Meadows Mental Health Policy Institute

Recommended Child & Youth Mental Health Outcome Metrics

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What makes for a good outcome metric?

There are many competing demands and considerations to be made when selecting metrics for use by behavioral health systems. Jakubowski & Frumkin (2010), for example, described strong metrics or indicators as "measurable, simple, sensitive, robust, credible, impartial, actionable, and reflective of community values."[1]

A noteworthy, recent exemplar for the selection of metrics comes from the Data Work Group (DWG) of the Texas Council of Community Centers. The DWG's framework helped their group determine which adult clinical quality measures to promote across the behavioral health sector. The framework was based upon two key objectives: clinical relevancy and operational feasibility. Applying these two objectives targets the selection metrics that are closely connected to consumer mental health and has a relatively low burden associated with data collection. The DWG also used the following principles in rating metrics under consideration:[2]

- Data can be readily produced with reporting systems that currently exist;
- Employ, where possible, outcome (not merely process) measures;
- Effectively convey to other care providers the value of behavioral health services in terms that are germane to other care providers;
- Communicable to the entire state, how behavioral health providers would like to encourage system-wide development.

MMHPI Framework for Recommending Child Outcome Metrics

The first core principle in our framework is *relevance to child/youth functioning and developmental trajectory*. Developmental trajectory refers to the projected capacity for a child or youth to function within real world domains (school, home, community). Service systems seek to enhance trajectories of child and youth who are confronted with various biopsychosocial challenges that threaten their healthy development. They also promote the resilience of the youth and family as they face biopsychosocial challenges.

Operational Feasibility is a second core principle. Chosen metrics associated with child mental health outcomes must be those for which meaningful data are available which require a level of burden that does not exceed the benefit of the metric for use by the system in assessing its performance. The table below displays one method of depicting this matrix for discerning quality child/youth mental health outcomes.

[1] Jakubowski B & Frumkin H. (2010). *Environmental metrics for community health improvement*. Preventing Chronic Disease. 7(4).
[2] Bergman D. (2013). Subject: Data Work Group Endorsed Measures. Correspondence with Melissa Rowan. Health Intelligence Partners.

Metric Selection Objectives		
	Feasibility (High)	**Feasibility (Low)**
Relevance to Developmental Trajectory (high)	Ideal	
Relevance to Developmental Trajectory (low)		

Pestronk (2010) suggests that good public health metrics should not only be valid and reliable but also easily understood and accepted by both the people using them and by people to whom the metrics refer.[3] Outcome metrics should be useful both to policy makers, mental health authorities, providers, advocates and families in estimating the performance of the mental health system. That is, the outcome metrics ought to be both immediately recognizable as important (which is closely related to our first principle above), but they also should represent measures that, through the implementation of best practices and increasingly effective system collaboration and coordination, can be improved. They must represent measures for which the system can "move the needle" in the direction that represents better performance.

The metrics recommend here are therefore intended to support efforts by the Texas policy makers, mental health authorities, and providers to enhance the system and its services, as well as to families, advocates, and other stakeholders as they seek to encourage better outcomes for themselves and those they care about.

A final consideration is that the set of outcome metrics chosen collectively should allow for tracking both the mental health of the child/adolescent population as a whole, as well as the publicly funded system's performance in serving children and adolescents who have come to its attention, or who have come to the attention of other child-serving systems, such as the child welfare and juvenile justice systems.

Methods

Utilizing the key objectives chosen for selecting child/youth mental health outcomes measures (Relevance to Developmental Trajectory and Operational Feasibility), MMHPI conducted a

[3] Pestronk RM. (2010). *Using metrics to improve population hea*lth. Preventing Chronic Disease. 7(4)

multi-faceted search for child and mental health metrics. The first research objective was to identify national and state standards for child/youth mental health outcomes measures. The second objective was to identify what metrics were already being collected in Texas. With selection objectives in mind, specific metrics pertaining to each developmental domain were selected for recommendation.

Key sources included academic publications, additional literature (state and national governmental documents, reports, briefings, etc.), and web-based content from special interest groups (e.g. National Wraparound Initiative, NAMI). Appendix F provides a list of key informative sources, which were most constructive in formulating the recommendations in this document.

Review of National and State Outcome/Performance Systems

National Recommendations

To date, few accomplishments have been made in establishing national standards for addressing child and youth mental health. Recently, two independent initiatives published child health outcomes, both of which included some measures of mental health.

As apart of the Affordable Care Act and the Children's Health Insurance Protection Reauthorization Act (CHIPRA), a legislatively mandated nationally committee[4,5] was created to establish national child health care quality measures. Independent from the efforts by CHIPRA, the National Quality Forum (NQF) developed a set of child health core standard recommendations. Established in 1999, the NQF is a member-based foundation focused on national, state and local health agencies/organizations. NQF pursues efforts to create healthcare policy, promote best practices and lower healthcare costs.

Among the 171 measures child health outcomes measures considered by both initiatives bodies, only nine (9) unique measures addressed mental health outcomes (see Appendix B). Recommendations included the following:

- Follow-Up Care for Children Prescribed ADHD medication,
- Management of ADHD in Primary care for school-aged children and adolescents,
- Follow-up after hospitalization for mental illness,
- Developmental screening in the first 3 years of life,
- Developmental screening by 2 years of age,

[4] PL 111-113 Children's Health Insurance Program Reauthorization Act. This act required identification, refinement and development of child health care quality measures for voluntary use in Medicaid and Children's Health Insurance (CHIP).
[5] PL 111-148 (HR 3590) Patient Protection and Affordable Care Act

- Pediatric Symptom Checklist,
- Depression Screening by 13 years of age,
- Depression Screening by 16 years of age,
- Risky behavior assessment by age 13,
- Risky behavior assessment by age 18,
- Suicide Risk Assessment,
- Documentation of DSM-IV/V diagnostic evaluation for depression, and
- Diagnosis of ADHD in primary care for school-aged children and adolescents.

The CHIPRA and NQF recommendations are a good start to establishing standardized measures for examining child/youth mental health outcomes. However, the list is primarily comprised of process measures (follow-ups, screenings, assessments, etc.). These measures do not address the real world outcomes of children and youth, previously described above. Texas needs outcome data that reflect the experienced burden on youth, families, and services they access.

One national source that has established a framework for priority outcomes is the National Wraparound Initiative (NWI).[6] NWI researchers have identified several outcome domains and specific metrics within those domains that collectively represent a core set of outcome metrics for consideration.[7] Outcome domains include the following:

- Living Situation,
- Youth Behavior,
- Youth Functioning, and
- Youth Community Adjustment.

The strength of the NWI approach is that it considers the full range of developmentally relevant outcomes that are necessary to understand the effects of treatment and support for children and youth with serious behavioral health challenges. Examples of specific outcome metrics included in Wraparound research and the summaries of that research by Eric Bruns and colleagues, include very useful real life child/youth outcomes, for example:

- Juvenile Justice Involvement
    - Fewer episodes and days of detention
    - Lower recidivism (re-offense and re-incarceration) rates
    - Less likely to be arrested
- School Functioning
    - Improved school GPA
    - Fewer disciplinary actions at school

[6] See http://www.nwi.pdx.edu for additional information on NWI.
[7] See Bruns, E. J., & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound.* Portland, OR: National Wraparound Initiative.

    - Fewer unexcused absences
- Living Situation/Permanency
    - Moved to less restrictive living environment
    - Fewer runaway episodes
    - Less likely to experience a lot of placement changes

The NWI provides a rich set of metrics that have been used in research with children and youth and which have typically been sensitive to change (that is, research has tended to show that wraparound services improved outcomes on metrics like those listed above). One challenge in using NWI related metrics is that they tend to be measured in the context of a controlled study in which children and youth served through Wraparound were compared over time to children and youth served through services as usual or to some other similar comparison group. Research resources can be applied to the relatively small set of children and youth being tracked for the study.

But in our case the need is to identify metrics that can be tracked at a larger level and to compare to the system's own performance over time and to different regions in Texas in order to gauge various levels of performance. This requires using readily available data for large number of children and youth that may not necessarily have a readily available control group or comparison group to which their data can be compared.

Selected State Child Outcome/Performance Measurement Systems

An extensive web-search was conducted to identify states that have implemented statewide child/youth mental health outcome measures and reporting systems. While some meaningful findings were discovered, this process was limited and yielded relatively few results. While the presumption is that most states lack strong child mental health outcome metrics, the limitation of States to publish relevant data and policies online is may have confounded this web-search. With that caveat, a targeted and structured key informant may yield additional results in the future.

Among states that collect child mental health data, most are limited to collecting service data (Medicaid or other healthcare plans) or collecting assessment data among children and youth who encounter the social service or juvenile justice system. In a survey of State Medicaid Directors by the National Association for Medicaid Directors to determine which states has mental health outcome systems, among respondents, the most common data sources were health and mental health plans.[8] In regards to assessment, Texas (like many other states) has

[8] Department of Health Care Services. (2013). Performance Outcomes System Plan for Medi-Cal Specialty Mental Health Services for Children & Youth. Retrieved from

adopted statewide utilization of the CANS assessment tool, developed by Dr. John Lyons. The CANS is an open domain, actionable, child assessment instrument that is easy for child health professionals to use for action planning. The CANS is currently implemented statewide in at least sixteen (16) states and has non-statewide presence in at least another eighteen (18) state.

Similarly many states have implemented the SAHMSA sponsored National Outcomes Measures System (NOMS) for collecting change, youth and adult. In addition to biometric testing, the NOMS collects self-report measures of overall health and functioning, symptoms of mood, experiences of trauma and social connectedness.

The CANS and the NOMS provide valuable and relevant data to appraising the status of mental health impact and children and youth. However, as stated previously, these tools do not provide hard outcomes or, as we have stated earlier, real world outcomes. These tools can be thought of a proxy measures. They measure perceived beliefs regarding a person's health/mental health status, and may even convey actual past experience – in regards to substance use or experiences of trauma, but they do not capture actual behaviors. For this reason, we recommend proxy measure only be used when measures of actual behaviors are unavailable to measure domains of interest.

New Jersey

In a 2010 report, the New Jersey Department of Children and Families (DCF) identified outcomes measures/performance indicators for six areas of service for children: in-home services, permanency services, out-of-home care, health and mental health service, adolescent services and family support services.[9] DCF required providers to use objective and verifiable tools and measures to assess service outcomes, program efficacy and contract compliance. In Appendix D, full summaries of domains and metrics used by DCF are provided. Here we will highlight only specific domains that contain measures relevant to identifying child/youth mental health outcomes.

In-Home Services

Companionship/Mentoring Services comprise in-home and community-based advocacy, recreational, vocational, educational, outreach or supportive services that incorporate positive youth development strategies and techniques to prevent out-of-home placement, deter juvenile delinquency, promote safety, prevent teen pregnancy, and help adolescents transition safely to adulthood. Outcome criteria include the following:

[9] DCF Contract Categories (Third Party Contracts Only), 2010; retrieved from http://www.nj.gov/dcf/documents/contract/performance/PBO_12_01_09.pdf

- Percentage of youth will move to less restrictive care, remain in their home, reside independently, or will be stabilized in foster care/group home within 12 months of implementation of services.
- Percentage of youth regularly attends school.
- Percentage of youth remains free of adjudication with the juvenile justice system.

Health and Mental Health Services

Therapeutic Interventions include services that provide ongoing mental health treatment to address and resolve the issues that prompted the referral (i.e., maltreatment, behavior or mental health challenge within family). Therapy modalities include individual, group and family therapy. Outcome criteria include the following:

- Percentage of children show improvement in school functioning, as measured by teacher reports and/or report cards.

Evidence-Based Treatment, include modalities such as Multisystemic Therapy (MST) and Family Functional Therapy (FFT), which are intensive family and community-based intervention that addresses multiple aspects of serious antisocial behavior in adolescents.

- Percentage of youth will remain at home with their families.
- Percentage of youth will have no further system involvement.
- Percentage of youth will maintain improved academic performance and attendance.

Partial Hospitalization / Partial Care (child/youth) is an intensive, nonresidential, therapeutic treatment program. The program provides clinical treatment services in a stable environment, generally 3-5 hours/day, up to 6 days/week. Outcome criteria include the following:

- One month and six months post discharge, percentage of children/youth will be in the home of residence at discharge.
- One month and six months post discharge; percentage of children/youth will not be hospitalized psychiatrically.
- Percentage of children/youth show improvement in school functioning, as measured by teacher reports and/or report cards.

New York

The Children's Plan (the Plan) of New York State's Office of Mental Health (NYS OMH) serves as a blueprint for improving the social and emotional well being of New York's children and their families. The Plan represents a fundamental reform effort in services for children and articulates a strategy for moving from intensive and expensive services for a few, toward early intervention, collaboration and improved outcomes for youth and families.

One theme that emerged from this plan was the call for data-driven measures that can be used to better understand and improve the quality of services (and services outcomes) for youth and families. Toward his end, the Children, Teens and Families Indicators Portal Project was initiated to expand the availability of data-driven measures on youth and family services in New York State. The project platform is an internet-based public information portal – the "Children, Teens and Families Indicators Portal" (or "Kids Indicators Portal").[10] The Kids Indicators Portal comprises reports derived from data captured on the NYS OMH Child and Adult Integrated Reporting System (CARIS), including youth behavior/symptoms, functioning, youth and family strengths, family characteristics, and lengths of stay; input from NYS OMH Youth Assessment of Care (YAC) and Family Assessment of Care (FAC) surveys; and results from Child and Adolescent Needs and Strengths – Mental Health assessment data. A full summary of New York State's Child Mental Health domains, indicators and treatment modalities can be found in Appendix E.

Although New York State exhibits what is in many cases an ideal data focused infrastructure for child mental health services, quality metrics for child mental health outcomes are lacking. Generally outcome data is restricted to caregiver self-report and child assessment measures.

California

California is currently in the process of implementing a statewide mental health performance outcomes plan for children and youth with mental illness. Although California has yet to choose their specific metrics or reporting methods, their development and implementation plan is referenced here as an example of large state undergoing a statewide change in how they approach their measurement and reporting of child and youth mental health outcomes.[11,12]

[10] New York State – Office of Mental Health (n.d.). Home - About the Children, Teens and Families Indicators Portal. Retrieved from http://bi.omh.ny.gov/kids/index

[11] Department of Health Care Services. (2013). *Performance Outcomes System Plan for Medi-Cal Specialty Mental Health Services for Children & Youth*. Retrieved from http://www.dhcs.ca.gov/formsandpubs/Documents/Legislative%20Reports/Mental%20Health/SMHS_Perf_Outcomes_System-Plan11-01-13.pdf

[12] Department of Health Care Services. (2014). *Performance Outcomes System Implementation Plan for Medi-Cal Specialty Mental Health Services for Children & Youth*. Retrieved from http://www.dhcs.ca.gov/individuals/Documents/StakeholderAdvisoryCommittee/Performance%20Outcomes%20System%20Implementation%20Plan%20-%20Final%202014-01-10.pdf

Texas

Along with its transition from a Resiliency and Disease Management to a Resilience and Recovery approach to overseeing behavioral health services, DSHS has adopted the statewide use of the CANS. Although the CANS is based on self-report and clinician assessment, versus objective measures of functioning, specific sections (e.g. substance use, school performance) may serve as proxies in the absence of more objective metrics. The CANS is used in over 20 different state mental health systems and carries the distinct advantage of being the most often used measure for children and adolescent. A second advantage is that the CANS easily ties in to the clinical process and to family-centered planning. The biggest disadvantage of the CANS may be that change reported along its various scales may not be meaningful to many policy makers who would like to see more objective indicators of service outcome.

Currently, the Texas Department of State Health Services (DSHS) reports on a number of child-related metrics that are used to monitor the performance of the state's Local Mental Health Authorities (LMHAs). The table below lists the metrics currently collected and reported from the Mental retardation and Behavioral health Outcomes Warehouse. These metrics generally are process oriented, as they focused on services received. The few focused on outcomes (noted in bold italics below) were dependent upon tools like the CANS or the home-grown CA-TRAG that provide a summary clinician judgment about the severity of need (reduced need represents an improvement or "outcome") rather than a more concrete outcome (such as improved school attendance). While these child/youth mental health metrics are not ideal as outcome measures, they are and should be part of a broader approach evaluating the Texas mental health system-of-care for children and youth.

DSHS Child – Related LMHA Performance Metrics
• Average monthly number of children receiving community mental health services • Average monthly cost per child receiving community mental health services • Average monthly percentage of children in community mental health services appropriately-authorized • Average monthly percentage of children in community mental health services receiving minimum number of recommended service hours • Percentage of children in community mental health services receiving first service encounter within 14 days of assessment • Percentage of children in community mental health services avoiding crisis[13] • Percentage of children in community mental health services admitted 3 or more times in 180 days to a state or community psychiatric hospital • ***Percentage of children in community mental health services with improved or***

[13] This is measured as a lack of a crisis service, so it is not strictly a measure of a lack of crisis. There may have been a crisis and the system simply may not have responded.

acceptable functioning per year

- ***Percentage of children in community mental health services with improved or acceptable problem severity per year***
- ***Percentage of children in community mental health services with improved school behavior per year***
- ***Percentage of children in community mental health services avoiding re-arrest per year***
- ***Percentage of children in community mental health services with improved or acceptable co-occurring substance use per year***
- Number of children on waiting list for community mental health services with percentage waiting for all services

Recommended Outcome Metrics

From our review above, and given our concern that metrics represent relevant, real world indicators of child and family functioning, we have identified the following outcome domains within which potential metrics are identified. We also identify outcome ratings, which typically are provided either by behavioral health providers, by families/caregivers of children/youth being served, or by both providers and caregivers.

- Juvenile Justice Involvement
- Family Permanency
- Placement in Restrictive Settings
- Crisis and Suicide
- School Performance
- Substance Use

Collectively, outcome metrics and ratings from these domains should provide a useful gauge on the extent to which systems are helping children, youth and their families avoid negative outcomes and attain or maintain positive functioning.

Some of the metrics recommended below could be obtained at the total population level (referencing all children and youth in the services area) or at the served level (referencing only those children/youth receiving behavioral health services). We believe it is useful to include population-level and service-level metrics so that both the performance of regional authorities and the performance of specific providers can be assessed. The adoption of population-level metrics can drive mental health planners and authorities to develop system improvements in order to reduce suicide rates, for example, or as another example, to work more closely in conjunction with the child welfare system to reduce the rate of case closure of children/youth with behavioral health problems. Population-level metrics often are more difficult to obtain,

however, because of challenges associated with knowing how many children/youth included in the statistics (e.g., served in the juvenile justice system) had behavioral health disorders and how many did not.

Service-level metrics serve to isolate better the performance of providers in serving children and youth with identified problems who have enrolled in services. Positive outcome results using service-level metrics indicate high quality services for those who were lucky enough to have enrolled in services. Positive service-level outcomes in the absence of positive population-level outcomes might indicate either that resources are sufficient only to serve a sub-set of the population, that services have not been focused on the children/youth most-in-need, or several other possible service system challenges. Good population outcomes in the absence of good service-level outcomes should be rare, but they could indicate that population-in-need is smaller or has less severe/intensive needs in a given region, or that natural supports and other less formal resources in the community are meeting some of the need. In any case, the mix of population-level and service level outcomes provides useful input to the system, as it plans its own local processes of drilling down into the data to identify system strengths and weaknesses.

Outcome ratings, using the CANS and other measurement instruments that are completed by providers and/or caregivers also have their places in an outcome measurement system. First, where actual outcome metrics are too difficult to obtain (or still in development), outcome ratings from these measures can serve as proxies to the more objective estimates provided by actual outcome metrics. Second, these measures often represent a wider array of proximal outcomes – that is, outcomes that are closer to what providers can directly affect in their programming – and therefore are useful at the clinical level. However, outcome ratings can be subject to rater effects, especially if significant penalties or rewards are applied based on outcome rating results.

The six tables of outcome metrics and ratings below, organized by outcome domains, summarize MMHPI's recommendations for child/youth outcomes measures for statewide implementation in Texas. For each metric or rating, the data source (who would produce the data) and metric source (the source – system or specific protocol – that inspired the metric) are indicated. Metrics and ratings that would be tracked at the population level (versus only for those receiving services) are indicated in parentheses. Lastly, metrics identified as particularly relevant are written in **bold** type, and metrics considered feasible are in *italics*. Use of both ***bold and italics*** indicates maximum combined relevance and feasibility.

Juvenile Justice metrics seek to capture the degree to which children/youth with behavioral health problems are involved in the justice system. Mental health systems that help providers intervene early in problem development, that effectively engage children, youth and families in

services, and that collaborate effectively with other systems, tend to relieve some of the pressure on the juvenile justice system to serve youth with externalizing problems, substance abuse, and family disruptions.

In the table below we identify a small set of ideal metrics for examining the rates of involvement and re-involvement in the juvenile justice system, among youth with behavioral health problems. Metrics were inspired by the National Wraparound Initiative and by the outcomes approach being used in New Jersey. At least two of the three metrics could be used at the population level, data permitting. Obtaining good data on these metrics will require the mental health and juvenile justice systems to work together collaboratively. Currently, data on these specific metrics are limited or will vary in completeness and quality from region to region in Texas. The Child and Adolescent Needs and Strengths (CANS) assessment tool provides a proxy for juvenile justice involvement. The CANS includes needs domains ("Risk Behaviors") and specific, one-item anchored scales ("Antisocial Behavior" and "Crime/Delinquency") that, when assessed at both baseline and six-month or 12-month follow-up can serve as a measure of outcome. Ratings are provided to mental health authorities by clinicians, working closely with families/caregivers to obtain the ratings. The Wraparound Fidelity Index also has an item that is useful to this domain.

Domain	Metric	Data Source	Metric Source
Juvenile Justice Involvement	**Outcome Metrics**		
	Number of episodes and days of detention and incarceration for youth with behavioral health disorders (population)	Texas Juvenile Justice Department	NWI
	Number of episodes and days of detention and incarceration for enrolled youth with histories of juvenile justice involvement	TJJD	NJ-DCF NWI
	Number of re-offenses committed by youth with behavioral health disorders, after first offense (population or service level)	TJJD / Police Departments	NJ-DCF
	Outcome Ratings		
	Change from baseline to clinical follow up on the Risk Behaviors Domain and on the specific Antisocial Behavior, Crime/Delinquency scales	Providers and Families/ Caregivers	CANS[14]
	Percentage of parents/caregivers who answer "yes" that "Since starting [services] my child or youth has had a negative contact with police"	Families/ Caregivers	NWI-Wraparound Fidelity Index

[14]DSHS also currently includes a "Juvenile Justice Involvement Child %" measure in its monitoring of LMHAs. This measure involves anchored ratings from providers on the CA-TRAG juvenile justice involvement scale.

Family Permanency metrics seek to capture the degree to which child/youth reside in their natural home environment and avoid instability in their living situations. These metrics include data associated with avoidance of child welfare system avoidance and the prevention of runaway episodes. Obtaining data on these metrics would require the mental health system to work collaboratively with Texas DFPS. Again, the CANS and the Wraparound Fidelity Index have items that speak to this domain and that can be used with those children/youth enrolled in services.

Domain	Metric	Data Source	Metric Source
Family Permanency	**Outcome Metrics**		
	Percent of enrolled children/youth who were open to child welfare system at beginning of year whose cases were closed to child welfare in the following year	Texas Department of Family and Protective Services and BH Providers	NWI
	Percent of enrolled children/youth with histories of child welfare or juvenile justice involvement who ran away from home	DFPS and BH Providers	NWI
	Outcome Ratings		
	Change from baseline to clinical follow up on the Family/Caregiver Needs and Strengths Domain and on the Permanency scale	Providers and Families/Caregivers	CANS
	Percentage of families/caregivers answering "yes" that, "Since starting [services] my child or youth has had a new placement in an institution."	Families/Caregivers	NWI Fidelity Index

Placement in Restrictive Settings is a domain that is closely related to Family Permanency. Metrics in this domain are concerned with the extent to which children/youth are spending time in settings that restrict their normal opportunities for development and community adjustment. In fact, such placements may sometimes serve to help children and youth be better prepared to participate in their natural settings, but, generally speaking, systems that provide effective and, at times intensive care and support in places where children, youth and families, live and function tend to have lower rates of the use of residential treatment facilities and hospitals. They also tend to reduce the number of changes in *undesirable* placements that children and youth experience.[15] Again, collection of complete and accurate data on these metrics will require inter-agency collaboration. The Wraparound Fidelity Index has a placement-

[15]One study of wraparound services found that the number of changes in placements increased for youth in wraparound versus a control/comparison group of youth. However, the increase was associated with more movement to *lower* levels of restrictiveness. See Mears, Yaffe, & Harris (2009). Evaluation of wraparound services for severely emotionally disturbed youths. *Research on Social Work Practice, 19,* 678-685.

related item that caregivers answer "yes" or "no" to and that provides a basic indicator of placement in a restrictive setting: "Since starting [services] my child or youth has had a new placement in an institution."

Domain	Metric	Data Source	Metric Source
Placement in Restrictive Settings	**Outcome Metrics**		
	12-month Rate of placement in Residential Treatment Facilities per 1,000 children/youth (population)	MBOW	QMHP-CS
	12-month Psychiatric hospitalization rate per 1,000 children/youth (population)	DSHS and Community Hospitals	NWI
	Average number of placement changes to same or higher level of restrictiveness per 12 months for enrolled children/youth	BH Providers	NWI
	Outcome Ratings		
	Percentage of families/caregivers answering "yes" that, "Since starting [services] my child or youth has had a new placement in an institution."	Families/Caregivers	NWI Fidelity Index

Crisis and Suicide: Fewer youth in systems that serve children and youth well should have crises and emergencies that lead to suicidal attempts or use of emergency-level services. We recommend use of data on emergency room visits from children and youth, for which the admitting reason was primarily due to a behavioral health problem, at the population level. Again, collaboration with hospitals and Emergency Departments around data collection will be needed to obtain good data.

Most youth who commit (or attempt) suicide suffer from a behavioral health disorders. The Texas Department of Vital Statistics tracks deaths by suicide, for ages 15-24, per 100,000 youth, by county. These data are reported annually and should be available for use in a statewide outcome measurement system that examines and compares separate regions. Data on suicide attempts also are available - through the Youth Risk Behavior Surveillance Survey, which is conducted nationally and in several locations around the state of Texas. State-level and region-level data are available from this population sample-based survey on the prevalence of treated (by a health professional) suicide attempts among high school students. (There is a separate survey item that indicates the rate of attempts treated by a doctor.) Other YRBSS data, not listed in the table below, also are available on the prevalence of suicide-related ideation among youth and on the prevalence of establishing a suicide plan among youth ages 15 to 24 in the population. The CANS includes several scales that indicate the degree to which youth are in

distress, but the most pertinent scale for this domain is that of "Danger to Self." The Wraparound Fidelity Index includes an item related to Emergency Department use.

Domain	Metric	Data Source	Metric Source
Crisis and Suicide	**Outcome Metrics**		
	Number of deaths by suicide per 100,000 population, ages 15-24 (population)	Texas Department of Vital Statistics	Texas Department of Vital Statistics
	Suicide attempt treated, per population (grades 9-12) (population)	YRBSS[16]	YRBSS
	Emergency Department visits, per child youth population, for which behavioral health problem/diagnosis was primary (population)	Emergency Departments	NWI
	Outcome Ratings		
	Change from baseline to clinical follow up on the Danger to Self scale	Providers and Families/ Caregivers	CANS[17]
	Percentage of parents/caregivers answering "yes" that, "Since starting [services] my child or youth has been treated in an Emergency Room due to a mental health problem."	Families/ Caregivers	NWI – Fidelity Index

School Performance is key component to the developmental process for children and youth. Research on wraparound services has includes several different outcome metrics in this domains, including days of school missed, rate of expulsion, and various indicators of school performance (e.g., GPA, graduation rates). Other applicable metrics for school performance include the graduation rate, GPA and days of school discipline among child and youth with MI or SED, each of which have been used in Wraparound program evaluations. Effective collaboration with Texas' independent school districts (ISDs) would be needed to obtain complete and accurate data. DSHS's statewide use of the CANS may also serve as a feasible proxy measure for assessing improved school behavior, attendance and achievement, as it has separate, anchored scales on each of those school performance-related items.

[16] Youth Risk Behavior Surveillance. Not collected annually. There is also an indicator that examines suicide attempts "treated by doctor."

[17] In its monitoring of LMHAs' performance DSHS currently utilizes a "Crisis Avoidance Child %" metric which includes the number of Client Crisis Months, as submitted by providers.

Domain	Metric	Data Source	Metric Source
School Performance	**Outcome Metrics**		
	Average number of days of school missed per child/youth with a BH disorder (service or population level)	Independent School Districts and BH Providers	NWI
	Rate of expulsion of children/youth with BH disorders (population)	ISDs	NWI
	School performance for children/youth with SED: GPA, grade completion, and graduation rates	Independent School Districts and BH Providers	NWI
	Outcome Ratings		
	Change from baseline to clinical follow up on the School Achievement, School Behavior and School Attendance scales	Providers and Families/ Caregivers	CANS[18]
	Percentage of parents/caregivers who answer "yes" to: "Since starting [services] my child or youth has had a negative contact with police"	Families/ Caregivers	NWI-Wraparound Fidelity Index

Substance Use: Youth living with behavioral health challenges are at risk for using substances. The YRBSS currently collects state-level data bi-annually on alcohol, tobacco, marijuana, street drug use and substance use with a major depressive episode. Changes in ratings on the CANS Substance Abuse scale also can be used as an outcome measures in this domain.

Domain	Metric	Data Source	Metric Source
Substance Use	**Outcome Metrics**		
	Teen Alcohol Use Rate (population)	**YRBSS**	**YRBSS**
	Teen Tobacco Use Rate (population)	**YRBSS**	**YRBSS**
	Teen Marijuana Use Rate (population)	**YRBSS**	**YRBSS**
	Teen Street Drug Use Rate (population)	**YRBSS**	**YRBSS**
	Substance Use with a Major Depressive Episode in the last 12 months	**YRBSS**	**YRBSS**
	Outcome Ratings		
	Change from baseline to clinical follow up on the Substance Abuse scale	Providers and Families/ Caregivers	CANS[19]

[18] In its monitoring of LMHAs' performance DSHS currently utilizes a "School Behavior Child %" metric which includes changes in providers' ratings of school behavior on the CA-TRAG.
[19] In its monitoring of LMHAs' performance DSHS currently utilizes a "Co-Occurring Substance Use Child %" metric which includes changes in providers' ratings of substance use on the CA-TRAG.

Appendix A: Leveraging Non-State Resources

Some child/youth mental health outcomes can be measured at a population-level, utilizing national-level population based surveys. The scope of data included in national population surveys includes prevalence measures, access, utilization and outcome measures. Limitations on population based surveys and databases include the regularity of data collection or reporting (few are conducted annually), none are focused specifically on mental health outcomes, demographic ranges vary, and when domains are similar (e.g. substance use) the specific items are often asked differently.

One of the most well known mental health surveys for children and youth is the Youth Behavioral Risk Surveillance Survey (YBRSS). YRBSS collects data on behaviors associated with injuries and violence, sexual behaviors, substance use, and dietary behaviors. Additionally, YRBSS is unique in that it collects information regarding teen suicidality.

Integrating national population based surveys as part of a statewide approach to measuring child/youth mental health outcomes can significantly increase the feasibility to capturing a respective mental health domain. Publically funded surveys (like YBRSS) often provide easy access to the actual items and survey implementation manuals for local systems to implement for their own reporting purposes. A thorough review of national databases that contribute to the measurement of child/youth mental health systems and outcomes can be found in McMorrow S & Howell E. (2010).[20]

As described above, population level data can be very beneficial when determining the depth of need within child/youth mental health in Texas, and comparing to system-served populations. Another beneficial approach to examining mental health outcomes is to further stratify populations served by sector or by domain (e.g., youth who have been hospitalized, youth involved in the justice system, or youth who live in restrictive placements). To engage in this depth of analysis, a broad set of outcomes is essential. If the metric pool is narrow, a high burden is placed on a few metrics to provide a clear picture of system-of-care performance. When the metric pool is broad, more measures are able to proportionally reflect the actual severity of impact experienced by children and youth across the state and across different systems-of-care. This latter approach allows behavioral health settings within different geographic settings to identify strengths and weakness in their approach. New Jersey has established a broad set of process and outcome measures across each of the system-of-care sectors. This approach allows them to make precision adjustments to their system, as needed (see Appendix D).

[20] McMorrow S & Howell E. (2010). See full citation above.

Appendix B: CHIRPA and NQF Child Mental Health Outcome Measures Recommendations

The following table summarizes the Child Mental Health Outcomes recommended for the Medicaid and CHIP Children's Health Care Quality Measures.

National Child Mental Health Outcome Measures	Initiative (CHIRPA/NQF)	Included in 2014 Core Set
Follow-Up Care for Children Prescribed ADHD medication	CHIRPA/NQF	Yes
Percentage of children 6-12 years of age as of the index prescription episode start date with an ambulatory prescription dispensed for and ADHD medication and who had 1 follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.		
Management of ADHD in Primary care for school-aged children and adolescents	NQF-Only	No
Percentage of patients treated with psycho-stimulant medication for the diagnosis of ADHD whose medical record contains documentation of a follow-up visit at least twice a year		
Follow-up after hospitalization for mental illness	CHIRPA/NQF	Yes
Percentage of discharges for members aged ≥6 years who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported. Rate 1 was the percentage of members who received follow-up within 30 days of discharge. Rate 2 was the percentage of members who received follow-up within 7 days of discharge.		
Developmental screening in the first 3 years of life	CHIRPA/NQF	Yes
Percentage of children screened for risk of developmental, behavioral, and social delays by using a standardized screening tool in the first 3 years of life. This is a measure of screening the first 3 years of life that incudes 3 age-specific indicators assessing whether children are screened by 12 months, 24 months, or 36 months of age.		
Developmental screening by 2 years of age	NQF-Only	No
Percentage of children who turned 2 years old during the measurement year who had a developmental screening performed between 12 and 24 months of age		
Pediatric Symptom Checklist	NQF-Only	No
The pediatric Symptom Checklist is a brief parent-report questionnaire that is sued to measure overall psychosocial functioning in children aged 4 to -16 years		
Depression Screening by 13 years of age	NQF-Only	No
Percentage of adolescents who turn 13 years of age in the measurement year who had a *screening for depression by using a standardized tool*		
Depression Screening by 16 years of age	NQF-Only	No

National Child Mental Health Outcome Measures	Initiative (CHIRPA/NQF)	Included in 2014 Core Set
Percentage of adolescents who turn 18 years of age in the measurement year who had a screening for depression by using a standardized tool		
Risky behavior assessment by age 13	NQF-Only	No
Percentage of children with documentation of a risk assessment or counseling for risky behaviors by the age of 13 years. Four rates are reported: risk assessment or counseling for alcohol use, tobacco use, other substance abuse, and sexual activity.		
Risky behavior assessment by age 18	NQF-Only	No
Percentage of children with documentation of a risk assessment or counseling for risky behaviors by the age of 18 years. Four rates are reported: risk assessment or counseling for alcohol use, tobacco use, other substance abuse, and sexual activity.		
Suicide Risk Assessment	NQF-Only	No
Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of MDD with an assessment for suicide risk.		
Documentation of DSM-IV diagnostic evaluation for depression	NQF-Only	No
Percentage of patient's aged 6 through 17 years with a diagnosis of MDD with documented evidence that they met the DSM-IV criteria during a visit in which the new diagnosis or recurrent episode was identified.		
Diagnosis of ADHD in primary care for school-aged children and adolescents	NQF-Only	No
Percentage of patients newly diagnosed with ADHD whose medial record contains documentation of DM-IV or Diagnostic and Statistical Manual for Primary Care criteria being addressed.		

Appendix C: Summary of Child and Adolescent Needs and Strengths Assessment Dimensions.

All items are scored on a likert scale with response anchors tailored to each respective item topic. For mental health outcome domains, this assessment tool provides a strong proxy measures for domains like school performance.

Dimension	Item Topics
Life Domain Functions	Family, Living Situation, Social Functioning, Recreational, Developmental, Job Functioning, Legal, Medical, Physical, Sexuality, Sleep, School Behavior, School Achievement, School Attendance
Child Strengths	Family, Interpersonal, Optimism, Educational, Vocational, Talents/Interest, Spiritual/Religious, Community Life, Relationship Permanence, Resiliency, Resourcefulness
Acculturation	Language, Identity, Ritual, Cultural Stress
Caregiver Needs & Strengths	Supervision, Involvement, Knowledge, Organization, Social Resources, Residential Stability, Physical, Mental Health, Substance Use, Developmental, Safety
Child Behavioral/Emotional Needs	Psychosis, Impulsivity/Hyperactivity, Depression, Anxiety, Oppositional, Conduct, Adjustment to Trauma, Anger Control, Substance Use
Child Risk Behaviors	Suicide Risk, Self-Mutilation, Other Self-Harm, Danger to Others, Sexual Aggression, Runaway, Delinquency, Judgment, Fire Setting, Social Behavior
Additional Modules	
Developmental Needs	Cognitive, Communication, Developmental, Self-Care Daily Living Skills
Trauma Module	Sexual Abuse, Physical Abuse, Emotional Abuse, Medical Trauma, Natural Disaster, Witness to Family Violence, Witness to Community Violence, Witness/Victim to Criminal Activity, Emotional Closeness to Perpetrator*, Frequency of Abuse, Duration*, Force*, Reaction to Disclosure*. Adjustment: Affect Regulation, Intrusions, Attachment, Dissociation
Substance Use Disorder Module	Severity of Use, Duration of Use, Stage of Recovery, Peer Influences, Parental Influences, Environmental Influences,
Violence	History of Physical Abuse, history or Violence, Witness of Violence, Witness to Domestic Violence, Witness to

Dimension	Item Topics
	Environmental Violence
Emotional/Behavioral Module	Bullying, Frustration Management, Hostility, Paranoid Thinking, Secondary Gains from Anger, Violent Thinking
Resiliency Factors	Awareness of Violence Potential, Response to Consequences, Commitment to Self Control, Treatment Involvement
Sexually Aggressive Behavior (SAB) Module	Relationship, Physical Force/Threat, Planning, Age Differential, Type of Sex Act, Response to Accusation, Temporal Consistency, History of Sexually Aggressive Behavior, Severity of Sexual Abuse, Prior Treatment
Runaway Module	Frequency of Running, Consistency of Destination, Safety of Destination, Involvement In Illegal Activities, Likelihood of Return on Own, Involvement with Other, Realistic Expectations, Planning
Juvenile Justice Module	Seriousness, History, Planning, Community Safety, Peer Influences, Parental Criminal Behavior, Environmental Influences
Fire Setting Module	Seriousness, History, Planning, Use of Accelerants, Intention to Harm, Community Safety, Response to Accusation, Remorse, Likelihood of Future Fire Setting,

Appendix D: New Jersey Statewide Outcome Measures

In-Home Services

Intensive In-Home Services comprise short-term, crisis intervention and related support services provided to clients in their own home. Services may include 24-hour emergency response in order to stabilize families, promote safety, prevent out of home placement and maintain children in their current living situation. Outcome criteria include the following:

- 90% of families that have completed an intervention will have their children at home at six (6) months post discharge.
- 85% of families that have completed an intervention will have their children at home at 12 months post discharge.
- 90% of families who have completed an intervention will have no new substantiated allegations of abuse or neglect at six (6) months post discharge.
- 85% of families who have completed an intervention will have no new substantiated allegations of abuse or neglect at 12 months post discharge.
- 80% of children participating in the program at a particular point will demonstrate an improvement in at least one life domain functioning as measured by an objective tool,
  - For DCBHS - post 72 hour Mobile Response and Stabilization Services period;
  - For other programs - TBD%

Teaching Homemaker / Homemaker / Home Visitation Services include homes management for clients in their own homes that are provided to achieve and/or maintain an adequate household and/or adequate personal healthcare. Outcome criteria include the following:

- 90% of families that have completed an intervention will have their children at home at six (6) months post discharge (targeted service: Teaching Homemaker).
- 85% of families that have completed an intervention will have their children at home at 12 months post discharge (targeted service: Teaching Homemaker).
- 90% of families who have completed an intervention will have no substantiated allegations of abuse or neglect at six (6) months post discharge (targeted service: Teaching Homemaker).
- 85% of families who have completed an intervention will have no substantiated allegations of abuse or neglect at 12 months post discharge (targeted service: Teaching Homemaker).
- 100% of children are enrolled in health insurance (targeted services: Home Visitation/Nurse-Family Partnership).
- 85% of children are up-to-date on immunizations (targeted services: Home Visitation/Nurse-Family Partnership).

- 80% of participants will increase their average inter-pregnancy interval (birth to conception) to 24 months (targeted services: Home Visitation/Nurse-Family Partnership).
- 90% of infants will be screened for developmental delays (targeted services: Home Visitation/Nurse-Family Partnership).

Companionship / Mentoring Services comprise in-home and community-based advocacy, recreational, vocational, educational, outreach or supportive services that incorporate positive youth development strategies and techniques to prevent out-of-home placement, deter juvenile delinquency, promote safety, prevent teen pregnancy, and help adolescents transition safely to adulthood. Outcome criteria include the following:

- 80% of youth will move to less restrictive care, remain in their home, reside independently, or will be stabilized in foster care/group home within 12 months of implementation of services.
- 80% of youth referred will be successfully transitioned to the community from out-of-home placement within 12 months of implementation of services.
- 80% of youth and families will show significant progress toward meeting priority needs as identified in their individual service plan within six months of referral.
- 80% of youth regularly attend school.
- 80% of youth remain free of adjudication with the juvenile justice system.

Case Management Services include assessing, monitoring and coordinating services to enable children to stay in their communities. The goal is to serve a child in the least restrictive environment possible with a seamless, coordinated system of care based on the needs and strengths of the child and family. Outcome criteria include the following:

- 75% of families participating will demonstrate their ability to manage their family plan.
- 75% of children will live in the least restrictive setting that is most appropriate for their clinical needs.
- 75% of children will improve or remain stable in their educational setting.
- 75% of children will have reduced length of stay in Detention post disposition (Care Management Organizations).
- 65% of children will have a decrease in emotional/behavioral needs and a reduction in risk behaviors.
- 65% of children enrolled with a current living situation of "least restrictive" will remain stable.
- 85% of families will indicate that they are satisfied or very satisfied with the service provided to them by the program (Differential Response).

- 65% of families will not have any substantiated allegations of child abuse and/or neglect within 12 months of completing services through the program (Differential Response),

Behavioral Support Services focus on maintaining the child in their home, supporting the resource parent, and providing behavioral assistance to children and families in their current living arrangements. Outcome criteria include the following:

- 80% of children will maintain placement at three (3) months and six (6) months as measured by follow-up phone call (child-specific program).
- 85% of children will show improvement through measurement by an objective tool (i.e., Child Well-Being Scale or Attachment Scale) (child-specific program).
- 85% of parents will be satisfied with the retention specialist and services provided (resource/adoptive parent-specific program).
- 90% of referral sources will be satisfied with the retention specialist and services provided (resource/adoptive parent-specific program).
- 75% of resource and adoptive parents receiving retention services will continue to care for a child placed with them until permanency is achieved (resource/adoptive parent-specific program).

Permanency Services

Family Reunification / Therapeutic Visitation Services occur when a child is in any type of substitute care. Case activities are directed toward safely returning the child to, or placing the child with, a parent when the circumstances necessitating out-of-home placement have been resolved, and the parent has expressed an interest in, and displays the willingness and ability to, care for the child, with supportive services, if necessary. Therapeutic visitation services safely reunite families separated due to abuse or neglect by teaching personal responsibility and parenting skills in a respectful, nurturing, home-like environment to reduce child abuse and neglect, decrease the time children spend in foster care, and strengthen families throughout the community. Outcome criteria include the following:

- 75% of referred cases (child-family and/or siblings) will achieve visitation two times per week within one month and 90% will achieve visitation weekly within one month.
- 90% of parent will have improved parenting skills. Providers are to use objective measures to assess outcomes.
- 90% of referred cases will achieve permanency within 12 months of the latest removal from their home (reunification; recommendation for adoption; recommendation for Kinship Legal Guardianship).
- 90% of children reunified with their family will remain in their home at six (6) months/12 months of return home.

- 95.2% of children reunified with family will have no new substantiations of abuse and neglect within six (6) months/12 months of return home.

Supervised Visitation Services provide supervision for visits between parents and children in out-of-home placements to preserve family connections and facilitate a safe return home (this may include transportation to and from visits). Outcome criteria include the following:

- 100% of the children transported will arrive to visitation and return from visitation safely (this may apply to contracts that only provide transportation services).
- 90% of children in out-of-home care will visit regularly with siblings in other placements in accordance with their case plans and if in the best interest of all involved siblings.
- 95% of reports documenting the interactions and reactions of all involved parties to the visitation will be submitted timely to the Division.
- 90% of children in out-of-home care will visit regularly with their parent(s) or other legally responsible family member at least weekly and in accordance with their case plan.
- 90% of all children and families will be either reunified or have an approved permanent plan within 12 months of the child's entry into out-of-home placement.
- 86% of children reunified with their families will not re-enter placement for at least 12 months following reunification.

Out-of-Home Care

Congregate Care comprises various levels of care which include a children's residential treatment center, a group home setting, or a youth shelter that provides 24 hour care seven (7) days a week. Outcome criteria includes the following:

- 70% of children will be discharged to a less restrictive setting/level of care within nine (9) to 12 months of admission.
- 70% of children will have lower aggregate scores on the Strengths and Needs Assessment from admission to discharge.
- TBD% of children will not have new out-of-home admissions at sixe (6) months post-discharge.
- Average length of stay will be reduced by 10% from the previous year until an agreed upon benchmark is reached.
- 99.47% of youth will not have any substantiated abuse or neglect while in shelter care.
- 95% of youth entering out-of-home care shall receive a full medical examination within 30 days of placement (targeted service: Shelter Care).
- 95% of youth will have a discharge plan developed within 48 hours of admission (Shelter Care).

Contracted Agency Home Care involves directly supervised by a private agency under contract with DCF to provide services to children in need of out-of-home placement for protective or other social services reasons. This service also includes treatment homes, bridge homes, alternative care homes, children's shelter homes, and juvenile-family in crisis shelter homes. Outcome criteria includes the following:

- 90% of children remain in their first placement since entry into care.
- 65% of children are placed within the community from which they were removed.
- 65% of children are placed with a group of two or three of their siblings in care at the same time or within 30 days of each other, if the level of care is compatible and it is in accordance with all their case plans.
- 70% of children will be discharged to a less restrictive setting/level of care (treatment homes) within nine (9) to 12 months.
- 70% of children will have lower aggregate scores on the Strength and Needs Assessment (treatment homes; DCBHS – administered at admission and discharge).
- Average length of stay will be reduced by 10% from the previous year (treatment home).

Health and Mental Health Services

Therapeutic Interventions include services that provide ongoing mental health treatment to address and resolve the issues that prompted the referral (i.e., maltreatment, behavior or mental health challenge within family). Therapy modalities include individual, group and family therapy. Outcome criteria include the following:

- TBD% of children show improvement in emotional, cognitive, and behavioral functioning as reported by the parent, school, community or appropriate standardized tests.
- TBD% of children show improvement in school functioning, as measured by teacher reports and/or report cards.
- TBD% of children served after being abused or neglected do not suffer repetition of abuse or neglect.

Evidence-Based Treatment, specifically Multisystemic Therapy (MST) and Family Functional Therapy (FFT), which are intensive family and community-based intervention that addresses multiple aspects of serious antisocial behavior in adolescents. MST typically targets chronic, aggressive juvenile offenders who are at high risk of out-of-home placement away from their families. FFT provides community-based services in a stable environment for up to three (3) hours per day, up to six days per week. Outcome criteria include the following:

- 85% of youth will remain at home with their families.
- 85% of youth will have no further system involvement.
- 85% of youth will maintain improved academic performance and attendance.

Partial Hospitalization / Partial Care (child/youth) is an intensive, nonresidential, therapeutic treatment program. The program provides clinical treatment services in a stable environment, generally 3-5 hours/day, up to 6 days/week. Outcome criteria include the following:

- One month and six months post discharge, 80% of consumers will be in the home of residence at discharge.
- One month and six months post discharge, 85% of consumers will not be hospitalized psychiatrically.
- TBD% of children show improvement in emotional, cognitive, and behavioral functioning as reported by the parent, school, community or appropriate standardized tests.
- TBD% of children show improvement in school functioning, as measured by teacher reports and/or report cards.

Substance Use Services provide comprehensive prevention, intervention, and treatment with a client-based approach. These programs include a comprehensive evaluation, individual therapy, intensive outpatient treatment, family groups, and specialized programs for the mentally ill chemical abuser and in most cases for adolescents as well. Outcome criteria include the following:

- 100% of assessed clients must either be: 1) referred into their prospective level of treatment; or 2) ruled out (Children's Protective Substance Abuse Initiative - CPSAI),
- 75% of referred clients will be involved in or complete an extended assessments (CPSAI).
- 85% of assessed clients will be placed in their perspective level of treatment (CPSAI).
- The 50% of clients using alcohol at admission versus discharge will decrease by TBD% (Child Welfare Treatment programs).
- The 50% of clients using other drugs at admission versus discharge will decrease by TBD% (Child Welfare Treatment programs).
- Employment rate for clients at admission versus discharge will increase by 50% (Child Welfare Treatment programs).
- The 75% of client arrests in past 30 days measured against admission and then against discharge will decrease by TBD% (Child Welfare Treatment programs).
- The 50% of homeless clients at admission versus discharge will decrease by TBD% (Child Welfare Treatment programs).

Health Center Services provide comprehensive health service for youth ages zero to 21 years. These services include but are not limited to: well baby checks, physicals, immunizations; services to address behavior and learning concerns, mental health, dental, and vision care. Outcome criteria includes the following:

- 80% of pediatric cases will receive immunizations.

- Of those users who enter Health Centers without insurance, 80% will be enrolled into subsidized insurance programs of New Jersey Uncompensated Care.

Child Assault Prevention (CAP) Services is a statewide program that trains children, parents, and teachers to prevent peer assault, stranger abduction and known adult assault. CAP staff work closely with local school districts, parent/teacher associations, home school groups and other community groups. CAP has a threefold educational approach to prevention, which includes staff in-services, parent programs and individual classroom workshops for children and teens.

- 85% of school staff and parents will report increased awareness of how to recognize, prevent, and address child abuse and bullying.
- 85% of youth will report increased awareness of interpersonal safety rights and appropriate boundaries.

Adolescent Services

After Care Services for Aging Out Youth / Transitional Support / Supportive Independent Living are, traditionally, 18 month programs designed to assist youth in living skills, obtaining employment or further education, and attempting to find permanent housing. The programs can be congregate or apartments and some of the programs will extend the young person's stay beyond the age of 18 years. Depending on the program, they address the needs of youth aged 16 to 21 or 18 to 21 years. The target population is youth aging out of the DYFS system or homeless youth. These are not generally therapeutic placements and would not be appropriate for young people with severe behavioral health need. Outcome criteria include the following:

- 85% of youth age 14 and older will have an independent living plan developed which identifies those programs and services that will be provided to assist the youth in transitioning from foster care to independence.
- 93% of youth served will improve their independent living skills based on pre and post Ansell-Casey performance measures.
- 85% of youth will successfully transition into safe permanent living situations.
- 80% of youth served will learn essential job readiness skills and obtain employment.
- 75% of youth served will be working towards obtaining a high school diploma, GED, or will attend technical school or pursue higher education.
- 85% of youth in placement at age 18 who qualify for Chafee Medicaid will be enrolled (excludes SSI recipients).

School Linked Services are open to all youth aged 10 to 19 years enrolled in the school that houses the program. Services are provided before, during and after school and throughout the summer. Major services included mental health and family services; health services; substance

abuse counseling; employment services; pregnancy prevention programs; learning support services; referrals to community-based services; and recreation.

- 90% of youth served who participate will remain in school (School Based Youth Services Program [SBYSP]).
- 90% of youth served will improve emotional well-being (SBYSP).
- 90% of youth whose families have been involved will graduate or remain in school (Family Empowerment Program [FEP]).
- 70% of those reporting difficulty will improve academic performance (FEP).
- 70% of youth will show an improvement in behavior in school (FEP).
- 92% of participating youth will demonstrate improvement in academic performance and/or social and emotional well-being (Family Friendly Center [FFC]).
- 80% of families will demonstrate awareness of supports and resources available in school and community (FFC).
- 97% of youth who complete the program will not become pregnant prior to high school graduation (Adolescent Pregnancy Prevention Initiative [APPI]).
- 95% of youth who complete the program will demonstrate improved knowledge of safe sex practices (APPI).
- 95% of teen parents will not have another pregnancy while enrolled in the program (Parent Linking Program [PLP]).
- 98% of seniors will graduate while enrolled in the program (PLP).
- 80% of youth will be connected to community, social and vocational activities (Refugee Program).

Youth Helpline is a statewide, 24-hour, interactive telephone line for youth and young adults (ages 10 to 24 years) that provide immediate, respectful professional service with linkages to information and resources. Outcome criteria include the following:

- 85% of youth who receive services from the NJ 2ndFLOOR Youth Helpline will report the call was helpful.
- Calls will increase in Cape May, Cumberland, Hudson, Salem and Sussex counties by 50%.

Outreach to At-Risk Youth / Prevention of Juvenile Delinquency are services designed to prevent crime/juvenile delinquency, and to deter gang involvement by providing enhanced recreation, vocational, educational, outreach or supportive services to youth, ages 13 to 18 years, with the option to serve youths until age 21. Services are located in communities with demonstrated high crime and gang violence. Outcome criteria includes the following:

- 91% of students will remain in school (Prevention of Juvenile Delinquency [PJD]).

- 99% of students will have no further incidents leading to juvenile detention while enrolled (PJD).
- 75% of youth will remain free of new criminal / delinquency charges (Outreach to At-Risk Youth [OTARY]).
- 75% of youth will show an increase in the number of days they attend school (OTARY).
- 75% of youth participating to improve anti-social behaviors will achieve their personal goals (OTARY).

Family Support Services

Family Success Centers are neighborhood-based gathering places where any community resident can find family support, information, and services. The purpose of the Center is to enrich the lives of children by making families and neighborhoods stronger. Services include employment, information and referral, parent education, health care, parent-child activities, home visiting, life skills training, advocacy, and housing. Outcome criteria includes the following:

- 50% of families requesting information and referrals are appropriately connected to resources that improve family functioning.
- 70% of Family Success Centers will be fully functioning involving parents and community members in governance planning.

Domestic Violence Services include the lead domestic violence program, including a shelter with a 24-hour hotline and response in each county. Services also provide information and referral, counseling, support groups, financial, legal, housing, and general advocacy, children's services and community education. Outcome criteria include the following:

- 65% of domestic violence survivors have strategies for enhancing their safety.
- 65% of domestic violence survivors have knowledge of available community resources.
- 75% of children show improved emotional, cognitive and behavioral functioning (Peace: A Learned Solution [PALS]).
- 75% of school-aged children show improvement in school functioning (PALS).

Family Support Organizations comprise family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of children with emotional and behavioral problems. Outcome criteria include the following:

- TBD% change in caregiver needs at 18 months.
- TBD% of "remained stable/improved" outcome status at 18 months.
- TBD% of youth in youth partnership.
- TBD% of CFT meetings attended.
- TBD% of hours of peer support.

Appendix E: New York State Outcomes Measures

CARIS Indicators

The CARIS indicator reports are presented by program type and the specific program unit where services are provided. (No individual client level data are available in this portal.) Data for children admitted to select programs from 2002 to the present is included.

Youth Symptoms / Behaviors and Functioning

Rate of Occurrence Report: This report provides the percent of youth admitted with mild to severe interference with daily activities and/or major role requirements as a result of the symptoms/behaviors or functional impairments, or who have engaged in high-risk behavior in the past 18 months (rarely to always levels).

Rank of Serious Impairment Report: This report provides rank ordering of percent of youth admitted with severe symptoms/behaviors (marginally severe and severe levels), severe functional impairments (marginally severe and severe levels), and high frequency of high-risk behaviors (often and always).

Distribution Report: This report provides the frequency distribution of levels of severity of symptoms/behaviors and functional impairments, and levels of occurrence of high-risk behaviors on admission to a program.

Outcomes Report: This report provides individual changes in levels of severity of symptoms/behaviors and functional impairments, and levels of occurrence of high-risk behaviors from admission to discharge.

The following table provides a list of indicators by indicator type as well as the program types included in the reports described above.

Indicator Type	Indicator	Program Type
Functional Impairments	Cognitive functioning Motor functioning Self-care Self-direction Social relationships	Blended Case Management (BM) Community Residence – Children and Youth (Community Residence) Crisis Residence (Crisis Residence) Family Based Treatment (FBT) Home Based Crisis Intervention (HBCI) Home and Community Based Services
High Risk Behaviors	Cruelty to animals Destruction to property	

Indicator Type	Indicator	Program Type
	Fire setting Suicide attempts	Waiver (HCBS Waiver) Intensive Case Management (ICM) Residential Treatment Facility – Children and Youth (RTF) Supportive Case Management (SCM)
Symptoms/Behaviors	Alcohol abuse Anxiety Dangerous to others Dangerous to self Depression Developmental delays Drug abuse Eating disorder Enuresis/Encopresis Hyperactive Impulsive Other Peer interactions Phobias Physical complaints Physically aggressive Psychotic symptoms Runaway Self-injury Sexually acting out Sexually aggressive Sexually inappropriate Sleep disorders Suicidal ideation Temper tantrums Verbally aggressive	

Youth and Family Strengths

Distribution Report: This report provides a frequency distribution of levels of child strengths and family strengths on admission to a program.

Outcomes Report: This report provides individual changes in levels of child strengths and family strengths from admission to discharge.

The following table provides a list of indicators by indicator type as well as the program types included in the reports described above.

Indicator Type	Indicator	Program Type
Child Strengths	Anger management Consequences Family Friends Hobby Intimacy Other Personal strengths Remorse Respects others Responsibility School attendance School performance	Blended Case Management (BM) Community Residence – Children and Youth (Community Residence) Crisis Residence (Crisis Residence) Family Based Treatment (FBT) Home Based Crisis Intervention (HBCI) Home and Community Based Services Waiver (HCBS Waiver) Intensive Case Management (ICM) Residential Treatment Facility – Children and Youth (RTF) Supportive Case Management (SCM)
Family Strengths	Emotional support Medications Resources Safety Supervision Treatment	

Family Stressors

Distribution Report: This report provides the frequency distribution of the extent to which family/environmental stressors interfere with the child's receipt of services on admission to a program. The following table provides a list of indicators and the program types included in this report.

Indicator	Program Type
Abused as a child Alcohol/substance abuse Chronic illness Domestic violence Family conflict Homelessness Housing needs	Blended Case Management (BM) Community Residence – Children and Youth (Community Residence) Crisis Residence (Crisis Residence) Family Based Treatment (FBT) Home Based Crisis Intervention (HBCI) Home and Community Based Services Waiver (HCBS

Indicator	Program Type
Incarceration	Waiver)
Medical disability	Intensive Case Management (ICM)
Mental illness	Residential Treatment Facility – Children and Youth
Mental retardation	(RTF)
Other	Supportive Case Management (SCM)
Poverty	
Unemployment	
Unstable relationships	

Length of Stay

Average Length of Stay Report: This report provides the average length of stay in days by program type (see tables above), by admission year.

Length of Stay Intervals Report: This report provides the length of stay in days grouped by time intervals (e.g., zero to three months, four to six months, etc.) by program type (see tables above), by admission year.

Assessment of Care Surveys

The NYS OMH Youth Assessment of Care (YACS) and Family Assessment of Care (FACS) surveys have been implemented to capture levels of consumer satisfaction[21] with mental health services, serving as a key outcome measure and quality assurance indicator to provide feedback essential to the improvement of mental health programs and to better meet the needs of children and families. The YACS and FACS includes questions in the following domains:

- Appropriateness of care
- Accessibility of services
- Cultural sensitivity
- Medication use
- Functioning/outcomes
- Global satisfaction
- Service related
- Social connectedness (family surveys only)

[21] Positive satisfaction is determined by responses to yes/no questions or questions involving a four point scale: agree, slightly agree, slightly disagree and disagree.

Satisfaction across these domains is also broken out by youth/family demographics (age, gender, and race) by region/county and by region/program type. Results are also provided for program types (see below for list) and individual agencies.

Surveys are distributed by service providers to eligible youth and all families of youth in care at the time of implementation. Program types covered in these surveys include the following:

Community Support Services	Treatment Services
Community Residence – Children and Youth	Clinic Treatment
Family Based Treatment	Day Treatment
HCBS Waiver Individualized Care Coordination	Kids ACT
Teaching Family Homes	Residential Treatment Facility – Children and Youth
	State Psychiatric Centers

Child and Adolescent Needs and Strengths – Mental Health (CANS-MH) Indicators

CANS-MH indicators were added during the second phase of the Children, Teens and Families Indicators Portal project, and support the increasing emphasis on the identification of strengths in mental health assessment and service delivery for youth and families.

The CANS-MH indicator reports are presented by program type and program unit where services are provided. Data is included for children who were admitted to select programs or who were determined to be eligible for single point of access services. These reports are derived from data submitted by service providers when a child is admitted and discharged from care, or when a child is deemed eligible for single point of access services. Program types include the following:

- Blended Case Management (BCM)
- Home and Community Based Services Waiver - Individualized Care Coordination (HSBS-ICF)
- Intensive Case Management (ICM)
- Residential Treatment Facility – Children and Youth (RTF)
- Supportive Case Management (SCM)

CANS-MH Dimension Level of Need Report: This report provides CANS-MH needs by dimension within each of the CANS-MH domains (Problem Presentation, Risk Behaviors, Functioning, Care Intensity, Child Strengths and Family Strengths) as measured at admission to a program or at the time of referral to a program through the single point of access process. (Needs are defined as having a rating of 2 or 3 on the CANS-MH scale.) This report provides the percent of youth admitted or deemed eligible in the single point of access process with need on the CANS-MH by domain. Reports are shown at the program type and program level of detail.

CANS-MH Domain Level of Need Report: This report displays CANS-MH needs by domain, which are calculated as percent of youth admitted or deemed eligible in the single point of access process with needs on more than 50% of the dimensions within a CANS-MH domain. (Needs on the dimension level are defined as having a rating of 2 or 3 on the CANS-MH scale.)

CANS-MH Outcomes Report: This report provides CANS-MH needs by dimension within each of the CANS-MH domains at admission compared to the last follow-up. (Needs are defined as having a rating of 2 or 3 on the CANS-MH scale.) The change in the level of need is computed as the difference between the number of youth with needs at admission compared to the number of youth with needs at follow-up divided by the total number of youth who had both an admission and follow-up CANS-MH completed. (Percent change in the level of needs is computed as the difference between the percent of youth with needs at admission compared to the percent of youth with needs at follow-up divided by the total number of youth who had both an admission and follow-up CANS-MH completed.)

CANS-MH Domain	CANS-MH Dimension
Problem Presentation	Adjustment to trauma Antisocial behavior Attachment Attention deficit/impulse Depression/anxiety Oppositional behavior Psychosis Situational consistency Substance abuse Temporal consistency
Risk Behaviors	Crime/delinquency Danger to others Danger to self Elopement

CANS-MH Domain	CANS-MH Dimension
	Sexually abusive behavior Social behavior
Functioning	Family Intellectual/developmental Physical/medical School achievement School attendance School behavior Sexual development
Care Intensity	Monitoring Service permanence Transportation Treatment
Child Strengths	Educational Family Inclusion Interpersonal Optimism Relationship permanence Spiritual/religious Talent/interests Vocational Well-being
Family Strengths	Involvement Knowledge Organization Physical/behavioral health Residential stability Resources Safety Supervision

Appendix F: Citations and Sources

Academic Publications

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Bruns E & Suter J. (n.d.). *Theory and Research: Chapter 3.5 – Summary of Wraparound Evidence Base: April 2010 to Date*. Retrieved from http://www.nwi.pdx.edu/NWI-book/Chapters/Bruns-3.5-(evidence-base).pdf

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