure
Collaterals	Workers interview collaterals such as extended kin, neighbors, school personnel, other providers, etc. to assess the family's needs, behaviors, and change.

Monitoring & QA

Certification	Program has a certification process to ensure all employees are properly trained in the program model.
Case reviews	Periodic case reviews are conducted to assess for quality and adherence to program model.
Observation	Periodic observation of workers is performed (e.g. by a supervisor) to assess for quality and adherence to program model.
Fidelity	Program has formal fidelity tools/processes built in (may include case reviews or observation, or other processes) which are used to monitor adherence to the program model.
Client survey	Program administers a survey or interview to obtain family feedback on the services they received.

APPENDIX C

Case ID# ________________ Date of Case Review ___ / ___ / ____ Reviewer: ________________

Referral and Case Background	
Date of initial referral: ____ / ____ / ____ Date of initial contact: ____ / ____ / ____ (Within 24 hours of referral? ☐ Y ☐ N)	
Gender of focal child: ☐Female ☐Male	Birthdate of focal child: ____ / _____ / _____
Adults in household in relation to child: Adult 1: ________________________ Adult 2: ________________________ Adult 3: ________________________	Birthdates of adults: Adult 1: ____ / _____ / _____ Adult 2: ____ / _____ / _____ Adult 3: ____ / _____ / _____
Reason for referral:	
Child's placement at in-take: ☐ In-Home ☐ Licensed Foster Home ☐ Relative/Non-Relative ☐ Detention facility ☐ Other: ________________________ If out-of-home placement, date child removed from home: ____ / ____ / ____	
Screening and Intake Assessment	
Date of assessment: ____ / ____ / ____ (Within 30 days of initial contact? ☐ Y ☐ N) Describe how the youth and family were included in the assessment process: Did the assessment consider the following: Caregivers' capacity to protect the child and manage his/her behavior. ☐ Y ☐ N Observations of interactions between the child and household members. ☐ Y ☐ N Whether the child can live safely in the current home or placement. ☐ Y ☐ N An assessment of the caregivers' strengths and resources. ☐ Y ☐ N An assessment of the caregivers' needs that hinder providing a safe and stable home. ☐ Y ☐ N An assessment of the youth's strengths and resources. ☐ Y ☐ N An assessment of the youth's needs and risk of dual system involvement. ☐ Y ☐ N Identification of special needs of the child and family. ☐ Y ☐ N ☐ NA The caregivers' perspective of their strengths and needs. ☐ Y ☐ N The youth's perspective of his/her strengths and needs. ☐ Y ☐ N	

Treatment and Service Plan
Date of treatment plan: ____ / ____ / ____ (Within 15 days of Intake Assessment? ☐ Y ☐ N) Does the file contain evidence that the treatment plan was discussed with the family and that the voice of the youth and the family were considered during the planning process? ☐ Y ☐ N Please explain: Was the treatment plan signed by all vested parties (parents, youth, providers) within 15 days of initial assessment? ☐ Y ☐ N If No, who has not signed? ____ Does the treatment plan include each of the following services: Family counseling? ☐ Y ☐ N Weekly youth group sessions? ☐ Y ☐ N Parental skill building? ☐ Y ☐ N Therapeutic mentor for youth? ☐ Y ☐ N Case management? ☐ Y ☐ N School or vocational engagement? ☐ Y ☐ N Skill building for transition to adulthood/ independent living? ☐ Y ☐ N Availability of 24/7 crisis support? ☐ Y ☐ N What other services and supports are included in the treatment plan? (Please indicate any EBPs) Are the services and supports identified in the treatment plan consistent with the identified needs and service recommendations from the family intake assessment? ☐ Y ☐ N Please explain:
Treatment Team Members and Meetings
Date of first treatment team staffing: ____/____/____ (within 30 days of family's intake? ☐ Y ☐ N) Who participated in the initial staffing?

Does the treatment team provided for the youth and family include:

Treatment coordinator? ☐ Y ☐ N

CPI or DCM? ☐ Y ☐ N

Juvenile Probation Officer? ☐ Y ☐ N

Guardian ad Litem? ☐ Y ☐ N

Other community partners? ☐ Y ☐ N Specify: ________________________________

Representative from school or vocational program? ☐ Y ☐ N

Other supports? ☐ Y ☐ N Specify: ____________________________________

Where did the treatment team usually meet? ____

How frequently did the treatment team meet? ______________________________________

Dates of weekly face-to-face contacts during first two months of treatment:

Month 1, Week 1: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 1, Week 2: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 1, Week 3: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 1, Week 4: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 2, Week 1: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 2, Week 2: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 2, Week 3: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Month 2, Week 4: ____ / ____ / ____ & ____ / ____ / ____ & ____ / ____ / ____

Were three weekly contacts held during the first two months of treatment? ☐ Y ☐ N

Did these contacts occur at a location that was convenient to the family? ☐ Y ☐ N

Please specify:

Is there evidence that the treatment team followed up with concerns expressed, questions asked, or additional needs identified by the family during meetings, visits, or other contacts? ☐Y ☐N

Please explain:

Is there evidence of efforts that were made to engage the family and youth in services? ☐Y ☐N

Please explain:

Discharge Planning
Date of discharge plan: ____ / ____ / ____ Summary of progress and reason(s) for discharge: ____ ____ Was an updated family assessment completed to determine whether the family's needs have been sufficiently met? ☐ Y ☐ N Date of assessment: ____/____/____ Is there documentation that the youth and family were actively engaged in services and necessary supports are in place? ☐ Y ☐ N Has there been any change in the child's placement since in-take? ☐ Y ☐ N If yes, child's placement at discharge: ☐ In-Home ☐ Licensed Foster Home ☐ Relative/Non-Relative ☐ Detention facility ☐ Other: __________________ Was the discharge plan signed by all vested parties prior to the family's discharge? ☐ Y ☐ N Date of discharge: ____ / ____ / ____
Post-Discharge Follow-Up
Date of first follow-up: ____ / ____ / ____ (3 months after discharge date? ☐ Y ☐ N) Did the youth and family indicate a need for additional services? ☐ Y ☐ N If yes, what services were the youth and family referred to? Date of second follow-up: ____ / ____ / ____ (6 months after discharge date? ☐ Y ☐ N) Did the youth and family indicate a need for additional services? ☐ Y ☐ N If yes, what services were the youth and family referred to?

APPENDIX D-1

<MM/DD/YYYY>

Dear Caregiver:

My name is Lodi Rohrer, and I am a researcher at the University of South Florida. I am writing to request your help with an important project that is being sponsored by the Florida Department of Children and Families. We are reaching out to people like you to learn about your experiences as a caregiver. The information you provide will help DCF better understand the needs of the families they serve, and how well services are able to meet those needs.

All of our questions can be found on the enclosed survey, which you completed a few weeks ago. As part of our project, we are asking you to complete the survey again. If you would like to participate, please complete the survey and give it to your child's treatment coordinator or therapist. Your participation is strictly voluntary. If you do not wish to participate, you do not have to complete the survey. There is no known risk to you if you choose to participate. If you decide that you no longer want to participate, you are free to withdraw at any time.

You will receive a $10 gift card for completing this survey. The gift card will be given to you by your child's treatment coordinator or therapist.

If you decide to participate, all your information will remain confidential. This means that we will not tell anyone outside our study team that you participated, and we will not include your name or any other information that could be used to identify you in any of our reports. To help ensure your confidentiality, please do not write your name on the survey.

Thank you for taking the time to assist us with this project. If you would like more information or have questions, you can find my phone number and email listed below.

Sincerely,

Lodi Rohrer

Lodi Rohrer
813-974-0517
llrohrer@usf.edu

APPENDIX D-2

Evaluation of Specialized Treatment Programs for Dually Served Youth
Caregiver Survey

Your responses to this survey are confidential. If you need assistance completing the form, please contact a member of the evaluation team at 813-974-0517.

Demographics: Please answer the following questions about you and your household.

Gender: ☐ Male ☐ Female ☐ Other: ______________________

Age (in years): ________

Race/Ethnicity (select all that apply):
- ☐ Native American or Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ African National/Caribbean Islander
- ☐ Hispanic or Latino
- ☐ Middle Eastern
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Multi-racial
- ☐ Other: ______________________

Marital Status
- ☐ Married
- ☐ Partnered (living together)
- ☐ Single
- ☐ Divorced
- ☐ Widowed
- ☐ Separated

Family Housing
- ☐ Own
- ☐ Rent
- ☐ Shared housing with relatives/friends
- ☐ Temporary (shelter, temporary with relatives/friends)
- ☐ Homeless

Total Family Income
- ☐ $0 - $10,000
- ☐ $10,001 - $20,000
- ☐ $20,001 - $30,000
- ☐ $30,001 - $40,000
- ☐ $40,001 - $50,000
- ☐ More than $50,001

Highest Level of Education
- ☐ Elementary or junior high school
- ☐ Some high school
- ☐ High school diploma or GED
- ☐ Trade/Vocational Training
- ☐ Some college
- ☐ 2-year college degree (Associate's)
- ☐ 4-year college degree (Bachelor's)
- ☐ Master's degree
- ☐ PhD or other advanced degree

Which, if any, of the following do you currently receive? (Check all that apply.)
- ☐ Food assistance (SNAP or WIC)
- ☐ Medicaid (State Health Insurance)
- ☐ Earned Income Tax Credit
- ☐ Unemployment benefits
- ☐ Housing assistance
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Head Start/Early Head Start Services
- ☐ Social Security Disability Insurance/Supplemental Security Income (SSDI/SSI)
- ☐ None of the above

Caregiver Survey

Please rate the following statements with the scale provided.

Item	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. The treatment team encourages my family to share their point of view.	1	2	3	4	5
2. The treatment team spends too much time focusing on my family's weaknesses.	1	2	3	4	5
3. Working with the treatment team has given me more hope about what my family life will be like in the future.	1	2	3	4	5
4. The treatment team values the knowledge I have of my own child.	1	2	3	4	5
5. It is hard for me to work with the treatment team.	1	2	3	4	5
6. The treatment team cares whether my family succeeds in treatment.	1	2	3	4	5
7. I feel alone in managing my family's case.	1	2	3	4	5
8. The treatment team is available when my family needs them.	1	2	3	4	5
9. The treatment team connects my family with the services we need.	1	2	3	4	5
10. I am involved in decisions about my family's case.	1	2	3	4	5
11. I realize that I need some help to make sure my family has what they need.	1	2	3	4	5
12. The treatment team does not understand my family's background or culture at all.	1	2	3	4	5

Pediatric Symptom Checklist-17

For each statement, please circle the response that best describes your child:

Item	Never	Sometimes	Often
1. Fidgety, unable to sit still	1	2	3
2. Feels sad, unhappy	1	2	3
3. Daydreams too much	1	2	3
4. Refuses to share	1	2	3
5. Does not understand other people’s feelings	1	2	3
6. Feels hopeless	1	2	3
7. Has trouble concentrating	1	2	3
8. Fights with other children	1	2	3
9. Is down on him/herself	1	2	3
10. Blames others for his or her troubles	1	2	3
11. Seems to be having less fun	1	2	3
12. Does not listen to rules	1	2	3
13. Acts as if driven by a motor	1	2	3
14. Teases others	1	2	3
15. Worries a lot	1	2	3
16. Takes things that do not belong to him or her	1	2	3
17. Distracted easily	1	2	3

Parenting Survey

Instructions: The following are a number of statements about your family. Please rate each item as to how often it typically occurs in your home.

Item	Never	Almost Never	Sometimes	Often	Always
1. You have a friendly talk with your child.	1	2	3	4	5
2. You threaten to punish your child and then do not actually punish him/her.	1	2	3	4	5
3. Your child fails to leave a note or let you know where he/she is going.	1	2	3	4	5
4. You yell or scream at your child when he/she has done something wrong.	1	2	3	4	5
5. You ignore your child when he/she is misbehaving.	1	2	3	4	5
6. You play games or do other fun things with your child.	1	2	3	4	5
7. Your child talks you out of being punished after he/she has done something wrong.	1	2	3	4	5
8. Your child stays out in the evening past the time he/she is supposed to be home.	1	2	3	4	5
9. You compliment or praise your child when he/she does something well.	1	2	3	4	5
10. You take away privileges or money from your child as a punishment.	1	2	3	4	5
11. You slap or spank your child when he/she has done something wrong.	1	2	3	4	5
12. You hit your child with a belt, switch, or other object when he/she has done something wrong.	1	2	3	4	5
13. Your child is out with friends you don't know.	1	2	3	4	5
14. You let your child out of a punishment early (like lift restrictions earlier than you originally said).	1	2	3	4	5
15. Your child helps plan family activities.	1	2	3	4	5
16. You calmly explain to your child why his/her behavior was wrong when he/she misbehaves.	1	2	3	4	5
17. Your child is home without adult supervision.	1	2	3	4	5

APPENDIX E-1

<MM/DD/YYYY>

Dear Participant:

My name is Lodi Rohrer, and I am a researcher at the University of South Florida. I am writing to request your help with an important project that is being sponsored by the Florida Department of Children and Families. We are reaching out to young people like you to learn about your feelings and experiences regarding school, well-being, and relationships with caregivers. The information you provide will help DCF better understand the needs of the youth and families they serve, and how well services are able to meet those needs.

All of our questions can be found on the enclosed survey, which you completed a few weeks ago. As part of our project, we are asking you to complete the survey again. If you would like to participate, please complete the survey and give it to your treatment coordinator or therapist. Your participation is strictly voluntary. If you do not wish to participate, you do not have to complete the survey. There is no known risk to you if you choose to participate. If you decide that you no longer want to participate, you are free to withdraw at any time.

You will receive a $10 gift card for completing this survey. The gift card will be given to you by your treatment coordinator or therapist.

If you decide to participate, all your information will remain confidential. This means that we will not tell anyone outside our study team that you participated, and we will not include your name or any other information that could be used to identify you in any of our reports. To help ensure your confidentiality, please do not write your name on the survey.

Thank you for taking the time to assist us with this project. If you would like more information or have questions, you can find my phone number and email listed below.

Sincerely,

Lodi Rohrer

Lodi Rohrer
813-974-0517
llrohrer@usf.edu

APPENDIX E-2

Evaluation of Specialized Treatment Programs for Dually Served Youth
Youth Survey

Your responses to this survey are confidential. If you need assistance completing the form, please contact a member of the evaluation team at 813-974-0517.

Demographics: Please answer the following questions about you and your household.

Gender: ☐ Male ☐ Female ☐ Other: ______________________________

Date of birth: (mm/dd/yyyy) ____

Race/Ethnicity (select all that apply):

☐ Native American or Alaskan Native
☐ Asian
☐ African American
☐ African National/Caribbean Islander
☐ Hispanic or Latino
☐ Middle Eastern
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Multi-racial
☐ Other: ______________________________

What grade are you in?

☐ 4th grade
☐ 5th grade
☐ 6th grade
☐ 7th grade
☐ 8th grade
☐ 9th grade
☐ 10th grade
☐ 11th grade
☐ 12th grade
☐ Dropped out of school

How many days of school have you missed in the past school month?

☐ 0 days
☐ 1-2 days
☐ 3-5 days
☐ 6-9 days
☐ 10 or more days

Please list all the <u>adults</u> that live in your household according to your relationship with them. This can include parents, grandparents, other relatives, foster parents, legal guardians, friends, and more.

☐ ____
☐ ____
☐ ____
☐ ____
☐ ____

School Survey

Please rate the following items with the scale provided.

Item	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I get along with my peers at school.	1	2	3	4	5
2. I respect most of my teachers.	1	2	3	4	5
3. I care about getting good grades.	1	2	3	4	5
4. Most of my teachers care about how I'm doing.	1	2	3	4	5
5. I try my best at school.	1	2	3	4	5
6. It is important to me that I complete my education.	1	2	3	4	5
7. I check my schoolwork for mistakes.	1	2	3	4	5
8. I think about dropping out of school often.	1	2	3	4	5
9. I get in trouble in school often.	1	2	3	4	5
10. I skip class or try to stay home from school frequently.	1	2	3	4	5

Risk Survey

Please rate the following statements with the scale provided.

In the next year, how likely is it that you would…	Not at all likely	Somewhat likely	Likely	Very likely
1. Skip school without an excuse?	1	2	3	4
2. Purposely damage, destroy, or set fire to someone else's property or belongings?	1	2	3	4
3. Steal something worth fifty dollars ($50) or less?	1	2	3	4
4. Go joyriding, that is, to take a motor vehicle such as a car or motorcycle for a ride without the owner's permission?	1	2	3	4
5. Hit someone or get into a physical fight?	1	2	3	4
6. Use a weapon, force, or strong arm methods to get money or things from people?	1	2	3	4
7. Use tobacco or drink alcohol?	1	2	3	4
8. Use illegal drugs (such as marijuana, LSD, ecstasy, cocaine, heroin, etc.) or prescription drugs (such as Vicodin, OxyContin, Fentanyl, Xanax, etc.) outside of their intended use?	1	2	3	4
9. Pressure or force someone into having sex (including oral, vaginal, or anal sex) when they don't want to?	1	2	3	4
10. Intentionally hurt or tease an animal to cause it pain?	1	2	3	4
11. Sell drugs?	1	2	3	4

Pediatric Symptom Checklist-17

For each statement, please circle the response that best describes you:

Item	Never	Sometimes	Often
1. Fidgety, unable to sit still	1	2	3
2. Feel sad, unhappy	1	2	3
3. Daydream too much	1	2	3
4. Refuse to share	1	2	3
5. Do not understand other people's feelings	1	2	3
6. Feel hopeless	1	2	3
7. Have trouble concentrating	1	2	3
8. Fight with other children	1	2	3
9. Down on yourself	1	2	3
10. Blame others for your troubles	1	2	3
11. Seem to be having less fun	1	2	3
12. Do not listen to rules	1	2	3
13. Act as if driven by a motor	1	2	3
14. Tease others	1	2	3
15. Worry a lot	1	2	3
16. Take things that do not belong to you	1	2	3
17. Distracted easily	1	2	3