

Stars Behavioral Health Group
Starlight Community Services
SYSTEM OF CARE PROGRAM REPORT
Report Date: October 18, 2011

Introduction

This report provides aggregate information regarding Starlight Community Services (SLCS) *System of Care* (SOC) program, which operates in Santa Clara County, updated through fiscal year (FY) 2010-2011, with historical notes since the program began in late 2004.¹

The SOC program builds upon national system of care² values, principles and practices for mental health and related support services to children and youth with serious emotional disturbances, and to their families. The program provides an intensive level of service contact and coordination due to the complexity of the youth's mental health problems, risk of out-of-home placements, and multi-system involvements. The service array encompasses a comprehensive, functionally oriented bio-psycho-social assessment, collaborative treatment teams, case management, and a range of individually tailored services and supports including individual and/or family therapy and rehabilitation, psychiatry services, and discharge planning. Many of the youth suffer from developmental trauma requiring careful attention to care plan formulation so that services and supports sequence well to their stage of recovery from trauma and readiness to move forward toward healthy and productive lives.

Referrals of youth and their families come from the *Santa Clara Valley Health and Hospital System's Mental Health Department* (55%) and the *Department of Social Services* (45%), and some youth are also involved with *Juvenile Probation* (5%). Many (60%) referred families have recent histories or current involvement with the child welfare system. Most of the youth live in San Jose (78%) with some in Milpitas (7%), and the rest in small numbers from over twenty different South Bay cities. Typically, they are either living at home (81%) or in non-relative foster care (16%) upon enrollment.

Starlight's SOC staffs include licensed mental health clinicians (27%), registered/supervised³ clinical interns (59%) and paraprofessionals (12%) providing mostly field based services (in home, school and community settings) and some outpatient clinic therapy appointments. Staffs have bi-lingual capacity (20%), mostly Spanish and one Tagalog speaker. The SOC team is relatively stable -- 24% turn-over in FY 10-11 compared to 28% in California for similar provider organizations⁴ -- which means the young clients and their families experience positive continuity of care and opportunities for meaningful, supportive relationships with their staff person(s). The agency selects, trains and supports staff for expertise in trauma, anxiety and mood disorders, grief counseling, cognitive-behavioral and creative arts therapies, schooling supports, developmental disability, gang affiliation, teen pregnancy, family therapy and domestic violence, among other relevant emphases.

The report profiles the youths and their families, program quality and fidelity, the outcomes of enrollment, and customer satisfaction with the services.

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Youth Profile

Demographics FY 08-09, FY 09-10 & FY 10-11

	Ages 0 Thru 10 (N=314; 46%)		Ages 11 Thru 18 (N=366; 54%)		Ethnic Sums:
	Female	Male	Female	Male	
African American	11	10	14	11	46 (6.8%)
Anglo American	14	19	27	30	90 (13.2%)
Asian American	7	1	4	16	28 (4.1%)
Hispanic/Latino	91	141	126	121	479 (70.4%)
Native American Incl. Pac. Islands	0	2	0	2	4 (.6%)
Mixed/Other	7	11	8	7	33 (4.9%)
Age x Gender:	130 (19.1%)	184 (27.1%)	179 (26.3%)	187 (27.5%)	680

At the time of program enrollment, the children and youth range in age from birth to 18, with an average (and median) age of 11 years. They are 46% female and 54% male. High percentages are Hispanic/Latino heritage, relative to the county population.⁵ Details are tabled at left and listed below:

Asian American

Vietnamese (16), Filipino (10), Unspecified (2)

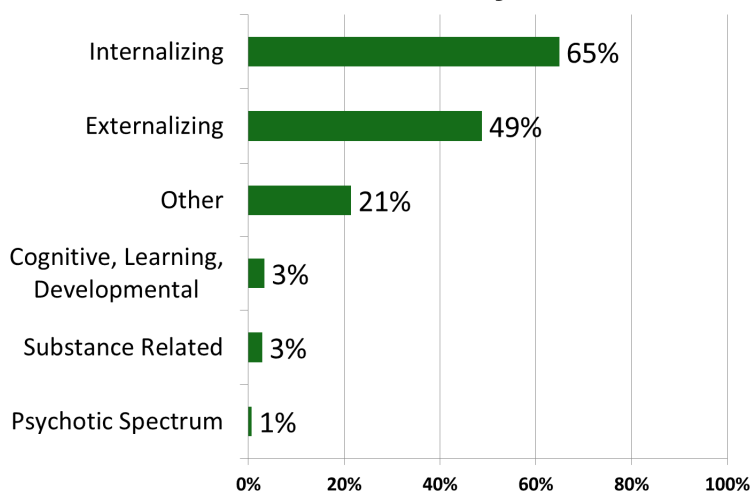
Native American/Pacific Islanders

Samoa (2), Hawaiian (1), Unspecified (1)

Mixed/Other

Anglo-Latino (8), African-Anglo (5), African-Latino (5), Unspecified (4), African-Asian (3), Anglo-Asian (3), African-Native (1), East Indian (1), Latino-Native (1), Pakistani (1), Persian (1)

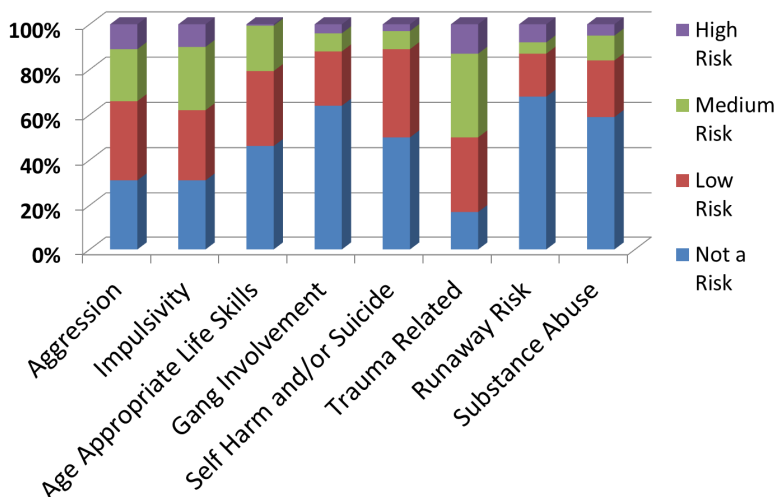
Clinical Pathways



Clinicians provide assessment and clinical diagnoses upon enrollment, which are organized into clinical pathways that guide and focus treatment interventions. Shown are the percentages of Axis I primary mental health diagnoses⁶ in the population, which add to more than 100% since some youth (30%) have more than one diagnoses (average = 1.6%; range 1 to 5).

The youths' problems reflect primarily internalizing, externalizing and/or "other" problems.⁷ Fully diagnosable substance abuse and psychotic disorders are uncommon.

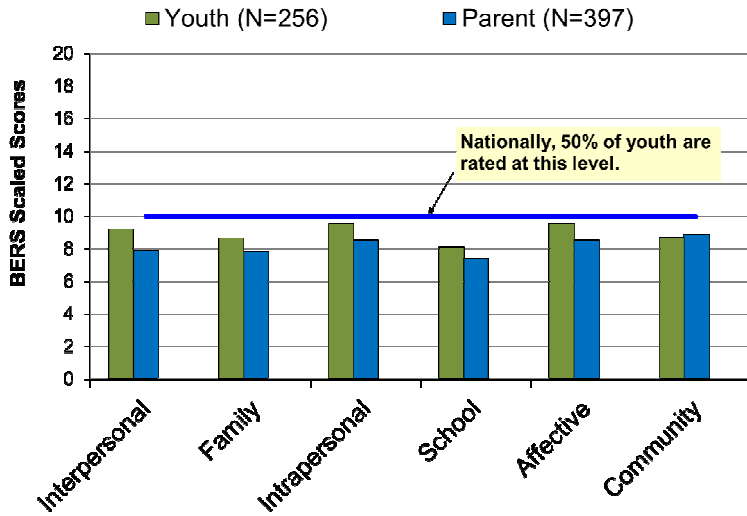
Behavioral Risks



All SLCS SOC youth exhibit risk behaviors of various types at their time of enrollment and 90% have one or more of the potentially serious risk behaviors shown⁸, arrayed by risk level (none, low, medium, or high).

Depending on the type of risk, from 10% (self-harm) to 50% (trauma) have medium to high risk, while another 20% to 40% have at least some (low) risk. Starlight staffs conduct thorough screenings related to such risks and develop safety plans from the outset of services, or at any point over the course of care as needed.

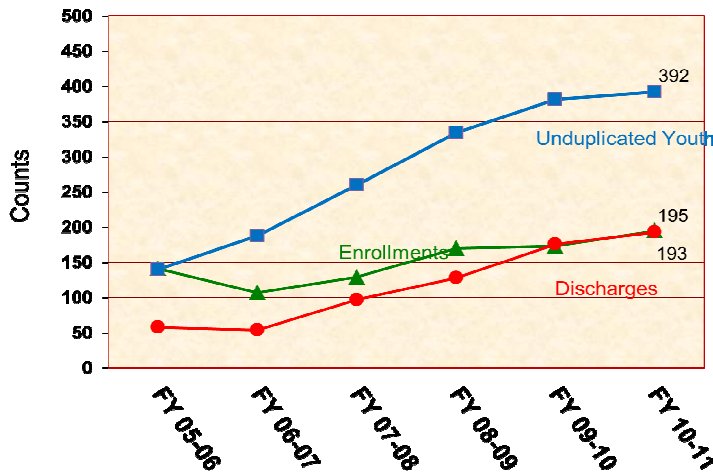
Behavioral and Emotional Strengths



Since last report there are increased records available regarding youth's functioning using the *Behavioral and Emotional Ratings Scale (BERS)*, a standardized, normative measurement.⁹ Shown are the baseline scores by BERS domains. The scores reveal that the parents especially, as well as the youth, report fewer strengths, particularly with respect to functioning interpersonally, with family, and at school. From the parent perspective in aggregate, these scales are roughly one-half to one standard deviation below national norms, or between 16th and 25th percentile rankings (that is, at least 75% of youth nationally score higher).

Service Utilization

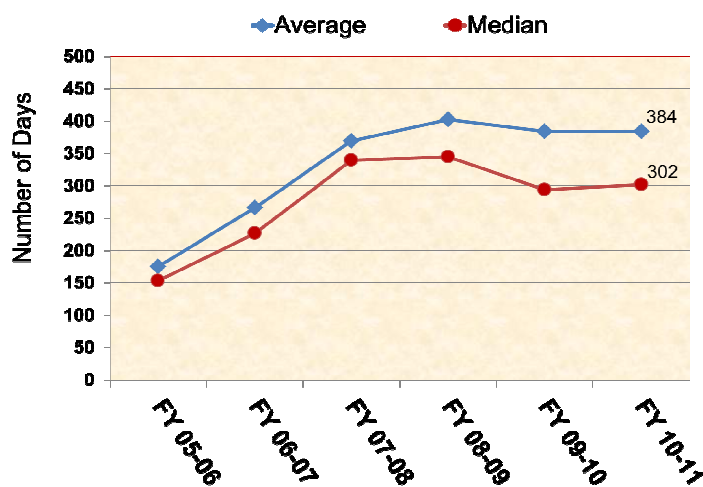
Starlight SOC Utilization



Since the program began, 868 unduplicated children and youth enrolled in 914 episodes of care. The great majority (95%) of youth had only one service episode across all years. On average, each fiscal year, there are 153 enrollments, 118 discharges, and 283 unduplicated clients served during 287 episodes of care.

In the most recent fiscal year there were 195 enrollments, 193 discharges, and 392 unduplicated youth. This includes 192 youth currently open in the program and an estimated 165 families.¹⁰

Length of Enrollment

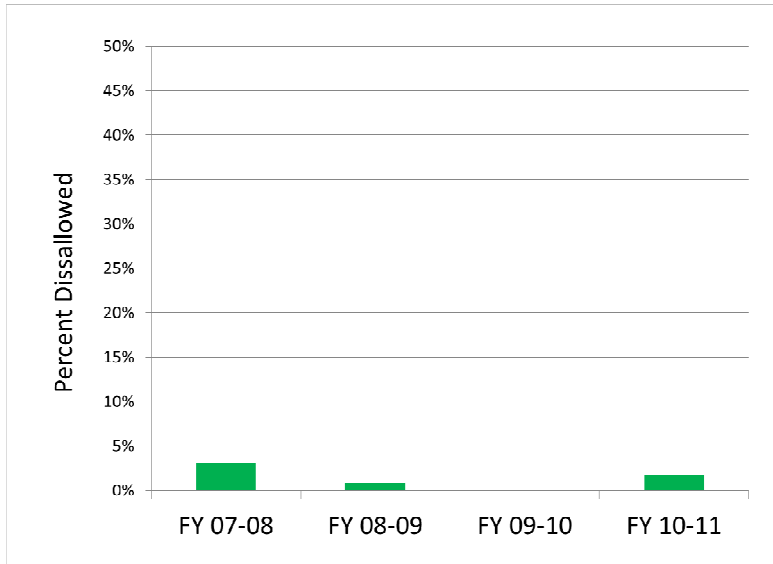


The average length of program enrollment among those discharged within a fiscal year climbed over the first few years of the program, peaked in FY 08-09, and subsequently decreased, stabilizing at a little over one year. The widening gap between the average and median (50% above and below) reflects persistence in services of a subset of clients over the last few program years – roughly 15% served two years or more.

Longer enrollments associate to children living in shelters, non-relative foster care, and high level group homes (RCL 10+).¹¹

Program Quality and Fidelity

Quality Assurance – External Audits Positive Trend Over Time



Starlight’s SOC program maintains ongoing attention to traditional quality assurance indicators. Highlights from among these activities over the past few years include:

- Implementation of peer reviews;
- Development of utilization review with case consultation for youth in services over two years; and,
- Refinement to SOC’s internal auditing system, which reduced recoupable error rates from 3.6% at the end of FY 07-08 to 0.2% consistently throughout FY 2011.

The graph shows a very low disallowance rate from external (county/state) audits of service documentation. SOC’s efforts help yield these low figures.¹²

Sample of Enriched Training Topics

- Adolescent Reinforcement Community Approach
- Adventure-Oriented Therapies and Interventions
- Assessment and Treatment of Child Maltreatment
- Client Directed Outcome Informed Approach
- Creating Bridges Out of Poverty
- In-Depth Trainings on Each Prevalent Diagnostic Group
- Mental Health Care for LGBTQ Youth
- Modular Approach to Treatment with Children
- Prevention of Dating Violence
- Risk Assessments, Status Exams and Safety Plans
- Trauma-Focused Cognitive Behavioral Therapy

SLCS and SOC managers pay much attention to staff development and support. In the last few years, the agency implemented “Live Supervision” whereby clinical supervisors accompany each staff into the field periodically in order to provide coaching based upon in-vivo service encounters.

The agency also sponsors trainings beyond initial orientation, county-mandated trainings, and trainings available through E-Learning. The team uses either internal or external subject matter experts in the development and delivery of enriched, interactive trainings.

An Award-Winning Agency

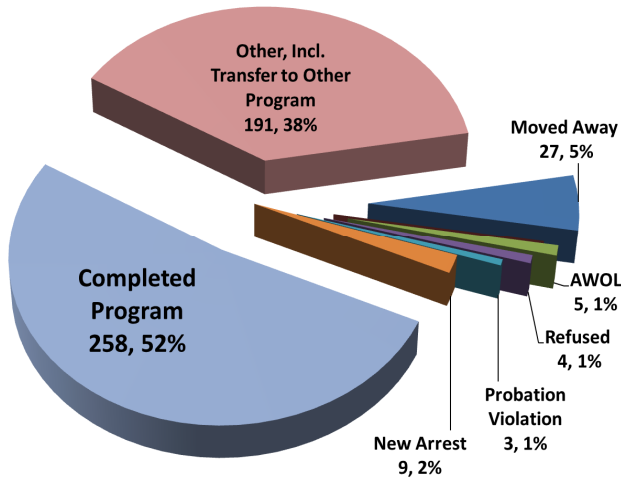
- ★ Modern Healthcare Spirit of Excellence Award (2009) for developing a strong internal program culture of teamwork and excellence for the delivery of home, school, and community based services, including intensive collaborations with gang-diversion programs.
<http://www.modernhealthcare.com>, search 2009 Spirit of Excellence Awards.
- ★ Bay Area Newsgroups Top Work Places Award (2010) included SLCS among the top 35 small workplaces in the greater San Francisco Bay Area based upon a written submission and 86% response rate among all SLCS employees to a series of 18 questions about their organization.
http://www.topworkplaces.com/survey/resultslist/bayarea_10

SLCS’s leadership team earns important recognitions for building a strong organizational culture that promotes service excellence, low staff turn-over, and high levels of employee satisfaction from internal surveys.¹³

External awards, such as those described, typically accrue to the entire agency, including SOC which is the largest program within SLCS.

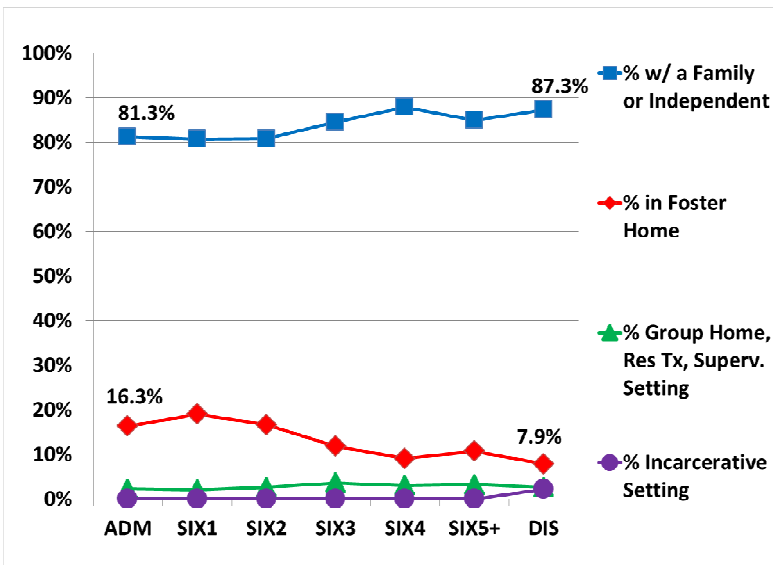
Youth & Family Outcomes

Completing the Program FY 08-09, FY 09-10 & FY 10-11



The statuses of clients at discharge are shown.¹⁴ There is a substantial uptick since last report (discharges through FY 07-08) in the proportions successfully completing the program -- from 33% to 52%. The agency goal is to achieve at least 60% successful program completions (most/all goals met)¹⁵, and to minimize the numbers of youth in group homes, juvenile detention, psychiatric hospitals, or AWOL from placement at the time of discharge. At the time of the last report, the exact proportion of high end placements at discharge was unknown. Since then, the team improved tracking and the current figure is 4.8%.

Making Progress Toward Permanency



ADM = admission, SIX1, SIX2, etc. = six month intervals throughout services, and DIS = discharge.

Mental health supports focused on child welfare populations help families address their issues so as to promote permanency of children's attachments and stability in their living situations.

SOC's mental health teams help the majority of children and youth either maintain or transition into family homes (incl. adoptive, parent, relatives); with the proportion in foster care reduced by over half during the course of services. At discharge a few youth (N=11) were in juvenile detention.

Among the subset of the population with current or historical dependency status, program completion and available records¹⁶ the SOC program helps youth move toward permanency:

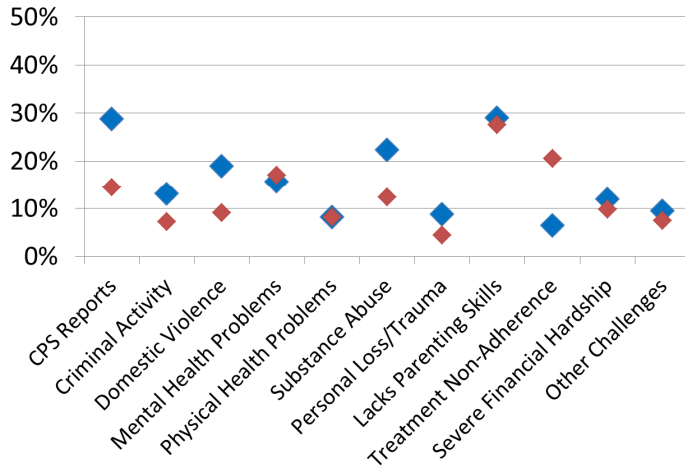
Reunification Status:	ADM	DIS
Reunification Achieved	25.7%	56.9%
Reunification Failed	12.5%	22.6%
Working on Reunification	61.8%	20.4%

Permanency Planning Underway:¹⁷

Family Finding Underway	10.0%	14.6%
Permanent Foster Care	43.3%	58.5%
Prospective Family Located	13.3%	17.1%
Youth Adopted	30.0%	9.8%
Emancipated/Working On	6.7%	14.6%

Reducing Caregiver Challenges

◆ Proportion at Enrollment ◆ Proportion at Discharge

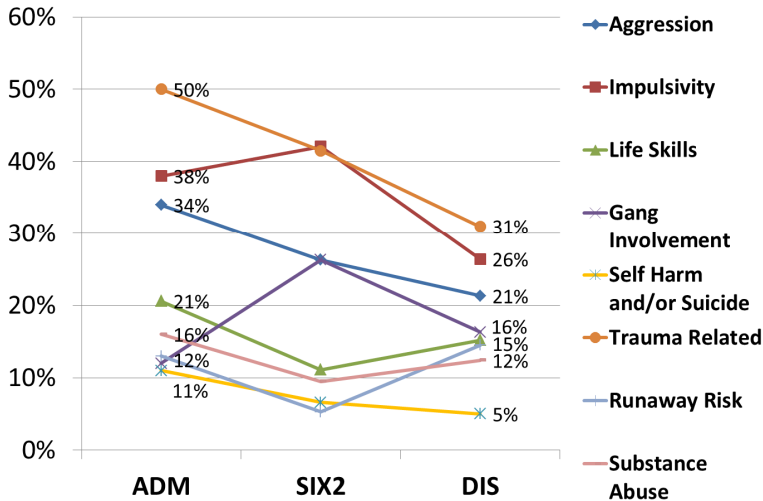


Caregiver challenges are circumstances or issues caregivers face and/or risky activities they engage in that impact the mental health and/or placement stability of their children/youth.

At the time of enrollment, clinicians identify one or more caregiver challenges among 60% of the families served. This percentage drops to 52% by discharge; the most impacted subgroup with three or more challenges drops from 24% to 16%. The average number of challenges per family declines 1.7 to 1.4.¹⁸

There are opportunities for program improvement. For example, there is not much movement on parenting skills, critically important to child development and well-being. Lack of parenting skills correlates strongly with disruptive behaviors and associated sequelae for children as they age.¹⁹ Mental health staffs can help parents build these skills and/or refer and support their attendance at relevant classes.

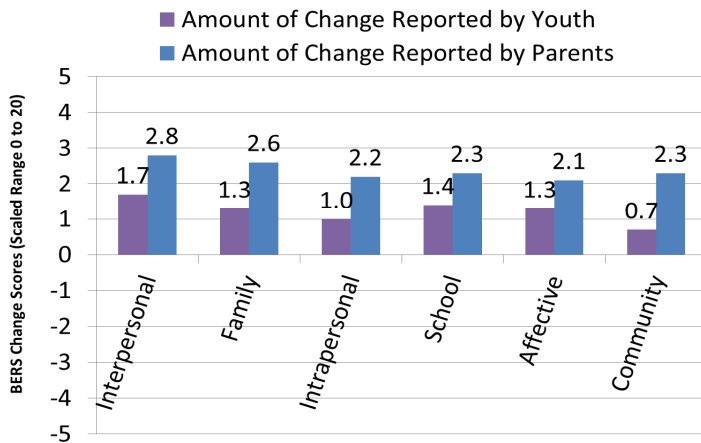
Reducing High Risk Behaviors



Shown are declining proportions of youth with medium or high risk ratings over three points of time – enrollment (ADM), one year (SIX2), and discharge (DIS).²⁰ SOC services are particularly effective at addressing aggression, impulsivity and trauma symptoms, which decline 13, 12 and 19 percentage points respectively. Also reduced are risks associated with self-harm/suicide, lack of life skills, and substance abuse.

There is opportunity for program improvements related to addressing the lure of street life, which attracts some youth more as they age – note the enrollment to discharge rises in runaways and gang involvements.

Increasing Youth Strengths



Although caregivers report fewer youth strengths at the time of enrollment than did the youth about themselves, the caregivers saw more gains in all areas from enrollment to discharge. Overall, youth reported a Total BERS Index increase of 11.7 points and parents reported 15.4.²¹ For parents, the increases were statistically significant across all domains except community; whereas for youth the amount of change was significant for all but intrapersonal and community.²²

Factors Affecting Strengths

From the Youth Perspective About Their Strengths:

Caregiver Challenge (CGC) at Intake	BERS Scale	Differential Discharge BERS Ratings ²³
Mental Illness	Community Strengths	If CGC Yes = 11.6 If CGC No = 8.5
Substance Abuse	Affective Strength	If CGC Yes = 10.3 If CGC No = 8.7
Personal Loss	Family Involvement	If CGC Yes = 12.0 If CGC No = 9.1
Tx Non-Adherence	Affective Strength	If CGC Yes = 7.8 If CGC No = 10.7

From the Caregiver Perspective About Youth Strengths:

Caregiver Challenge (CGC) at Intake	BERS Scale	Differential Discharge BERS Ratings ²⁴
Economic Hardship	Family Involvement	If CGC Yes = 10.1 If CGC No = 7.3
Economic Hardship	Affective Strength	If CGC Yes = 9.9 If CGC No = 7.7
Tx Non-Adherence	Interpersonal Strength	If CGC Yes = 14.4 If CGC No = 7.7
Tx Non-Adherence	Intrapersonal Strength	If CGC Yes = 13.8 If CGC No = 8.1
Tx Non-Adherence	School Strength	If CGC Yes = 6.0 If CGC No = 9.5

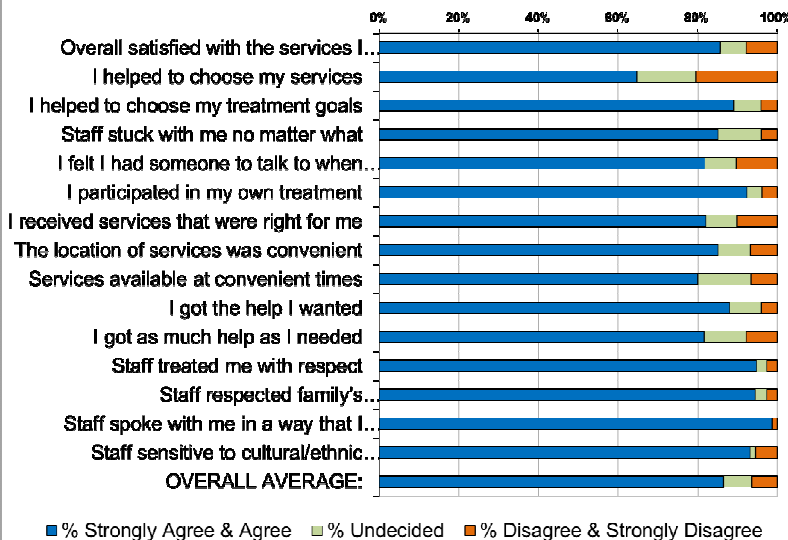
On the BERS, higher scores reflect more strength in the area. For most of these scales, youth with caregivers challenged in the ways identified had more strengths reported at discharge than those without such caregiver challenges.

Analyses of factors that associate to or predict outcomes were conducted on 185 youth.²⁵ A summary:

- There were no demographic or diagnostic predictors in the dataset of BERS change scores.
- Varying by BERS domain, and who reports the strengths (caregiver or youth), caregiver challenges at the time of admission relate to discharge BERS scores (differential results summarized in the table). The overall pattern suggests the SOC program is especially helpful to the families challenged in the ways shown among all those served. Two exceptions are the unfavorable impact of caregivers' treatment non-adherence on youths' affective strengths and school strengths.²⁶
- There were some factors interacting with completion status and BERS discharge scores. For example, children in families with economic hardship whom complete the program (all/most goals met) report more overall child/youth strengths at discharge. Youth in such families may be getting the most out of the program!²⁷

Satisfied Clients

MAY 2011 Youth Respondents = 78



Starlight Community Services receives positive feedback from youth, shown left, and also from families --overall 90% satisfaction at last survey (Spring 2011); and, from agency partners – overall 96% satisfaction (Summer, 2010). Examples of agency partners' positive comments:

- My experience working with Starlight is positive. I am especially impressed by the quality of services under the great leadership of the program administrator.*
- The community needs Starlight!*
- I work with several Starlight staff on several cases... very good experiences. The people who choose Starlight while they are working towards licensing seem to be high-quality.*
- Starlight is my preferred agency to work with.*

Summary

Starlight’s System of Care (SOC) program is based upon national best practices for comprehensive and coordinated individualized services, and in partnership with county agencies, the program attunes proficiently to critical needs of a predominately child welfare service population. This report traces the SOC program’s growth, stabilization of service lengths, recent years’ client profiles and challenges among families and caregivers. Analyses of sufficient, valid datasets reveal important strides made toward permanency, significant reductions in youths’ high risk behaviors, and statistically significant gains made on standardized measurements of functioning, from both youths’ and caregivers’ perspectives. Additionally, classic quality assurance indicators are very positive, as is customer satisfaction. Starlight merits status as an award winning human service agency, and the SOC program contributes significantly to Starlight’s overall positive profile.

The leadership and team continuously strive for quality improvements through a built capacity to measure, track, report out, reflect upon and act on profile, utilization, quality, outcomes and satisfaction data. This is accomplished in SLCS’ creative and distinctive version of the SBHG *Total Quality Management* (TQM) program with stakeholders such as staff, youth, families and agency partners at the table during tri-annual quality councils. From this report, there are important threads to follow for enhancing outcomes, such as attending further to the complex caregiver challenges, strains in youths’ relationships to their families, and/or ecological threats (e.g., neighborhood gangs) shaping youths’ results. Starlight’s SOC program truly embodies the agency mission of “Partnering with People for Positive Change” and we invite you to attend and participate in our forums for doing so.

Angela Nunes
Associate Administrator,
Starlight Community Services

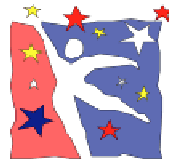
Michelle McDonald
Northern California
Regional Administrator
Stars Behavioral Health Group

Kent Dunlap
Senior Vice President of
Operations
Stars Behavioral Health Group

Peter Zucker
President and Chief
Executive Officer
Stars Behavioral Health Group

Stars Behavioral Health Group

“Partnering with People for Positive Change”



SBHG Core Values

- Equip People with Skills and Appreciate their Strengths**
- Enhance the Lives of Individuals and Families**
- Embrace Cultural Diversity**
- Act with Integrity**

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Endnotes

¹ The last comprehensive report published September 25, 2008 and addressed program start-up (Oct 2005) through FY 2007-2008. The current report focuses primarily on data for FYs 2008-2009, 2009-2010, and 2010-2011, unless otherwise noted. Fiscal year cycles run July through June. The data reflect complete population values (100% samples), unless specifically annotated with sampling information.

² “System of care” is a national model, built from evidence into an informed best practice. For full explication of systems of care values and principles and how these translate to program practices and service procedures, the following resources are recommended: 1) Stroul, B. A., & Friedman, R. (1994), *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center; 2) President’s New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental healthcare in America: Final report* (DHHS Publication SMA-03-3831), Rockville, MD: U.S. Department of Health and Human Services; 3) Pires, S. A. (2002), *Building systems of care: A primer*. Washington DC: National Technical Assistance Center for Children’s Mental Health; and, 4) Hernandez, M., Worthington, J., & Davis, C. S. (2005), *Measuring the fidelity of service planning and delivery to system of care principles: The system of care practice review (SOCPR) (Making children’s mental health services successful series, 223-1)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute.

³ Among the licensed clinicians are 7 clinical supervisors. There were 41 SOC staff total as of end of FY 10-11.

⁴ The comparison figure is the same from two distinct sources: 1) *California Alliance for Children and Family Services (CACFS) Behavioral Pathway Systems (BPS) benchmarking report*, June 2011, for agencies of same budget size as Starlight; and, 2) *Bureau of Labor Statistics*, report for western region, healthcare and social assistance labor market, June 2011, www.bls.gov.

⁵ Based on 2010 U.S. census data, comparable proportions in the Santa Clara County child/youth population ages 0 thru 18 are as follows. There are multiple methods of categorization used in the census; the table below reflects the method that maps closest to the way SLCS collects such information.

Age Range	Gender	Ethnicity
0 thru 10 = 59%	Male = 51%	African American = 2%
11 thru 18 = 41%	Female = 49%	Anglo American = 27%
		Asian American = 23%
		Latino/Hispanic = 28%
		Native incl. Pac Islands = 1%
		Mixed/Other = 19%

To locate census reports, visit: http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010 or <http://quickfacts.census.gov/qfd/states/06/06085.html>

⁶ Per nomenclature of the American Psychiatric Association (2000), Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR.

⁷ The most common (at least 5% of population) diagnostic groups within clinical pathways, in descending order are:
 INTERNALIZING = Mood, Dysthymia, Depression NOS (26%); Anxiety (16%); Post Traumatic Stress (13%); Adjustment Problems w/ Anxiety, Mood, Depressed Features (11%)
 EXTERNALIZING = Disruptive, Impulsive, Oppositional (27%); Attention Deficit and/or Hyperactivity (19%); Adjustment Problems w/ Conduct Features (5%)
 OTHER = Relational Problems w/ Parent, Siblings (10%); Child Maltreatment (victim) (7%). NOTE: the DSM addresses acute symptoms related to current/recent maltreatment; whereas most SOC clients suffer from current, recent, or historical maltreatment.

⁸ Available samples vary due to a change in the risk indicators -- new ones added and definitional criteria refined -- upon integration of SBHG’s Client Outcomes Report (COR) within the agency’s Electronic Medical Record (EMR) in FY 09-10. There are 25% samples on most of the risk factors, and 79% samples on aggression, substance abuse, and self-harm/suicide scales. Because of these changes to datasets, accurate counts of total risk behaviors and related analyses per client over time in treatment are not possible at this juncture, but will be in the future. For definitional criteria, please contact the report author. For one example, trauma-related risk speaks to potentially diverse symptoms including but not limited to those usually associated with PTSD (e.g., re-experiencing, avoidance, arousal) and/or complex developmental trauma (attachment problems, emotional dysregulation, sensory/body dissociation), but in any event related to the experience, threat, and/or witnessing of physical harm, either recently or historically. The trauma rating scale is: 0) Not Applicable: Client shows no symptoms related to psychological trauma; 1) Low Risk: One or a few mild symptoms are related to psychological trauma; 2) Medium Risk: At least one or more symptoms related to psychological trauma are impacting current functioning; and, 3) High Risk: At least one or more symptoms related to psychological trauma are seriously undermining current functioning.

⁹ At last report there were a couple dozen completed BERS forms available. The program greatly increased attention to collecting their outcome data. The subscales' scaled scores derive from raw scores in the large normative population samples used during psychometric development of the BERS, expressed as standard deviation units to indicate a scores' distance from the average rating in the normative sample. BERS scaled scores range from 1 to 20, with a mean of 10 and standard deviation of 3. In the future, the team plans to replace the BERS with the *Child and Adolescent Needs Scale* (CANS) to enable comparisons with other SLCS, SBHG, and Santa Clara County programs. This report "closes out" analyses using the BERS and will address correlates and predictors related to the BERS in the outcomes section.

¹⁰ Per numbers of apparent sibling sets in the datasets.

¹¹ The differences are statistically significant -- for example, 542 days for those in non-relative foster care compared to 356 days if in family home -- yet living environment at enrollment accounts for only a small amount of the overall variability in lengths of stay ($p < .000$; $R^2 = .052$). Additional factors are at work.

¹² State audits address a range of factors that bear directly upon the veracity and quality of client care; if not found sufficient, amounts paid through Medi-Cal must be returned to the state and the provider absorbs the costs of the services (which have already been delivered). Examples of factors assessed include: whether there are informed consents for treatment signed by the legal guardian and/or older youth; whether assessments consider client/family culture and build upon strengths; whether diagnoses are correct given presenting symptoms and behaviors; and, whether there is coherence between the statement of needs/problems, goals, objectives, and interventions, including that the legal guardian signed onto the plan. Starlight routinely achieves very high levels of adherence to these quality indicators.

¹³ Based on SBHG's employee surveys, SLCS regularly achieves over 90% satisfaction on each of 7 measured dimensions: supervision and support, resources to do the job, inter departmental communication, intra- departmental communication, benefits and policies, job satisfaction and overall satisfaction. Company philosophy is that well supported staffs do better work, which benefits youth and their families.

¹⁴ The contract specifies the categories of discharge as one or more of the following circumstances: 1) mutual (treatment team) agreement that the goals of treatment have been met; 2) parent/guardian refusal of services or refusal to comply with objectives outlined in the Treatment Plan; 3) parent/guardian unilateral decision to terminate treatment; 4) good faith determination that the individual youth cannot be effectively served by the program; 5) determination that the individual is a danger to other youth, staff or the individual; and, 6) transfer of the youth to another program or out of the county. Regardless of discharge circumstance, appropriate service linkage is provided. The category "other" on the graph groups parent/guardian terminations; good faith terminations; those related to danger risks; and, program transfers.

¹⁵ Clinicians' rate program completions as either: no goals met, some goals met, or most/all goals met, pertaining to the mutually agreed upon goals listed on the treatment plan, freshly conceived in Santa Clara County as Transformative Care Plans, and developed through the collaborative treatment team process.

¹⁶ The graph is based on complete (100%) enrollment and discharge records; the interim records are solid but not complete samples. Among the 60% with current/historical dependency status, available data on reunification and permanency statuses from the Client Outcomes Report (COR) are: 75% enrollment and 71% discharge.

¹⁷ Due to parallel approaches and efforts taken on behalf of some children in the child welfare system, pursuit of these planning outcomes can add to more than 100%. Also note, the proportions adopted and/or working toward emancipation are additive over time -- e.g., 30% adopted at time of enrollment and another 10% by discharge.

¹⁸ Available sample (COR Data) is 85%. The reduction in counts of caregiver challenges over time in treatment is significant (ANOVA, $F=6.45$, $p<.000$)

¹⁹ Specifically, in the near term, such sequelae include peer rejection, school behavior problems, and low academic performance.

²⁰ Recall from prior (baseline) note that the most robust samples, related to longest use of consistent measurement protocols, are the ratings of aggression, substance abuse, and self-harm/suicide. This is also true of available anniversary and discharge records. Additionally, samples for admission and discharge tend to be more complete than the interim measurements.

²¹ The overall BERS Strength Index has a mean of 100 and a standard deviation of 15, based on large normative population samples and is the most reliable of all the scores generated on the BERS. The parents' ratings increased one standard deviation, meaning, in their view, the youth closed the gap to the national average by time of discharge. The research department also values confirmation of overall patterns in our findings, and we look for additional evidence in separate measurements. Regarding increases in youth's overall functional strengths, the *Children's Global Assessment Scale* (C-GAS) moved 6.5 points on average, a significant improvement (Paired samples t-test, $t = 14.2$, $p<.000$).

²² Paired samples t-test, $t=6.8$, $p<.000$.

²³ ANOVAs: Mental Illness $F=7.24$, $p<.008$; Substance Abuse $F=4.60$, $p<.034$; Loss, Abandonment $F=3.701$, $p<.06$; Treatment Non-compliance $F 4.25$ to 13.5 , $p<.045$ to $.001$.

²⁴ ANOVAs: Economic Hardship F 5.63 to 11.5, $p < .019$ to $.001$; Treatment Non-compliance F 4.25 to 13.5, $p < .045$ to $.001$.

²⁵ The complete and matched datasets incorporate client registration (e.g., referral information, demographics, diagnostics), Client Outcomes Report (COR) data (multiple variables), and BERS domain and total scores from parent and youth reports among those discharged during the three year time period of this report.

²⁶ These nuances may also point to quality improvement opportunities – e.g., when caregivers have a history of non-adherence with service programs based on intake assessments, take extra care to work on wellness education and family/youth interventions on behalf of youths’ emotions; and, pay particular attention to whether caregivers are supporting youths’ schooling sufficiently.

²⁷ Per the Parent’s BERS Total Index, the economic hardship groups’ average score at discharge was 122, compared to 93 among others completing the program. The result is primarily driven by the Affective Strength (ANOVA: $F=5.63$, $p < .01$) and Family Involvement (ANOVA $F=11.53$, $p < .001$) subscales. Additionally, there is a very strong linear relationship between youth’s Family Involvement scores at enrollment and their likelihood of completing the program, as shown in the prediction table below. The higher the Family Involvement score at enrollment, the more likely the youth will successfully complete the program (most/all goals met). This suggests that youth positively engaged with their families may be more likely to positively engage with the program; and be supported in doing so by their families. Therefore, addressing and improving upon youth’s perceptions and experiences of their strengths and involvements vis a vis family – early on -- is an optimal route to increasing treatment motivation, retention, and completion success. Examples of Family Involvement items on the BERS are: “My family makes me feel wanted”; “I trust at least one person very much”; “I get along well with my parents”; and, “I do things with my family”.

Completion Probability as a Function of Family Involvement at Enrollment
(Youths' Perspective About Their Own Family Involvements)

