REPORT

Unclaimed Children Revisited

Focusing on Outcomes – A Case Study of the Michigan Level of Functioning Project

Patti Banghart | Janice L. Cooper

May 2010

National Center for Children in Poverty
Mailman School of Public Health
Columbia University

The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

UNCLAIMED CHILDREN REVISITED

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Child on Top of a Greenhouse

The wind billowing out the seat of my britches,

My feet crackling splinters of glass and dried putty,

The half-grown chrysanthemums staring up like accusers,

Up through the streaked glass, flashing with sunlight,

A few white clouds all rushing eastward,

A line of elms plunging and tossing like horses,

And everyone, everyone pointing up and shouting!

– Theodore Roethke
Poet, Saginaw, MI
(May 25, 1908 - August 1, 1963)

Introduction

Unclaimed Children Revisited Background

Unclaimed Children Revisited (*UCR*) updates *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services* (1982), a seminal report authored by NCCP's former director, Dr. Jane Knitzer. The initial report served to rally the child and adolescent mental health field to take policy action towards reform.

The current study is a multi-pronged initiative that generates new knowledge about policies across the United States that promote or inhibit the delivery of high-quality mental health services and supports to children, youth, and families. *UCR* places a strong emphasis on identifying services that are culturally competent, developmentally appropriate, and research-informed. The initiative encompasses four main projects:

- national survey of state-level children's mental health directors and advocates (http://nccp.org/publications/pub_853.html);
- statewide case study of California, with a focus on 11 counties (http://nccp.org/projects/ucr_cacasestudy_pubs.html);
- case study of outcomes-based management in children's mental health service delivery in Michigan; and,
- working paper series that explore the state of the field on family and youth engagement (http://nccp.org/publications/pub_673.html), financing (http://nccp.org/publications/pub_804.html), trauma (http://nccp.org/publications/pub_737.html), school-based mental health and cross-systems support of effective practices.

The Michigan Case Study

The major aim of *Unclaimed Children Revisited* is to identify policy-supported state efforts to promote quality of care for children and youth with mental health conditions in the public mental health system. The Michigan Case Study examines one such initiative - Michigan's Level of Functioning Project (LOF). It is a 14 year-old effort to monitor and improve outcomes for children and youth with severe emotional disturbance (SED), through the use of the Child and Adolescent Functional Assessment Scale (CAFAS), a research-based tool that measures children's daily functioning (See Box 1). The LOF aims to gather data on outcomes for children and youth with SED served through Michigan's public mental health system. This data can then be used to inform decision-making at the policy and service delivery levels.

In 1998 Michigan mandated contracted providers in the public mental health system to use a functional assessment tool. The Child and Adolescent Functional Assessment Scale (CAFAS) was mandated for every child with SED enrolled in county mental health services. Michigan leads a county-run, state-supervised public mental health system through the Michigan Department of Community Health. It requires, through its Medicaid Provider Manual, that all children and youth accessing public mental health services receive an assessment using the CAFAS. Data from the CAFAS is then used to inform both clinical and administrative decision-making. Michigan also uses the CAFAS as a tool to assist in determining service entry. While different programs have different standards for entry, in general, home based services require a total CAFAS score of 80 (and one caregiver subscale score of 20 or 30) and the state's Medicaid home-and community-based waiver program [1915(c)] requires a score of 90 or higher, if the child is age 12 or under, and a CAFAS score of 120 or higher, if age 13 or older (see Box 1). These state guidelines for program entry were established based on data analysis and recommendations of the LOF.

Box 1: Child and Adolescent Functional Assessment Scale

The **Child and Adolescent Functional Assessment Scale** (CAFAS) is a validated assessment tool that measures a child's degree of everyday functioning in contexts such as home, school, and the community. It is essentially a list of behavioral descriptors the rater (provider) selects to describe the youth based on a variety of their informational sources (such as intake assessment, or clinical intake). The CAFAS is completed at intake, during periodic intervals (quarterly), and at discharge. It generally takes approximately 20 minutes to complete at intake and 10 minutes at each interval assessment. The CAFAS contains eight subscales to measure the child's functioning:

- School/work
- Home
- Community
- Behavior toward others
- Moods/emotions
- Self-harmful behavior
- Substance use
- Thinking

Each subscale consists of a set of behavioral descriptors (such as failing most classes) grouped into levels of impairment. The rater identifies which descriptors best describe the severity of the youth's level of functioning during the last month. Levels of impairment are assigned numerical values: Severe impairment (30), moderate impairment (20), mild impairment (10) or minimal or no impairment (0). The scores across all eight subscales are then totaled, ranging from 0 to 240. For each subscale, there is also a corresponding set of goals and strengths relevant to the domain. The scores allow for providers to then track changes in functioning over time to help assess treatment progress.

Bates, M. P.; Furlong, M. J.; Green, J. G. 2006. Are CAFAS Subscales and Item Weights Valid? A Preliminary Investigation of the Child and Adolescent Functional Assessment Scale. *Administration and Policy in Mental Health & Mental Health Services Research* 33: 682-695.

Hodges, K; Xue, Y.; Wotring, J. 2004. Use of the CAFAS to Evaluate Outcomes for Youths with SED Served by Public Mental Health. *Journal of Child and Family Studies* 13(3): 325-339.

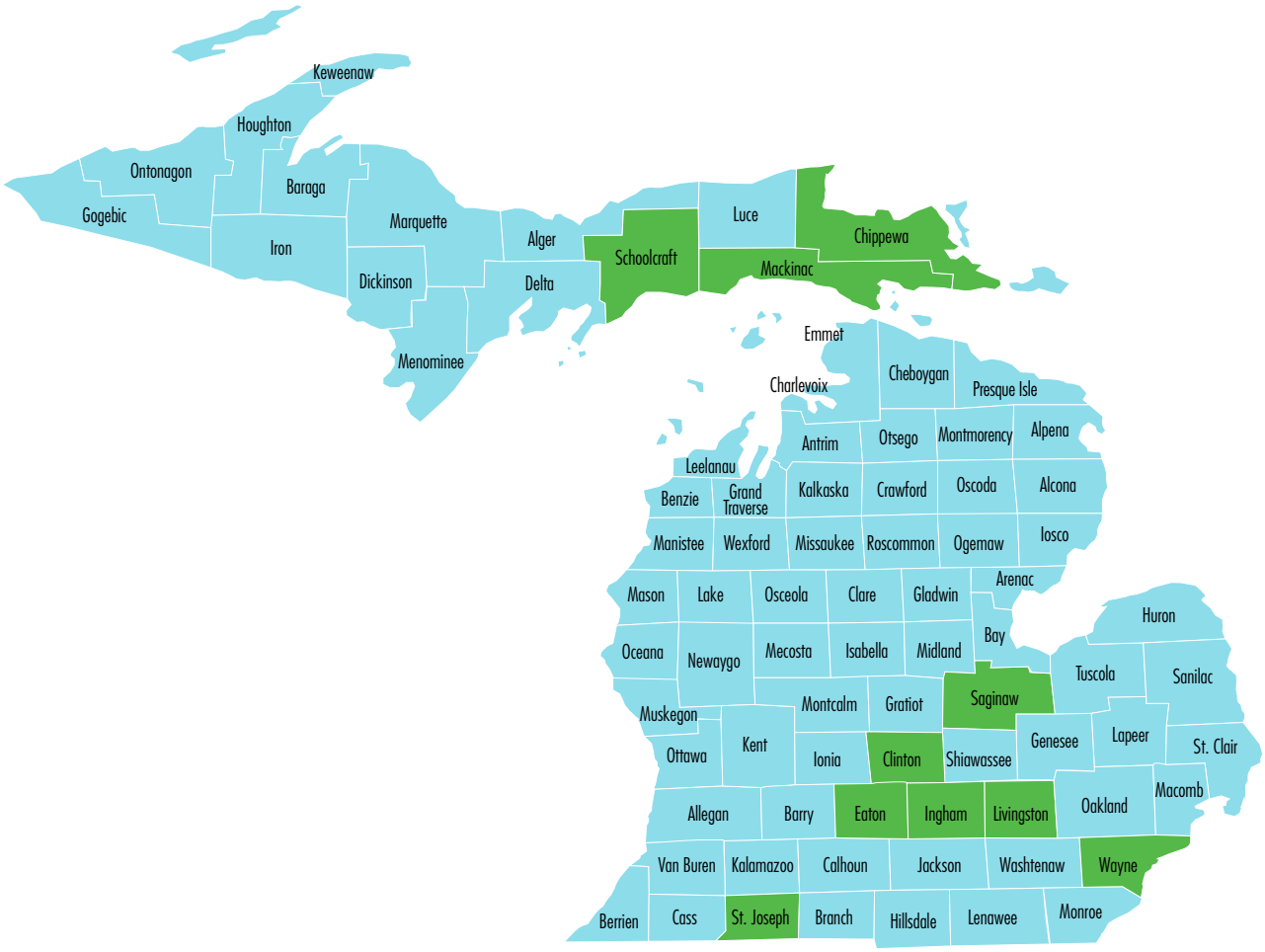
Michigan's Level of Functioning Project (LOF) couples its' CAFAS mandate with a voluntary program of technical assistance, data analysis and support, and a learning collaborative to assist counties and their providers in collecting and analyzing CAFAS data and monitoring quality. The state contracts with Eastern Michigan University for Kay Hodges, a Michigan-based researcher and the CAFAS' author, to direct the project. Along with Dr. Hodges, two graduate research assistants collect data from participating community mental health centers (CMHCs). These CMHCs encompass 163 participating programs. According to Dr. Hodges, between 85-90 percent of the state is represented in the LOF.[1]

Each provider that uses the CAFAS must undertake a competency-based training and receive biennial booster trainings. CAFAS coordinators from CMHCs who participate in LOF have quarterly meetings and receive monthly, quarterly, and semi-annual reports as well as a report card on children's progress in their center. CAFAS coordinators help providers review individual-level data and meet monthly with supervisors to compare their progress with overall state progress and benchmarks. Additionally, the LOF data collection and analysis has been used by state administrators. State officials reported that they base their selection of evidence-based practices on CAFAS data. For instance, CAFAS data showed a large number of youth with a behavioral disorder. As a result, state officials implemented provider training for an evidence-based practice: Parent Management Training - Oregon model (PMTO).[2] One state administrator explained, ***"It came out of a meeting about the ones we can't improve, the severe kids. [That] there's no EBP that (can help) isn't true, so let's look at the data, and that made the introduction of EBPs the easiest system change in my career."***

The study's aims were to:

- describe Michigan's efforts to infuse a culture of quality and a focus on outcomes management in its child mental health service delivery system; and
- highlight ways in which outcomes-based management has facilitated:
  - improved service quality as measured by the implementation of evidence-based practices;
  - infrastructure-related support for access and quality;
  - service redesign;
  - application of System of Care principles such as, family and youth empowerment, and cross-systems collaboration;
  - use of a public health, age-appropriate services delivery approach, and
  - concrete examples of the lessons learned in Michigan relevant for states and localities interested in leading a quality movement.

Map 1: **Michigan Case Study Sites**



Our Research Questions

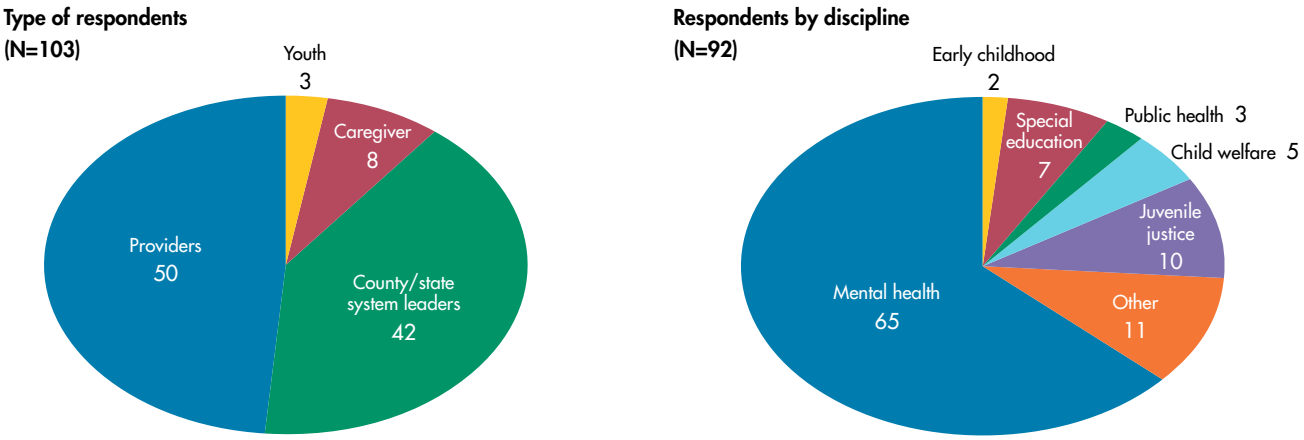
- What are the strengths of the LOF's use of a measurement tool (in this case the CAFAS) by Michigan counties to enhance service delivery?
- What major barriers did counties encounter?
- How did the use of a measurement tool like the CAFAS promote and assist in improving services?
- How did the use of a measurement tool like the CAFAS promote and support other system goals?*

Our Research Approach

NCCP investigators interviewed 103 stakeholders at the state and local level across the following six Michigan community mental health service delivery regions: Wayne, St. Joseph, Saginaw, Livingston, Ingham, and Hiawatha, covering 10 counties in total (see map 1). Stakeholders in these communities included county and state system leaders, service providers, and families and youth (see figure 1). Interviews were conducted between December 2007 and May 2008. While the majority of system leaders and service providers interviewed were part of the

* Investigators focused on system goals such as: family and youth engagement, public health focus, and cross-systems collaboration.

Figure 1: **Type of Respondents and Respondents by Discipline**



public mental health sector (70 percent), respondents from juvenile justice (11 percent), education (eight percent), child welfare (five percent), and public health (three percent) sectors were also interviewed to assess their knowledge of the CAFAS and the degree of collaboration across systems. This research was overseen by the Columbia University Medical Center's Institutional Review Board.

Due to the large number of respondents, MaxQDA,© a qualitative analysis software tool, was used to organize and synthesize the large amount of interview and focus group data. We used the software to organize data by a coding scheme related to the research questions. Once responses were coded we analyzed data by respondent type and county to identify common themes. Responses were also quantified using STATA statistical software.

Our research approach provided insight into how the use of a functional assessment tool across the state is working on the ground level. As with any research design however, this study has several limitations.

- While efforts were made to address all of the protocol questions with each respondent, response rates vary for questions, either due to time limitations where there was not enough time to ask all of the questions on the protocol, or due to the respondent's inability to answer certain questions (such as respondents outside of mental health who were not using functional assessments). Response rates for questions are listed throughout the findings.
- System leaders and providers across mental health and non-mental health agencies were questioned about their knowledge and use of the CAFAS – even though only mental health providers are mandated to use the CAFAS – to see if the functional assessment tool was used beyond mental health agencies in the state. Given that there is no expectation that providers outside of mental health know about the CAFAS, we present when relevant the findings for mental health and non-mental health providers and system leaders.
- While not a major focus of the study, youth and parents or caregivers were interviewed to capture their knowledge of and perspective on the CAFAS. County agencies identified the families for us to interview, however, due to resource limitations, we were only able to interview a small sample of youth and family members.
- While the interview data collected provides practical insights from providers into the benefits and challenges of using a functional assessment tool, this study is not an assessment of the CAFAS tool and its psychometric properties.

About the Michigan Community Mental Health Service Regions (see Appendix 2)

- Wayne County had the highest total population in 2008 of 1,981,654 persons.
- Wayne County had the highest percentage of persons in poverty (21 percent).
- Hiawatha region had the lowest median household income of $39,782 and Livingston County had the highest median household income of $72,700.
- Wayne County also had the largest number of children 695,035 while the Hiawatha region had the smallest number of children 31, 090.
- Wayne County had the highest percentage of African-American children (45 percent), Saginaw County had the largest percentage of Latino children (nine percent), Ingham had the largest percentage of Asian children (five percent), and the Hiawatha region had the largest percentage of American-Indian/Alaska Native American children (10 percent).

About the Respondents (see Figure 1)

- The majority of the respondents were service providers (49 percent or N=50).
- System leaders at the state and county levels were the next largest group (40 percent or N=42).
- Other respondents included family members or caregivers and youth (11 percent or N=11).

The experiences of the system leaders, providers, and families involved in data monitoring efforts, such as the LOF project, provide important guidance in helping to understand how such efforts can improve individual and system level outcomes. These perspectives collectively can inform others interested in replicating Michigan's approach. In this report, we highlight the findings and discuss their implications in order to help guide others interested in implementing an outcome measurement system.

Michigan's Service Delivery System

> "(The) most encouraging thing is that they (providers) are beginning to talk as a service delivery system – all the same kids (from Juvenile Justice, Children's Mental Health, Department of Human Services). They (youth) touch all the systems."
>
> – Wayne County system leader

Current research reveals very little about the policy and practice contexts of the service systems in which functional assessment tools, such as the Child and Adolescent Functional Assessment Scale (CAFAS), have been implemented. However, research suggests that there are factors that lead to the adoption of effective practices. For instance, leaders' and providers' attitudes are critical to the successful adoption of evidence-based practices (EBP).[3] System leaders and policymakers play a pivotal role in increasing rates of empirically supported practice.[4] Research also reveals barriers to implementing evidence-based practices, including: tension between fidelity and community modifications, the mismatch between provider preparation and expectations of evidence-based practices, and large variation in the ability to transport EBPs from one setting to another.[5] Research also shows that implementation of effective services without knowledge about the contexts of the delivery system is likely to be inefficient, impractical, and costly.[6]

Here we present stakeholder's views of their service system including:

- who they serve well or struggle to serve;
- service strengths and challenges;
- provider relationships;
- service goals;
- use of evidence-based practices; and
- general knowledge about the state's mandated assessment tool (the CAFAS).

Populations Michigan Serves Well and Struggles to Serve

Nearly half (N=48) of system leaders, providers, and stakeholders identified children, youth, and families that were served particularly well (see Figure 2). Of these respondents, over a quarter, across all six service regions, thought they served youth with severe emotional disturbance (SED) or those with the highest needs best. Respondents also thought those they served well included: youth with mental health issues in general (12 percent or N=7), compliant (that is those youth and families who are susceptible to services) youth (10 percent or N=6); and nearly one of 10 respondents thought they served all youth and families well.

While respondents were not specifically asked why they thought these groups of youth were served particularly well, comments from one state system leader captures a common theme: statewide, there is an emphasis on serving those with the highest impairments, although this varies by county. According to this system leader, ***"I would say it appears that Michigan, like other states, puts emphasis on the most severely impaired, keeping with the trend towards that, and Michigan doesn't seem any different… from my perspective there is great variability across localities, so I think it appears to vary by their strengths. For example, the more impaired youth in Lansing are served particularly well but (that's) not necessarily the case in other localities."*** These observations may also reflect that both the state CAFAS mandate and its 14-year history in developing the LOF has focused on youth with SED.

Figure 2: **Populations Identified as Served Well**

N=48 with multiple respondents

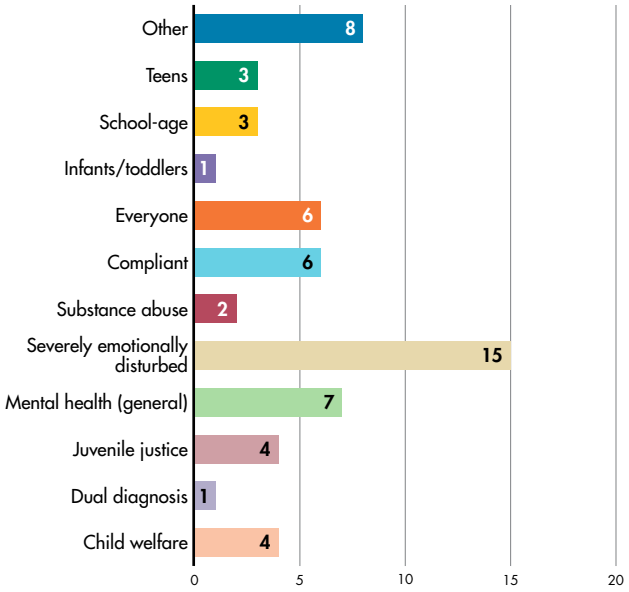
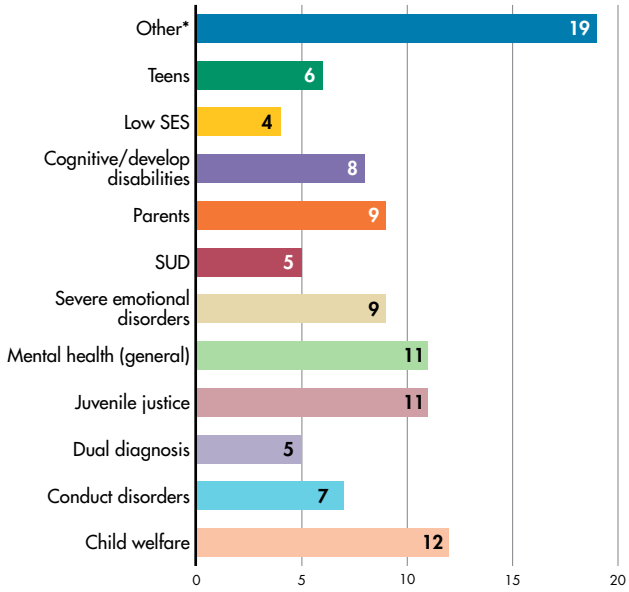


Figure 3: **Populations Identified as Hard to Serve**

N=55 with multiple respondents



* Includes responses such as: those who were resistent to services, those with severe emotional disturbances (SED), and infants and toddlers.

System leaders, providers, and stakeholders also reported on who they or the system struggle(s) to serve appropriately (see Figure 3). Fifty-five respondents answered. While answers varied widely the most frequently cited responses (11 percent or N=12) pointed to youth in the child welfare system as those that were the hardest to serve. Youth in the juvenile justice system were the next most frequently referenced group (N=11) followed by youth with generalized mental health problems (N=11).

Some respondents also highlighted populations that were difficult to serve, specific to their location. For instance, serving individuals from various racial, ethnic, or cultural groups was a challenge in some regions in the state. Providers in the Upper Peninsula region (Chippewa, Mackinac and Schoolcraft) spoke of the unique challenges of serving American-Indian families and the stigma associated with accessing mental health services within the tribes. Providers in St Joseph's County said they struggled to serve two groups with unique language access and cultural needs: a new wave of Mexican immigrants that has moved to the county, as well as, a large Amish population, where the primary language spoken at home was German. A large and diverse refugee population in Ingham County represented a challenge for its providers. The county is a major hub for refugee resettlement. In Wayne County, they struggled to meet the needs of large pockets of different racial and ethnic groups, ranging from African-Americans, Latinos, Asian-Pacific Islanders, American Indian/Alaska Natives, Hmong, Eastern Europeans and Arab-Americans. Respondents also alluded to the specific difficulties serving urban (in Saginaw and Wayne) and rural populations (in the Upper Peninsula and Livingston). A provider in Saginaw County noted that their's is a city of much violence and hence, a lot of trauma, when recalling the shooting of an infant in a car. An elementary school-age child was part of the group charged with the shooting. He would be charged as an adult. According to another provider in the county, ***"(We are) known in the state for serving the most troubled."*** Providers in Wayne County pointed to the large pockets of poverty in their county, noting that they had some of the poorest ZIP codes in the United States. According to one provider, ***"the 15th Congressional district, one of the poorest in the country, second only to a district in Mississippi"*** is in Wayne County. These providers discussed the impact of intergenerational poverty and unemployment. Respondents from rural areas reported that they struggled to reach all families, given how spread out services were. In St. Joseph's County, one provider noted the county has one of highest teen pregnancy rates in the state. He also reported an estimated 70 percent of the babies born are to mothers with Medicaid coverage.

Service Capacity: Provider Relationships and Collaboration

Respondents were asked to discuss the strengths and challenges that providers faced in Michigan. Overall, 59 respondents discussed strengths they saw and 69 spoke of observed challenges. Strengths discussed included:

- high quality staff and/or programs (44 percent);
- strong collaboration among providers (36 percent);
- coverage or availability of services (19 percent);
- committed staff (17 percent); and
- use of data and EBPs (eight percent)

Of those who discussed strengths, nearly half (44 percent) of the respondents -across all six service regions- discussed the high quality of the staff and programs in their counties. Many spoke of "champions" in their service system as well as the strong qualifications of providers and the desire to be effective clinicians. Over one-third (36 percent) of providers, in all six service regions, spoke of collaboration as a strength of providers in Michigan. As one provider summed up, ***"When I think of the system, I think of our kids and how the broader community serves them. We are a collaborative community, not playing hot potato. (We're a) very strength-based agency. (We) look at what the other systems strengths are and combine strengths to serve kids better."*** Providers in Wayne and St. Joseph's counties focused particularly on collaborative efforts. In the case of Wayne County, respondents offered that a possible explanation for improved collaboration was the "successful marriage" between Juvenile Justice and Mental Health where there had historically been a disconnect. Similarly, system leaders and providers in St. Joseph's County spoke of collaboration and positive relationships among providers across systems, such as the courts, Department of Human Services, Intermediate School District (ISD), and Children's Mental Health. One system leader in St. Joseph County noted, ***"(We) worked hard so (that) everyone has a niche (and so there's) no duplication of resources. Now people are not as territorial."*** Another system leader added, ***"We play fairly nice together. We work well together to put the child and family first."*** Other strengths of providers included: the availability of programs to serve those in need (19 percent), committed staff who remained in their positions (17 percent), and agencies' increased use of data, focus on outcomes, and use of EBPs (eight percent).

Provider and system challenges mentioned varied widely but included:

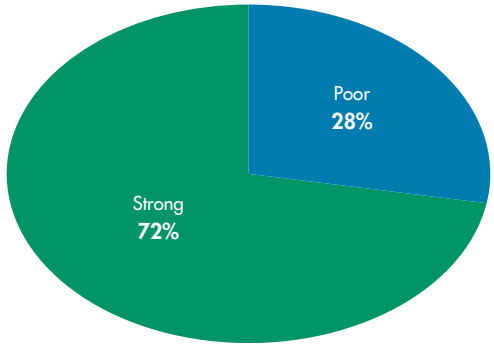
- insufficient services or staff shortages (26 percent);
- lack of funding (14 percent);
- providers being overwhelmed (seven percent);
- providers in need of better training (13 percent); and
- and staff turnover (12 percent).

Over one-quarter of respondents from all of the study service areas, except Ingham County, discussed the challenge of too few providers or lack of certain services available for youth and families. The unmet service needs they emphasized varied across service areas and included: day programs, transportation, and programs for teens in Wayne County; psychologists in St. Joseph and Saginaw counties; mobile crisis teams and trauma services in Saginaw County; substance use disorder (SUD) treatments for adolescents and expanded wrap-around services in Livingston County; and child welfare services in the Hiawatha area. A provider in Saginaw County explained, ***"(We) have limits on who we serve… (We) do not have the array of services we would like."*** Other service challenges mentioned were lack of funding; providers being overwhelmed with paperwork and cases; providers in need of more training; and staff turnover.

Relationships among providers across systems serving children and youth were also explored. Nearly three-quarters of respondents thought providers have strong relationships with one another (see Figure 4). Additionally, other respondents noted this is an area that is improving. One system leader from Wayne County explained, ***"(The) most encouraging thing is that they (providers) are beginning to talk as a service delivery system – all the same kids (from Juvenile Justice, Children's Mental Health, Department of Human Services). They (youth) touch all the systems."*** Another system leader from that county added, ***"Over the last couple of years, (there's) more collaboration and more sharing of resources and referring to niche programs. (We're doing a) better job of knowing what's out there."***

Figure 4: **Strength of Provider Collaborative Relationships**

(N=57)



Relationship-related challenges among providers were also a factor, according to some respondents (28 percent). This was especially true of the relationship with the child welfare and public education systems. Among state leaders, there was less talk about collaboration with those from the education and child welfare sectors. County system leaders and providers found collaboration with their education and child welfare partners to be challenging at times. For instance, one provider in Saginaw County said, ***"(We're) working hard on better (cross) system involvement. There isn't collaboration with the schools, which they need to have. We ran numbers and at least two thirds (of children) have moderate to severe (problems) in school functioning. Schools are welcoming, but there are still turf issues. (We) could also do better with kids in foster care… (we're) working on that."*** The comments reported here may reflect the service challenges the Michigan child welfare system was facing at the time. Box 2 outlines a settlement the state child welfare agency reached with an advocacy group after the field work for this study was completed. Other places of tension were relationships with private providers, including private medical providers. Providers and system leaders thought that there is little collaboration with private doctors who serve the same families.

Box 2: Michigan Department of Human Services' Settled Lawsuit Promises Service Improvement

In 2006 a federal class action known as Dwayne B. v. Granholm, was brought against the state of Michigan by the national child welfare watchdog group Children's Rights, the international law firm McDermott Will & Emery, and local counsel Kienbaum Opperwall Hardy & Pelton. The lawsuit charged the state with violating the constitutional rights of the approximately 19,000 children in its custody by failing to protect their safety and well-being and find them permanent homes. In 2008, the state and Children's Rights settled the lawsuit.

The agreement reached included many changes and improvements to be made regarding outcome measures, quality assurance, and child welfare services of the Michigan Department of Human Services. Examples of the settlement's changes include:

- The creation of the Children's Services Administration to consolidate all policy development, child welfare improvement, field operations in the largest counties, data collection, and training functions under one director.
- Phone lines used for the reporting of suspected abuse or neglect of children currently operated at the county level, are to be converted to one state-centralized abuse hotline by October 2010.
- The State must establish separate units for the investigation of allegations of abuse and neglect of children in foster care custody, and must be available statewide as of April 2010.
- All caseworkers will be required to complete a minimum of 40 hours of training annually.
- By 2011, the final staff ratios are required to be: 95 percent of supervisors are required to oversee no more than five caseworkers; 95 percent of foster care and adoption caseworkers are required to have no more than 15 cases; 95 percent child protection service caseworkers are required to have 17 or fewer cases; 95 percent of licensing workers are required to have 30 or fewer cases.*
- The DHS is now required to consult family, foster parents, the DHS, and other relevant parties when major decisions are being considered.
- Additional policy changes are required to expedite the movement of children from foster placements to more permanent arrangements.
  - Such changes discourage maintaining a permanency goal of reunification beyond one year.
  - Require "concurrent planning" for placing children with an adoptive parent while reunification services are delivered.
  - If the child's permanency goal is changed to adoption then DHS and the assigned contract agency has 30 days from the change to: assign a worker to the case, determine if the foster parent(s) or relative(s) of the child are interested in adoption or identify other adoptive resources and adoption recruitment plans.

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* The Child Welfare League of America recommends CPS caseloads be no more than 12 active investigations per month. http://www.cwla.org/programs/standards/cwlacaseloadstandards.htm

<http://www.michigan.gov/documents/dhs/DHS-LegalPolicy-ChildWelfareReform-Settlement_243876_7.pdf>.

Box 3: County Collaboration Examples

Livingston County

Providers in Livingston County spoke of a collaboration to treat youth who are in both the juvenile justice and foster care systems. It addresses teenagers in foster care with challenging behaviors including: sexual offenders, fire starters, and those with a severe emotional disturbance disorder. Providers treat the family as the service user and apply a structured decision-making tool to identify high risk, medium risk, and low risk cases. Risk assessments may then result in a petition to the court for a particular care plan.

Another child welfare initiative in Livingston County called *Family to Family* supports children who are at risk of being removed from their families by bringing to the table family members and community agencies to make "team decisions" about how best to support families. The goal of the program is for communities to be involved to help support parents' financial and other needs in order to reduce the number of residential placements.

Ingham County

IMPACT is a county program of the courts designed to be a "more intentional way of working with people." It includes intensive family services and coordination efforts (across the child welfare, school, and court systems) for children in the child welfare system and addresses youth delinquency and truancy. It is the only county in Michigan where the court has an intensive in-home neglect and abuse treatment program. The program provides services for abuse and neglect with the intention of reducing out-of-home placements. IMPACT also offers evening tutoring, mentoring, therapeutic groups, and classes for youth who are delinquent or truant, in an effort to reduce crime, particularly during the evening hours. A special tax called the juvenile justice mileage helps fund these services.

Across the board, county system leaders spoke about their outcomes management and its role in system facilitation.

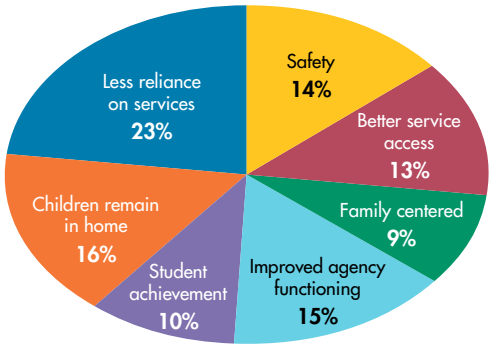
Service Goals

Research shows that an outcomes-driven framework to ensure continuous quality improvement contributes to effective services.[7] We therefore, explored the extent to which service providers in Michigan were focused on outcomes and service goals for the youth and families they served.

System leaders and providers discussed their top service goals for systems serving youth. Figure 5 shows these goals. Respondents most commonly reported that their goal was to help reduce families' need for services and empower families. Other common goals included: helping children remain in their homes or decreasing the number of out of home placements, improving agency performance

Figure 5: Service Goals of System Leaders and Providers

(N=57)

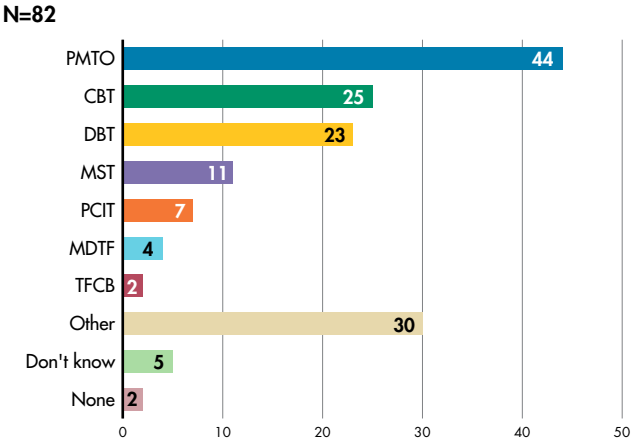


(that is increasing staff training, more funding, expanding service capacity, and ensuring treatment goals are met), public safety, better family access to services, improving student achievement, and having family-centered services.

Use of Evidence-based Practices

Given the growing movement toward evidence-based practices (EBPs),[8] stakeholders were asked which EBPs their community has adopted. Figure 6 below shows the types of evidence-based practices reported. The most commonly cited EBPs included: Parent Management Training - Oregon Model (PMTO), Cognitive Behavorial Therapy (CBT), and Dialectic Behavioral Therapy (DBT) (See Box 4 for more information on the evidence-based practices listed). The use of each of these three EBPs was reported across all six of the service regions; while wrap-around was reported in three counties (Wayne, Livingston, and Ingham), and Multisystemic Therapy (MST) was also reported in three counties (Wayne, Saginaw, and Livingston). The widespread use of EBPs in Michigan is most likely tied to the development of a culture that promotes quality supported by the LOF. The State encouraged and incentivized the use of CBT, DBT, and PMTO through coordinating and facilitating a joint purchasing agreement and developing a train-the-trainer model. This pivotal role of the state may also be the reason for the high level of awareness of EBPs in Michigan. Further findings on the knowledge of EBPs and how the CAFAS contributed to the use of EBPs follow.

Figure 6: Use of Evidence-based Practices as Reported by Respondents



* Twelve respondents also listed Wraparound (a best practice) when naming evidence-based practices that have been implemented.

Use of and Knowledge About the CAFAS

Over half of all respondents (61 percent or N=63) indicated that they or their agency use the CAFAS. Twenty-nine of these respondents belonged to the mental health sector. The remaining respondents (34) were non-mental health providers (including respondents working in child welfare, early childhood, special education, and juvenile justice). Eighty-three respondents answered questions on whether they had any knowledge about the CAFAS. Of these, 66 respondents (80 percent) across all six service regions were able to describe the CAFAS and its' use. Of those, 37 respondents were mental health workers however, 29 respondents outside of mental health had knowledge about the CAFAS. This demonstrates that while other systems are not mandated to use the CAFAS there is considerable knowledge about it outside of mental health agencies. Additionally, only 15 respondents (18 percent) specifically stated that they are not familiar with the CAFAS and/or do not use it, and of those 14 were non-mental health workers. Additionally, 18 of the respondents (22 percent) knew specifically about the state mandate to use the CAFAS. These findings suggest that in general, there is widespread use and knowledge about the CAFAS across the counties studied.

Box 4: Evidence-based Practices Commonly Used in Michigan

Parent Management Training Oregon Model (PMTO) is an evidence-based family intervention designed for children and adolescents ages 4 to 12 with behavior problems. PMTO has been found to be especially effective in preventing noncompliance, substance use, and delinquency. The intervention focuses on five core parenting skills to improve behavior in children: encouragement, limit setting, monitoring and supervision, family problem solving, and positive parent involvement.

Cognitive Behavioral Therapy (CBT) is an evidence-based intervention to teach youth to change their thoughts and feelings. It has been demonstrated as one of the most effective treatments for youth depression.

Dialectic Behavioral Therapy (DBT) is a type of cognitive behavioral therapy commonly used with youth that teaches stress management, how to regulate emotions, and improve relationships with others.

Multisystemic Therapy (MST) is a community- and family-based treatment model for youth with serious behavioral problems. The goal of MST is to reduce antisocial behavior. MST involves multiple systems (schools, peers, caregivers, etc.) to promote change.

Parent Child Interaction Therapy (PCIT) is a family-centered treatment for children and youth and their caregivers. It addresses children's behavioral problems by addressing negative parent-child interaction patterns that may be contributing to the child's disruptive behavior. Research has shown that as a result of PCIT, parents learn more effective parenting techniques, the behavior problems of children decrease, and the quality of the parent-child relationship improves.

Multidimensional Treatment Foster Care (MTF) is a treatment for adolescents ages 12 to 16 with chronic disruptive behaviors or severe emotional disturbances. MTF is intended as an alternative to regular foster care, group or residential treatment, and incarceration.

Trauma Focused Cognitive Behavioral Therapy (TFCBT) is designed for children ages 4 to 18. The goals of TFCB are to decrease post traumatic stress disorder symptoms, decrease externalizing behavior problems, decrease negative attributes about the traumatic event, decrease parental depression and improve parenting. TFCBT was found to be effective in reducing depression, anxiety, feelings of shame and mistrust and has also been related to decreased depression in parents and their own emotional distress over their child being abused and is associated with increased positive parenting practices.

Sources: Cooper, J. C. 2008. Towards Better Behavioral Health for Children, Youth, and Families: Financing that Supports Knowledge. New York, NY: National Center for Children in Poverty. Association for Children's Mental Health. 2004. Evidence Based Practice Beliefs, Definitions, and Suggestions for Families. Okemos, MI: Association for Children's Mental Health. http://www.acmh-mi.org/41447_ACMH_Booklet.pdf

How Functional Assessments Can Lead to Improved Mental Health Services and Efforts to Promote Evidence-based Practices

> "It creates a fish-or-cut-bait environment. Once you begin to measure outcomes, you are either lucky or it creates a clear call to action about the need to change. Especially if there are evidence based practices that create measurable results, as a manager of a public trust you need to decide what to stay with."
>
> – County mental health director

Children and youth often do not get the mental health services they need. The consequences for children not receiving adequate mental health services can be severe, including premature mortality.[9] This has led to a widespread call for greater accountability in the delivery of health and mental health services. The President's New Freedom Commission's Subcommittee on Children and Families called for a clear focal point for responsibility and accountability for children's mental health care. It noted that services and systems should be guided by: standards for access to, and quality of, care, performance measures of service delivery and outcomes in order to reduce inappropriate and ineffective care, and to produce data for continuous quality improvement of services and supports.[10]

The *UCR* national report revealed that states have made some progress towards implementing an infrastructure that tracks outcomes and facilitates continuous quality improvement. Eight states considered themselves at an "advanced" stage: collecting, analyzing, and using demographic, service utilization, and functional outcomes data across service systems for planning and quality improvement. Twenty-nine states thought they were at an "intermediate stage" where they collected and used the same type of data as above for planning and quality improvement but this was only within the mental health system. However, 14 states considered themselves at the "rudimentary" stage where they collected demographic and service utilization data but did not collect functional outcomes data. Use of this data for planning and continuous quality assessment was still limited or infrequent.[11] These data suggest that for a select group of children and youth, Michigan may be a national leader for implementing a mechanism for accountability.

Since so few states were at an "advanced" stage of collecting functional outcomes data to be used for systems planning and quality improvement, a closer examination of the Level of Functioning (LOF) project (and its use of the CAFAS) provides insight into the benefits and drawbacks of creating an infrastructure to support accountability. In this section, we present Michigan respondents' views on the benefits and challenges of using a functional assessment tool, in this case the CAFAS, and how this data was used as empirical support for effective programs and to promote evidence-based practices.

Michigan stakeholders were queried on: strengths of the LOF project (and its use of the CAFAS); and areas for improvement and challenges of the LOF project (and its use of the CAFAS).

Findings: Benefits of Using a Functional Assessment Tool

Respondents recognized that systematic use of a standardized functional assessment tool, like the CAFAS, allowed them to better monitor outcomes and guide services. About half (49 percent) of the 61 respondents who discussed benefits recognized the value of having individual-level data to help track what was working well and not working well for children served. They saw it as a non-threatening way to help identify needs and weaknesses, to see what progress is being made, and as an aid in decision making at individual, local, and state levels. One state administrator explained, ***"I would have still been making decisions by the seat of my pants. Making decisions at this level is always scary business because you know it will impact thousands of people… I wanted the data to help make decisions… having client-level data is so powerful, more powerful than any other data we have to make decisions on."***

Respondents valued measuring behavioral functioning and saw it as an opportunity to improve their system's effectiveness through more objective assessment. Many of the respondents (60 percent) who discussed benefits also thought that the CAFAS was a useful tool in this process since it helped them examine and track behavioral functioning to inform treatment plans, which they may have missed through clinical treatment alone.

Lessons Learned

Using data to guide services and track outcomes enhances systems' ability to improve services. The majority of respondents saw the CAFAS as a valuable tool for guiding services. They found the tool to be effective and objective. Through outcomes monitoring system leaders can target interventions that work, and address factors that support or impede quality. For example they are better able to identify which providers and intervention strategies consistently lead to positive outcomes for children and youth. The data presented here suggests that Michigan has made great strides in implementing an outcomes-focused approach to service delivery.

*Findings: Limitations of Using Functional Assessments**

Concerns about the level of subjectivity of the CAFAS tool remain. Respondents who discussed limitations of the CAFAS (N=66), displayed some skepticism about the usefulness of the CAFAS. Some of these respondents (32 percent) found the tool to be subjective when making determinations between categories and assigning scores, particularly since they felt the assessment tool only captures a single point in time. While others (38 percent) thought the tool could be superficial (particularly around measuring self-harmful behaviors) for determining clinical treatment decisions. Respondents also discussed their desire to see more subscales developed and have greater distinction among the scales. A minority of respondents indicated that the state mandate was the primary reason for using the CAFAS. One respondent explained, ***"The perception (is) that we have to do this for the state and that is why we are doing it (using the CAFAS)."***

A more developed functional assessment of parents and families is needed. Several respondents (24 percent or N=16) noted that while the caregiver wish list (a parenting skills assessment supplement to the CAFAS) was helpful in identifying areas of improvement for parenting, it does not fully capture parental or family functioning. (See Box 5 for more information about the caregiver's wish list). Respondents suggested that there should be further assessment scales available in additional areas of family functioning. They also noted that this would help in continuing to make services even more family centered. As one system leader explained, ***"How the family is functioning affects the youth. (It) never makes sense (to have a) family scale with families who have problems and the families who don't have enough resources all thrown in together. (It's) well intentioned, as families who are actively involved with criminal behavior or substance abuse preventing them from being better parents… (but) parent scales are not fine-tuned (and) need additional scales."***

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* The challenges presented here are not meant to be a formal critique of the technical properties of the CAFAS, but rather reflect the perspectives of providers using functional assessment tools.

Box 5: Child and Adolescent Functional Assessment Scale (CAFAS)- Caregiver Wish List©

The Caregiver Wish List allows caregivers to identify with their child's counselor their parenting strengths or what they may need to improve on to help with their child's behavior problems. The list consists of two "skill wish lists." The first asks caregivers about their child's skills; the second asks about the caregiver's skills. The five response options range from "Hardly ever" to "Most of the time." Caregivers are also asked to give their "Three top wishes" as goals to work towards.

Examples from the skill wish list related to the child:

- When you tell your child to do something, how often does your child do it?
- How often does your child act like he/she wants to please you or make you proud of him/her?
- Examples of questions from the skill wish list for caregivers:
- When your child behaves well, how often do you praise or compliment your child?
- When your child goes out, how much do you know about what he/she is doing and where he/she is going?

For more information see: http://www.fasoutcomes.com/Content.aspx?ContentID=15

There were concerns over how to present functional assessment results in a strength-based way. A small number of respondents (approximately 17 percent or 11 of the 66 respondents) expressed concern that the CAFAS measures deficits in functioning. For instance, one respondent indicated that questions on the CAFAS focus on problem behaviors and that she'd like to see more questions oriented toward strengths to help motivate youth. Another respondent explained how it was difficult to discuss a child's CAFAS results with the family while maintaining a strengths-based perspective. She remarked, ***"The challenge is the CAFAS measures the kids' worst behavior, so even if the child is doing better and try to focus on strengths (then we) spend (a) half hour bumming the family out…constantly trying to find out the worst thing he did, and now we are going to swing back to positive."***

The CAFAS can be administratively burdensome. A few respondents (12 percent or N=8) voiced concern that it can be time-consuming to fill out the CAFAS and enter the data into one (sometimes two) computer system(s) in addition to their other responsibilities.

CAFAS scores are a large component of determining eligibility for service. A small number of respondents (six percent) thought the fact that the state established CAFAS thresholds for service eligibility (although this was upon recommendations established by providers involved in the LOF) created the potential for perverse incentives. They noted the potential for providers to try to keep youth within certain scores in order to keep them in services. Some also find that this makes it difficult for "outliers" who need services but may not have a CAFAS score appropriate for eligibility.

Lessons Learned

Getting providers invested in assessments and data analysis may help with utilization. Respondents expressed concerns about the subjectivity and superficiality of the CAFAS tool. They were worried about service eligibility being linked to CAFAS scores. Some were also concerned that the tool is not congruent with a strengths-based approach, making it difficult to communicate CAFAS outcomes with youth and parents. These concerns may create unintended results, such as fuelling a reluctance to fully use the tool as intended or as tempting providers to adjust a child's score to enter treatment or keep them in services longer. It is worth noting that only about one-fifth of respondents expressed these concerns.

These findings suggest that providers may benefit from further information at the outset of CAFAS use on: (a) the broad purposes and general applicability of the CAFAS; (b) the demonstrated effectiveness of the tool for decision making; and (c) how to share CAFAS results using a strengths-based approach with youth and families. For example, in one study county, significant efforts have been made to train clinicians to conduct strengths-based assessments. In another region, a concerted effort has been made to share CAFAS results with families, compelling providers to address their own ways of presenting information to families. Additionally, if the CAFAS is used with all children and youth, compared to just with children and youth with SED (as the case in Michigan), the issue of service eligibility criteria would diminish substantially.

Need to consider providers' responsibilities when implementing the CAFAS. A small minority of respondents (14 percent) reported that the CAFAS is burdensome and time consuming to use. Since the CAFAS is a quick tool to use (by most accounts it takes 10 minutes to complete), the response that it is administratively burdensome may relate more to the gathering of information necessary to use the tool or to respondents' lack of familiarity with the tool. Analysis of the time needed to gather information should be calculated and efforts made to streamline this process. This information should also be conveyed to practitioners. Otherwise, perceived time constraints may prevent some providers from utilizing it. Further analysis is warranted based on provider profile and background to see whether this response can be generalized across disciplines. Our preliminary analysis indicates that those considering implementing data measurement systems should consider the administrative burden and providers' overall workload.

Any functional assessment tool that is the center of an outcome-based management effort like the LOF may need to examine overall family functioning. More than a quarter of respondents (28 percent) who discussed challenges were concerned that the CAFAS does not fully capture family functioning. Research suggests that engaging the family is critical to treatment success; measuring family functioning is important for effective treatment.[12] Integrating family functioning into an existing functional assessment tool or supplementing it with other assessment measures of family functioning would further benefit the child's treatment and increase the effectiveness of a state's outcome management system.

Generating the Use of Evidence Based Practices

Widespread use of ineffective practices, combined with an external movement in health care to raise the bar on the quality of service delivery, has propelled the EBP movement.[13] In children's mental health services research, the term EBPs refers to scientific-based knowledge about service practices. It provides "a shorthand term that denotes the quality, robustness, or validity of scientific evidence as it is brought to bear on these issues."[14] Nationally, we know that nearly all states are promoting or requiring the implementation of empirically-supported practices while the scope of initiatives tends to be limited.[15]

One benefit of managing outcomes is that when data is generated and analyzed stakeholders can use it to better guide implementation of empirically-supported practices. System leaders, providers, and families in Michigan were therefore asked about their knowledge of EBPs to gauge how the CAFAS may have contributed to their use. Interviews and focus groups revealed the following:

There were high levels of awareness and statewide use of evidence-based practices. A high percentage (80 percent) of Michigan respondents were able to identify the EBPs in their community, including 38 percent of parents and caregivers who were able to identify EBPs they or their child were involved in. Such a high level of awareness in the state about EBPs may not be typical. For example, our case study in California found that 69 percent of community leaders, 11 percent of family members, and seven percent of youth had heard about evidence-based practices. This high level of awareness may be a result of the LOF project.

The LOF's focus on the CAFAS and the state's mandate of its use helped facilitate the adoption of EBPs by identifying the need for EBPs and by demonstrating their effectiveness. Individual-level data from all participating providers was pooled into a state database revealing to state administrators the large number of youths and parents with conditions that could be treated with specific evidence based practices. The state therefore implemented training programs for CBT, DBT, and PMTO as well as obtained grant money to study

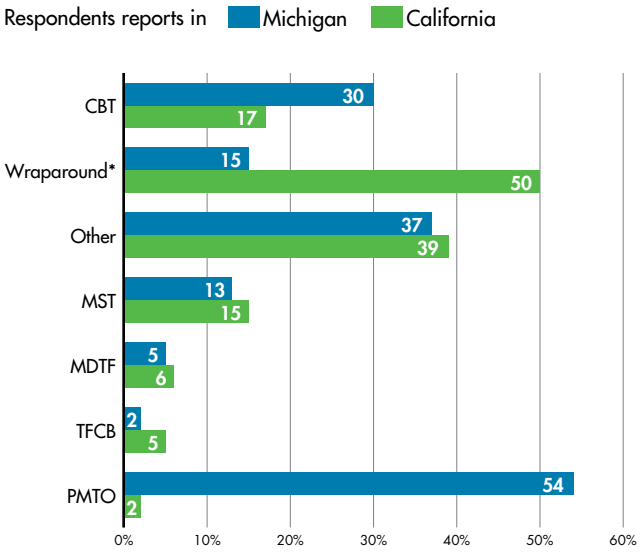
how to disseminate evidence-based treatments in public mental health settings.

Twenty-nine percent of those who discussed the LOF project thought the CAFAS and the LOF project facilitated the use of EBPs. When asked which EBPs had been implemented in their community:

- 54 percent said Parent Management Training – Oregon model (PMTO)
- 30 percent said Cognitive Behavioral Therapy (CBT)
- 28 percent said Dialectical Behavior Therapy (DBT)
- 15 percent said wraparound (a best practice)
- 13 percent said Multisystemic Therapy (MST)

The most commonly cited EBPs in Michigan included: PMTO, CBT, and DBT. These were similar to the EBPs that California respondents reported but varied. Particularly (see Figure 7), the reported use of PMTO was much higher in Michigan. One county mental health director noted: ***"It creates a fish-or-cut-bait environment. Once you begin to measure outcomes, you are either lucky or it creates a clear call to action about the need to change. Especially if there are evidence based practices that create measurable results, as a manager of a public trust you need to decide what to stay with."***

Figure 7: **Use of Evidence-based Practices**



* A best practice.

Lessons Learned

Statewide attention to outcomes and encouragement of EBPs helps to facilitate awareness about and implementation of EBPs. A vast majority of respondents demonstrated awareness of EBPs, including parents. A number of respondents thought that the use of CAFAS and the LOF project was directly linked to the use of EBPs. Michigan also implemented statewide efforts to implement three EBPs: PMTO, DBT, and CBT as a result of the LOF project. The high degree of awareness of EBPs in Michigan and the higher levels of use of the state-initiated EBPs suggest that Michigan's mandate plus technical assistance approach to outcomes has positively impacted the implementation of EBPs.

The Impact of CAFAS on Cross-system Collaboration and Support for Other System Goals*

> "Multiple systems tend to blame one another, but with the CAFAS (we) can look at what is going on… we're less likely to blame (each other)."
>
> – Provider from Ingham County

Cross-system Collaboration

One of the major sources of unmet need in children's mental health stems from a lack of adequate capacity to treat all children and youth with mental health problems across various settings. These include insufficient number of providers, too few community-based treatment slots, poor alignment between the service systems that children and youth are in, and the availability of resources.[16] In the national *Unclaimed Children Revisited (UCR)* study, states reported poor capacity of mental health service delivery as one of the top three challenges facing the system. Cross-system coordination is increasingly recognized as a way to expand service capacity and more effectively serve children, youth, and families.[17]

Coordination among systems presents a challenge however, to many. Nationally, cross-system collaboration was named (in 16 states) as one of the most challenging obstacles to serving children properly.[18] Twenty-one states (38 percent) reported effective strategies in collaboration with other child serving systems ranging from juvenile justice, child welfare, substance abuse agencies, schools and public health. Only 29 states reported on initiatives to improve cross-system outcomes. States grapple with how to advance services for children and youth, and the families of children and youth, with mental health conditions involved in multiple systems, including how to pay for services. The inability of child serving systems to develop and track shared outcomes impedes collaboration across systems.

Michigan has taken several steps to foster collaboration across systems. In Michigan's response to the national UCR report its leaders highlighted that 15 Michigan counties are blending and braiding funding across systems to provide services to families.[19] Instituting the statewide use of the CAFAS was also seen as a potential way to help county mental health and other systems track outcomes and develop shared programming and better collaboration.

Many state and county leaders and providers raised the potential for the CAFAS to be used as a collaboration and communication tool.

Findings: Cross-system Collaboration

Data derived from the CAFAS propelled cross-agency and cross-system collaboration in some counties, but this was not universal. Less than one-fifth of respondents (16 percent) recognized the value of having a "common language" to communicate across agencies, and as in the case in some counties – across systems. For example, respondents in one county spoke about how use of the CAFAS across systems has helped facilitate referrals. According to a provider in one county,

* Investigators focused on family and youth engagement, public health focus, and cross-systems collaboration.

"Now we speak about 80 versus 120 and know what it means. We can now speak as professionals to each other – can use scores to discuss a case. (The CAFAS) is more widely accepted across agencies. It's a common language now."* Another provider also thought that the CAFAS has led to better relationships between systems. She explained, *"Multiple systems tend to blame one another, but with the CAFAS (we) can look at what is going on… we're less likely to blame (each other)."*

While cross-system collaboration within individual counties is evident, the use of the CAFAS is not widespread outside of community mental health. Approximately one third of respondents who discussed agencies using the CAFAS, could identify entities outside of community mental health that used the CAFAS. In one county, the school-based mental health worker explained, *"A couple of years ago, [we did] the whole piece where we taught schools [to] rate. I thought it was great when we were doing it. [We used] a different version, the JIFF, we brought in school counselors, and spent a whole day (training), teaching them how to rate. Nobody used it."*

The slow uptake of the use of the CAFAS outside of mental health described by this respondent may be because traditionally it was developed for and used by mental health providers. According to the LOF project director, there was never any expectation that the LOF generate any cross system collaboration or support other system of care goals.[20]

Two other CAFAS spin-off tools, the Juvenile Inventory for Functioning (JIFF) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS), seem to be more easily used in other sectors.** There have been efforts by the community mental health authority to train personnel from other sectors to use the CAFAS but often they have chosen not to use it. There are other instances where the mental health and juvenile justice systems have paired to implement the CAFAS. In Livingston County, all probation officers and juvenile corrections personnel have been trained in the use of the CAFAS. In other places two assessment tools may be used simultaneously. For example, the JIFF assessment and the CAFAS may be used for a juvenile justice involved youth. In Wayne County every juvenile justice involved youth is screened using the CAFAS and the JIFF. According to one system leader in Wayne County, *"(We're) getting the juvenile justice world to change… we do the CAFAS and/or JIFF – if there are mental health needs we address them. Every three months we do another CAFAS and/or JIFF. The agencies want the reports to engage with the families to explain the plans or goals."*

Lessons Learned

Use of a standardized assessment tool like the CAFAS across systems and systems coordination should be encouraged. Some respondents (15 percent) acknowledged that a strength of the CAFAS is its ability to foster cross-system collaboration. The CAFAS can demonstrate youths' needs across systems through measurement in domains such as school, community, substance use, and the home, which can flag when youth are struggling in those areas and when referrals to juvenile justice, substance use, or child welfare would be appropriate. Providers across agencies and systems can all understand what CAFAS scores mean and give clear guidelines for service eligibility, thus facilitating referrals. Systems would benefit from the adoption of the CAFAS early on to maximize cross-system collaboration and facilitate better coordination.

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* For the purpose of generating a quantitative score, level of impairment for each subscale is assigned a score: severe is 30; moderate, 20; mild, 10; and minimal or no impairment, 0. The subscales are then added so that scores range from 0 to 240. A higher score indicates a greater impairment (Hodges; Wotring, 2004).

** The JIFF is not part of the LOF project.

Family-empowerment

The need for a strong role for families and youth in their own care planning, decision-making and service delivery is universally recognized. It formed a major focus of the design of this study, of the system of care movement and of the original Unclaimed Children report. In the over two decades since Unclaimed Children, which itself elevated the voices of children and families, the movement to embed family and youth perspectives in practice and policy has been largely credited with the success of family and youth organizations nationwide and with the increased role families and youth take in their own care planning and decision-making.[21] Research demonstrates and policy increasingly recognizes the importance of families and youth service users in their own care management and attaining positive outcomes.[22] Family engagement has been associated with improved outcomes in children's mental health.[23]

Nationally, 39 states reported on a range of efforts they have implemented to strengthen family and youth voices in policy. Strategies ranged from having a family and youth regulatory or legislative body, state mental-health authority decision-making board, organized parent advocacy network, service delivery leadership and advocacy, to some other leadership role.[24]

Michigan respondents were asked several questions related to family and youth involvement. Use of a standardized tool, like the CAFAS, represents an opportunity for agencies to share individual outcomes within and across agencies. It also presents opportunities for providers to engage families and share individual service progress of youth with their families. System leaders and providers were asked about the extent to which they share CAFAS results with families. Respondents were also asked about what role family members and youth play in the LOF project and how they are involved in outcomes management.

Findings: Family-empowerment

A standardized assessment tool like the CAFAS offers opportunities for providers to communicate with families about child outcomes but nearly one-third of providers did not share the CAFAS results with families. The CAFAS scores presented an opportunity to engage family members in treatment planning. Over one-third of respondents (35 percent), who discussed CAFAS strengths (N=61), listed the utility to share with families as a major strength of the measurement tool. These system leaders and providers said they were able to objectively present progress and validate treatment decisions through a mechanism similar to a report card, which was easy to communicate for them and easily understood by parents and youth. For example, a provider in Wayne County explained how she presents CAFAS data, ***"(I'll go over) the child's CAFAS scores with the family. When the child (has) done much better, (I encourage the family to use the CAFAS charts as) refrigerator art (to highlight their child's progress)."*** Additionally, according to one youth in Saginaw County, ***"(The CAFAS) gives us a lot of insight into what to work on…If I slip up one week it sets my CAFAS so much higher. That's what I do not like about it… (but) I would not change anything. It gives you all areas of concern."***

Of those providers who discussed sharing CAFAS results with families and youth (N=38), the majority of respondents (74 percent), said that scores are shared with families. While the scores are shared, it is unclear how deep the conversations are around what the scores mean and what are the implications for these discussions. Despite the benefits of assessment results in engaging families, some respondents (29 percent) specifically said that CAFAS scores are not shared with families. Only three of the 11 family members interviewed indicated any knowledge about the CAFAS. This disconnect between providers information sharing and family members' knowledge is reinforced by a family survey about the CAFAS. A family survey conducted in one county showed that less than half of the parents surveyed reported having CAFAS scores shared with them. One system leader noted: ***"I think (we're) still seeing, and getting over the more, traditional, clinical model of the therapist***

treats the child. A parent said that she goes into the center, the therapist takes her child in, and after 50 minutes sends her child back out and says 'See you next week!' We were like, 'does that really still happen?' It's that whole family-centered piece. We need to get people on that wavelength – that you can't treat the kid by himself. You treat the whole family." Additionally, one parent reported that while the CAFAS was administered with her daughter, she did not learn about the CAFAS until she attended a family impact meeting (community council).

Lessons Learned

Providers should be encouraged to share results from a functional assessment with youth and families. While the majority of respondents said that CAFAS scores are shared with families, this was not universal and few of the youth and family members we interviewed were aware of the CAFAS. In fact, sharing scores with providers has been a topic addressed at LOF meetings. Inconsistencies across providers sharing CAFAS scores with youth and family members may suggest the following:

- lack of adequate training on how to present CAFAS data to youth and families;
- lack of understanding of how families and youth could benefit from this information; and
- lack of encouragement on the part of agencies, counties, and the state of family involvement in the use of the CAFAS.

Research demonstrates and policy is increasingly recognizing the importance of families and youth service users in their own care management and attaining positive outcomes.[25] Providers should therefore, be educated on how best to share scores with youth and families and given encouragement to involve families through agency-, county-, or state-level policy.

Culturally and Linguistically Competent

Cultural and linguistic competence has been a focus in children's mental health since the emergence of the Child and Adolescent Service System Program that aimed to deliver mental health services based on a System of Care model.[26] The System of Care approach seeks to reduce fragmentation of services for children with serious emotional disturbances (SED) by creating a community-based network of services. The key to System of Care values is that every aspect of a child should be respected within the context of his or her family and as such, the principles of a system of care include a focus on individual strengths, family, community, and culture.

Cross, Bazron, Dennis, and Isaacs (1989) defined the obligations of system leaders to attend to race and ethnicity (later language access) by calling for cultural competence. They describe cultural competence as embodying policies, attitudes, and behaviors that enable providers and entire systems to effectively serve individuals from diverse backgrounds.[27] The need for linguistic competency, propelled by disproportionate access based on language barriers that further exacerbate access problems, is equally compelling.[28] Today, disparities persist in access to quality mental health care, especially effective practice that is based upon race, ethnicity, and English-language competence.[29] Challenges abound, particularly in creating clear policies and methods to develop reliable funding streams, a culturally and linguistically competent workforce, and accountability measures.

Latino and African-American youth are less likely to receive services if they have an identified mental health problem than their white counterparts.[30] Language barriers further exacerbate access problems.[31] Research also points to overrepresentation of children and youth of color in child welfare, juvenile justice, and special education. For example, African-American students make up a disproportionate number of youth referred for assessment and intervention in special education and among youth placed in restrictive settings.[32] When it comes to access to appropriate care, however, children and youth from diverse backgrounds lag behind.[33] In specialty mental health, disparities in access to

quality care remain evident, especially guideline-level care, based upon race, ethnicity, and English-language competence.[34]

The national *UCR* report examined what steps states had taken to make services culturally and linguistically competent.[35] Only three states reported that they have implemented a range of purposeful steps to promote cultural and linguistic competence including competency-based training, workforce development, assessment and strategic planning, and stakeholder involvement in policy and programming. Twenty-two states provide training to improve the state's workforce's level of cultural and linguistic competence but only eight of these states reported that these trainings are competency-based.

There were several steps taken during the development of the CAFAS to ensure that the instrument was culturally competent. Our interview with Kay Hodges, author of the CAFAS, revealed that formal feedback was sought on the cultural competency of the instrument from 360 sources, including clinicians and 120 experts on racial minority issues. The Michigan study examined respondents' opinions on whether or not the CAFAS tool was culturally competent.

Findings: Culturally competent

While opinions were mixed, most respondents did not find the CAFAS to be culturally biased. System leaders and providers in the Michigan study were asked if they found the CAFAS to be a culturally-competent tool. A smaller number of respondents (N=34) discussed cultural competence. Most of those who responded on this topic did not find the assessment to be culturally-biased (74 percent). As one respondent explained, ***"We used it with all different kinds of kids and didn't find any variance and so it never had any issues."*** Another added, ***"In doing the CAFAS I have not seen that, in terms of rating behavior, as an issue. For example, if an African American boy gets expelled I have never thought whether they are racial issues or aggression issues, we still have to address the problem."*** At the same time, several respondents indicated that the tool may need to be examined further to determine if it is culturally biased. ***"I think people ask questions about that, whether it is appropriate and what I understand is very culturally sensitive…we try to reassure people that this is the best we have right now,"*** offered one respondent.

Some respondents (26 percent or N=9) expressed concerns that the CAFAS is not a culturally competent tool. For example, one provider thought the CAFAS reflects middle class values. He commented, ***"Some part of me sees the CAFAS as middle class values and how to aspire to middle class values... (it) pathologizes behavior that does not need pathologizing… have long way to go in process of culture."***

Some respondents noted that they use interpreters to help complete the CAFAS for families with limited English proficiency. We did not specifically ask respondents about how they serve individuals with limited English language proficiency or how they complete the CAFAS with these families. Respondents however, noted that they work with a culturally and linguistically diverse population. Several respondents discussed the linguistic competence of the CAFAS (N=16). Specifically, some of these respondents said that they use an interpreter when delivering services to families with limited English proficiency and completing and/or discussing the results of the CAFAS (N=7). The CAFAS has been translated and validated in Spanish[36] and has also been translated into French and other languages.

Lessons Learned

A behavioral assessment tool that is culturally-normed or viewed as culturally and linguistically competent should be considered for use. The CAFAS tool was not considered culturally-biased for the overwhelming majority of respondents. Responses from some respondents suggested a need to examine its cultural and linguistic compatibility for service users. The use of the Spanish version of the CAFAS has been studied in a group of Spanish children however, our system leader and provider interviews add some practical knowledge about using the tool among diverse groups.

The Impact of CAFAS on Infrastructure and Fiscal Policy

Information Technology Compatibility and Use of CAFAS Data

Given that information technology use as a means for demonstrating positive clinical outcomes is gaining momentum in the human services field,[37] Unclaimed Children Revisited (UCR) examined the use of information technology in the context of outcomes-based management and the CAFAS. Information technology (IT) systems have also been recognized as a way for providers to share information across sectors that serve the same families to increase the responsiveness and effectiveness of services.

We explored the use of information technology in the UCR national study. Nationally, states lag behind in developing the information technology infrastructure needed to support children's mental health services. According to states' self-assessments of their technology systems, only two states reported advanced[a] information technology infrastructure to support children's mental health service delivery, however 24 states reported intermediate[b] systems, and 19 states described their IT systems as rudimentary.[c] The push for a robust IT infrastructure supports a fundamental shift to a quality improvement focus in the system of care delivery, management and policy support. At the heart of implementation of empirically supported practices are data systems that provide close to real time data exchange, information management and quality monitoring.[38]

In Michigan, system leaders and providers were also asked about their use of information technology. Respondents' answers varied widely but in general they discussed several elements of their IT systems to different degrees. These elements included: whether they used an electronic version of the CAFAS, if the CAFAS is compatible with electronic health records, and whether IT systems were shared with other agencies. None of the respondents who discussed IT systems (N=50) indicated that they had electronic records that the CAFAS was compatible or integrated with, but many respondents, including a state system leader, explained that they were either in the process of implementing this or would like to integrate the CAFAS with their electronic medical records. Respondents also expressed a strong interest in having CAFAS data integrated with electronic records as a way to save time and facilitate ease of use. One system leader explained, ***"Even those who have the software (for the electronic version of the CAFAS), it's separate from the electronic medical record (EMR) – it's not integrated… If it can be linked to an EMR that will be huge."****

Fiscal Policy and Use of the CAFAS to Generate Funding

While not a specific focus of this case study, fiscal concerns emerged as a challenge for system leaders and providers. Thirty-six respondents (77 percent of those who discussed funding) brought up facing challenges with funding. As one respondent explained, ***"We are limited with the money on the things we can do."*** Another added, ***"The most challenging thing is funding. (Our) friends at DHS have been stripped to the bone so that their staffing allocation was cut so much it's hard for them to do their jobs."***

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a. Advanced = children's mental health part of the electronic health records, providers routinely using technology for clinical decision making, etc.

b. Intermediate = clinical records automated, some information sharing and use of technology to support systems planning, management, and evaluation.

c. Rudimentary = at early state of development (majority of clinical records still not automated, few providers using technology).

* A new web-hosted software application for the CAFAS became available after this study. It delivers interpretive information (that is, CAFAS clinical markers that help with decision making at the client level) and outcomes (that is, various outcome indicators and change in CAFAS scores) to practitioners, supervisors, and administrators. The program also includes a strengths-based Family Report and a method for tracking evidence based practices at the client level. This new application, referred to as "FAS Outcomes" because it includes other measures besides the CAFAS, expands an agency's capacity to use data for continuous quality improvement at every level.

Specific challenges commonly mentioned by these respondents were grouped (see Figure 8). Insufficient funding to administer service programs was the most commonly mentioned fiscal challenge, followed by concerns that the CAFAS is expensive. Since the CAFAS is funded through the state for community mental health centers that participate in the LOF, the cost of the CAFAS was mainly a concern for respondents outside of the mental health sector. Other concerns included: not enough funding for adequate staff, competition among agencies for funding, and that evidence-based practices (EBPs) were too expensive to implement.

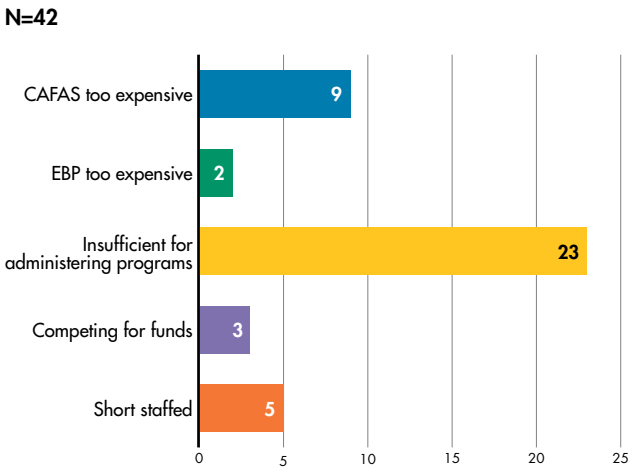
While only a few respondents mentioned fiscal concerns about implementing the LOF and using the CAFAS, we highlight these as potential considerations for others interested in implementing similar assessment tools. Fiscal concerns included:

- balancing the cost of using the CAFAS with other program costs. A respondent explains, ***"We want to expand the use of the CAFAS. In your current fiscal year you need to think about how much you will need for your next fiscal year. You need to think about supplies, staff and staff training. You also need to think about program design. You need to think about if the CAFAS is going to replace an existing program;"***
- having more funding to "do it right" would be helpful. A state respondent thought this would include: enough funding to have a CAFAS evaluator in every mental health center, upgraded software and IT systems for CAFAS, and research money for pulling apart the data; and
- obtaining enough funding for a common assessment tool to be used beyond the CMH contracted agencies. Respondents recognized the value of using the CAFAS but acknowledged that it was difficult to expand the use of CAFAS - beyond the mandated child mental health contracted providers - due to limited resources needed for staff time and other resources involved.

Findings: Generating Funding

Despite some of the fiscal concerns voiced, respondents also recognized that data generated from a functional assessment tool could be used to generate funding for additional program support.

Figure 8: **Funding Challenges**



Data generated from the CAFAS helped to gain support for additional funding and to market programs' success. A small proportion of respondents (11 percent of those who discussed using empirical evidence of CAFAS) talked about using CAFAS data to apply for continuing program funding. As one respondent reasoned, ***"CAFAS has heightened the sensitivity to what you are buying."*** Another respondent remarked: ***"(We) use the CAFAS data to report to the community. At the annual Human Services Collaborative Board meeting [we showed CAFAS data to] leaders to signify that wraparound is working well. [We also used it for] our 10-year wraparound celebration press release."***

Lessons Learned

Empirical evidence of program effectiveness can help secure financial support of EBPs. Respondents talked about how evidence of program effectiveness helped them secure funding for continuing to administer programs. Given often limited monies available to public programs, outcome data is an important tool for program continuation. Programs should use outcome data for securing funding.

Cost-benefit analysis could be useful. The costs of using a standardized functional assessment tool may be less than potential program support earned from demonstrating positive outcomes.

Conclusions – Implications for Implementing Functional Assessment Tools: The LOF Example

The Michigan case study of the Level of Functioning (LOF) project presents several important implementation lessons for other states and localities interested in using functioning assessment tools.

- **The CAFAS is a tool for improving individual- and systems-level decision making.**

  Our case study of the LOF project suggests that Michigan may be a national leader in implementing a mechanism for state accountability in children's mental health. Respondents overall discussed how CAFAS data was helpful in decision-making at the individual and larger community levels. The CAFAS data provided empirical evidence for treatment planning, systems planning, and quality improvement initiatives.

- **Assessment tools can promote cross-system collaboration, a focus on outcomes, and the use of evidence-based practices.**

  A functional assessment tool like the CAFAS highlights domains of functioning where the youth is not doing well (such as school or community) and thus can help providers facilitate referrals across systems. As respondents in Michigan noted, their assessment tool also gives providers a "common language" to discuss child and families' progress and outcomes. The objectivity of the scores helps providers working with youth to understand one another better and alleviate blame.

  Additionally, the focus on outcomes can help states and communities identify where youth and family needs lie. In Michigan, it helped counties identify where there was a strong need for specific empirically-informed practices. Through an outcome monitoring system leaders can target interventions that work, and address factors that support or impede quality.

- **Assessments can be a communication tool between providers and with families.**

  A child's progress as measured by a validated instrument can be objective information that is easily shared with the child's family members and offers a way to implement a whole-family approach to services. These results could be shared across providers serving the same child and family to communicate progress and facilitate planning treatment. While the majority of respondents said that they do share a child's CAFAS information with family members, nearly a third do not. This suggests that states and localities who currently use or are considering implementing a functional assessment tool should emphasize to providers the benefits of sharing results.

- **Provider buy-in and training is important.**

  While more than half of all respondents (61 percent) indicated that they or their agency use the CAFAS, there were still some concerns about the tool that remained. These concerns may lead to providers not fully utilizing a tool and the outcomes information it generates. These findings suggest that providers could benefit from training at the outset on a specific tool's use with a focus on: (a) the broad purposes; (b) the demonstrated effectiveness of the tool for decision-making; and (c) how to share results using a strengths-based approach with youth and families. States and localities looking to implement functional assessments should therefore consider making strong efforts to obtain provider buy-in at the onset to help fully utilize the tool and the outcome data collected.

- **The cultural and language competency of a functional assessment scale should be established.**

  A few respondents had concerns that the CAFAS was not culturally competent and input on the tool's cultural competence was sought by experts during the initial creation of the CAFAS. Further research is needed to more fully understand the effectiveness of validated assessment tools across cultures. In addition, more research is needed on how well any functional assessment tool works when translated for various language groups.

States and localities interested in implementing a functional assessment tool may want to seek input from area cultural and language experts that represent the populations they work with to address issues of language and culture.

- **Financing assessments: Outcomes data offers opportunities for sustaining and developing programs.**

  Given the economic challenges that many public agencies face, it is not surprising that respondents in this study see the cost of implementing and administering a functional assessment tool and balancing this cost with other program expenditures as a major challenge. While our analysis did not include a cost-benefit-analysis of the CAFAS, respondents discussed certain tradeoffs. For instance, staff time to fill out the paperwork for the assessments and implementing new information technology for the electronic version of the CAFAS ranked high. At the same time, respondents also discussed how further funding for EBPs could be acquired more easily through demonstrating individual outcomes with CAFAS data. States and localities should therefore consider the potential financial benefit for having outcomes data to offer evidence of program success in order to help sustain programming and improve programs using evidence-based practices.

  The state of Michigan has offered an example for state financing of outcomes and supporting accountability in children's mental health. One lesson from this endeavor is the opportunity to support accountability with limited resources. Michigan and other states should invest in a well-supported accountability initiative to reach the full potential of such an outcomes-based management system.

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APPENDIX 1-B
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David Neuchterlien (Juvenile Intervention Specialist), Varil Williams (Juvenile Intervention Specialist), Ginny Reed (Director of Network Services and Public Policy), Barbara Glassheim (Consultant), Fran Erwin (Saginaw Psychological Services Director), Mary Baukus (Westlund Guidance Center Supervisor), Christina Guiterrez (Family Intervention and PMTO Specialist), Heidi Wale (CAFAS Coordinator), Dr. Renee Clark (Medical Director), Robert White (Infant Mental Health Supervisor), Lori Denter (Family Services Unit Supervisor), Linda Schnieder (Clinical Director), Linda Tilot (Director of Care Management and Quality Systems) Sherrhonda Brown (staff of Care Management and Quality Systems), Kimberly Walter (Administrative Assistant, Care Management and Quality Systems), Vurlia Wheeler (Care Management, Care Management and Quality Systems), Dalia Smith (Parent Advocate), Barbara Beckman (Deputy Court Administrator), Tim Metro (Detention Center Director), Heidi Wale (Consultant for CAFAS).*

St. Joseph

Matt Chambers (President/CEO), Leslie Pitts (Children's Case Manager), Liz O'Dell (Executive Director), Joyce Wilson (School Based Prevention Specialist), Roger Rathburn (Superintendent), Jay Raycraft (Special Education Director), Larry Smoker (School Personnel), Hunter Raiford (School Personnel), Holly Pribble (School Personnel), Paula Smith (School Personnel), Stacie Carlson (Home Based Therapist), Lynelle Thrasher (Childrens Clinical Director),* Heather Kerr (Childrens Clinical Supervisor), Cecily Bierlein (Home Based Therapist/EarlyChildhood Therapist).

Wayne

Daniel Chaney (Director of Juvenile Services), Shaun Cooper (Clinical Director, Juvenile Assessment Center), Jane Damren (Clinical Nurse Specialist), Arezell Brown (Director of School Social Work Service), Stephanie Miller (Child Welfare Reform Coordinator), Risa Coleman (Director of Clinical Services-D-WCCMHA), Evelyn Thomas (Gateway Community Health-SED), Paul Anderson (Gateway Community Health-SED), Dawn Brooks (Carelink Network), Debbie Snyder (staff D-WCCMHA), Carla Lee (staff, D-WCCMHA), Joan Abbey (Research Scientist, EMU Social Work), Pasquale Vignola (Supervisor, The Guidance Center), Carlynn Perkins (Directors, Children's Special Initiative), Cindy Smith (Executive Director/President, Juvenile Assessment Center), Carrie Banks Patterson (Children's Services Special Projects- D-WCCMHA), Mareitta Alston, Ph.D., MA, LLP, (Program Supervisor, Black Family Development), Patricia Lynett (Chief Operating Officer, Vista Maria), Christel Danna (Development Center, Inc), Marissa Howard (Director of Health Services, Starfish), Cheryl Greer (Clinician, Lincoln Behavioral Center), Kenyatta Stephens (Chief Operating Officer, Black Family Development), Kim Hunt (Director of Southwest Detroit Association for Children's Mental Health), Lindsay Beaudry (staff, Children's Services Special Projects).*

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* County leads who helped to arrange interviews and coordinate logistics in each county.

For confidentiality purposes, this list does not include the names of the youth and family members who participated in this study.

APPENDIX 2
Michigan County Profiles

WAYNE COUNTY

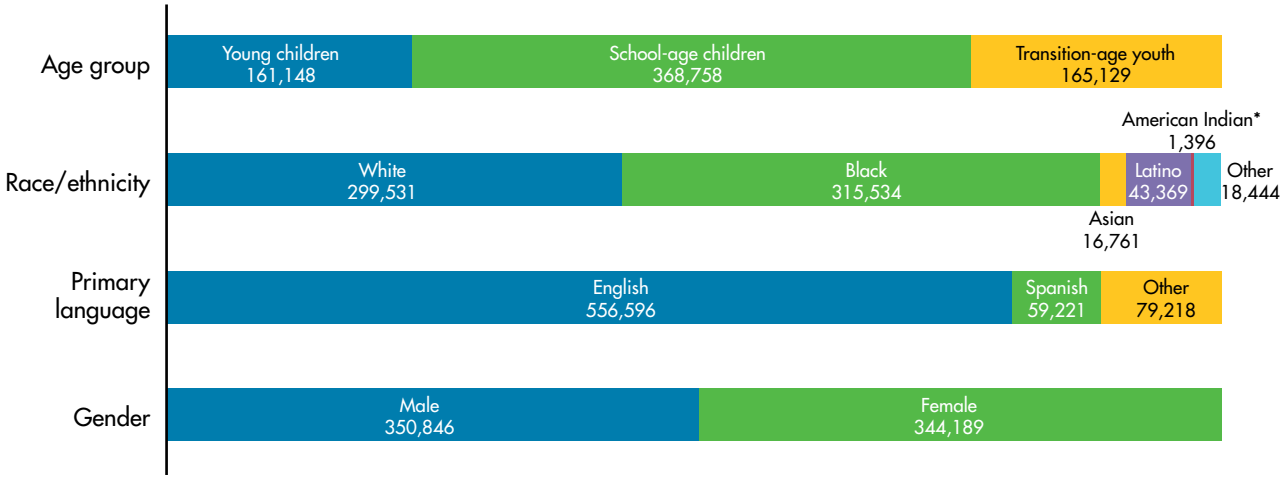
Poverty and income	Number	Percent
Total county population	1,981,654	
Number of all persons in poverty (2008)	393,147	21%
Number of children under the age of 18 in poverty (2008)	146,293	29%
Median household income, in dollars (2008)	$42,463	

Population of children by race	Number	Percent
Total population	695,035	
White	299,531	43%
Black	315,534	45%
Latino	43,369	6%
Asian	16,761	2%
Other	18,444	3%
American Indian	1,396	.2%

Population of children by age	Number	Percent
Total population	695,035	
Young children	161,148	23%
School-age children	368,758	53%
Transition-age youth	165,129	24%

Population of children by primary language	Number	Percent
Total population	695,035	
English	556,596	80%
Spanish	59,221	9%
Other	79,218	11%

Wayne County (n=695,035)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

ST. JOSEPH COUNTY

Poverty and income	Number	Percent
Total county population	62,291	
Number of all persons in poverty (2008)	8,833	14%
Number of children under the age of 18 in poverty (2008)	3,294	21%
Median household income, in dollars (2008)	$44,034	

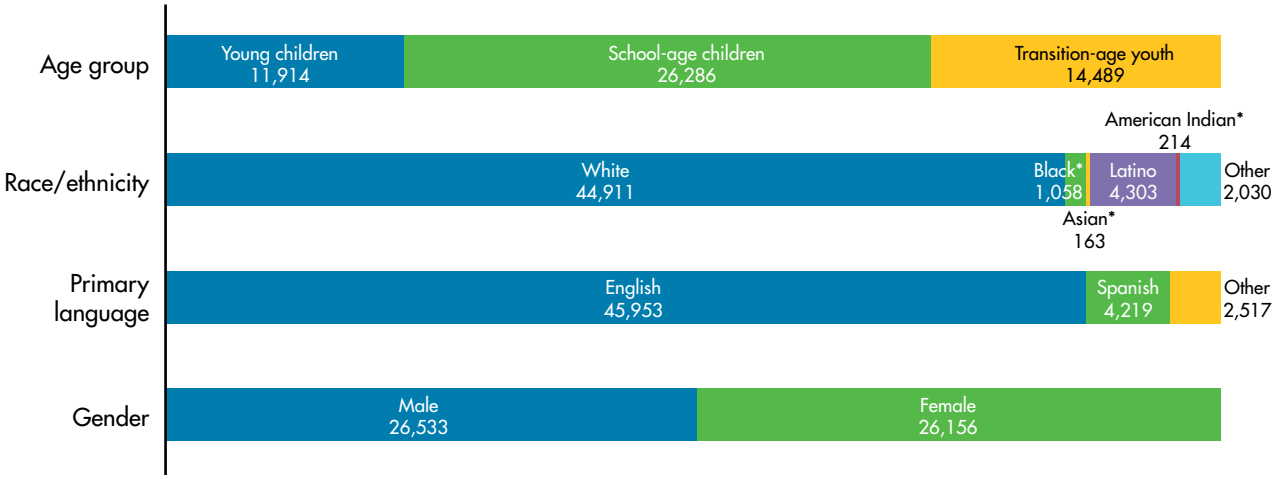
Population of children by race*	Number	Percent
Total population	52,689	
White	44,911	85%
Black	1,058	2%
Latino	4,303	8%
Asian	163	.3%
Other	2,030	4%
American Indian	214	.4%

Population of children by age*	Number	Percent
Total population	52,689	
Young children	11,914	23%
School-age children	26,286	50%
Transition-age youth	14,489	27%

Population of children by primary language*	Number	Percent
Total population	52,689	
English	45,953	87%
Spanish	4,219	8%
Other	2,517	5%

* Data for St. Joseph County could not be distinguished from Branch and Cass Counties, so these data are grouped.

Branch, Cass, St. Joseph Counties (n=52,689)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

SAGINAW COUNTY

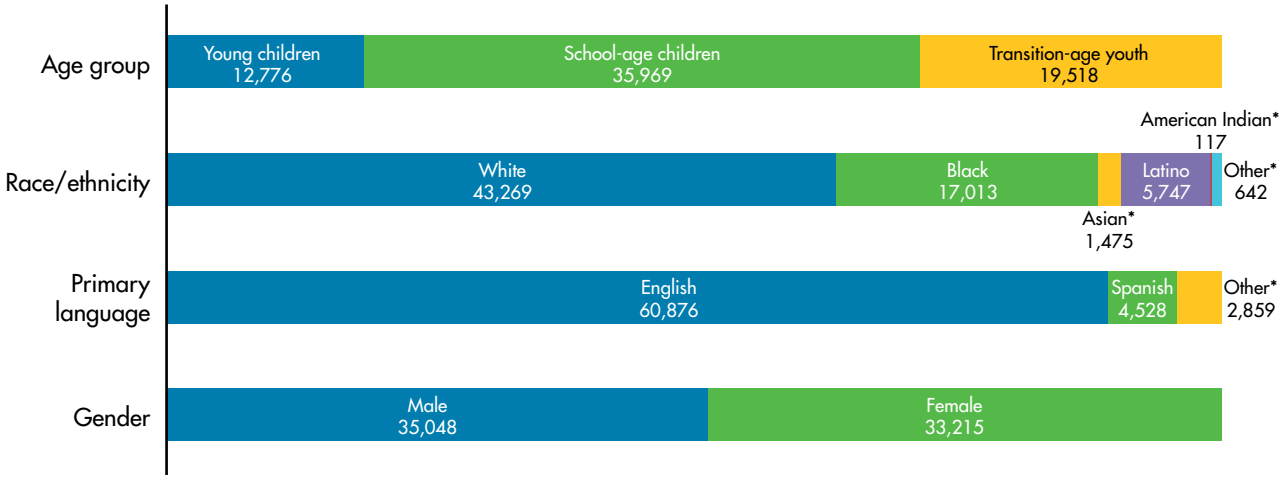
Poverty and income	Number	Percent
Total county population	202,272	
Number of all persons in poverty (2008)	37,324	19%
Number of children under the age of 18 in poverty (2008)	12,385	26%
Median household income, in dollars (2008)	$41,806	

Population of children by race	Number	Percent
Total population	68,263	
White	43,269	63%
Black	17,013	25%
Latino	5,747	9%
Asian	1,475	2%
Other	642	1%
American Indian	n/a	

Population of children by age	Number	Percent
Total population	68,263	
Young children	12,776	19%
School-age children	35,969	53%
Transition-age youth	19,518	28%

Population of children by primary language	Number	Percent
Total population	68,263	
English	60,876	89%
Spanish	4,528	7%
Other	2,859	4%

Saginaw County (n=68,263)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

LIVINGSTON COUNTY

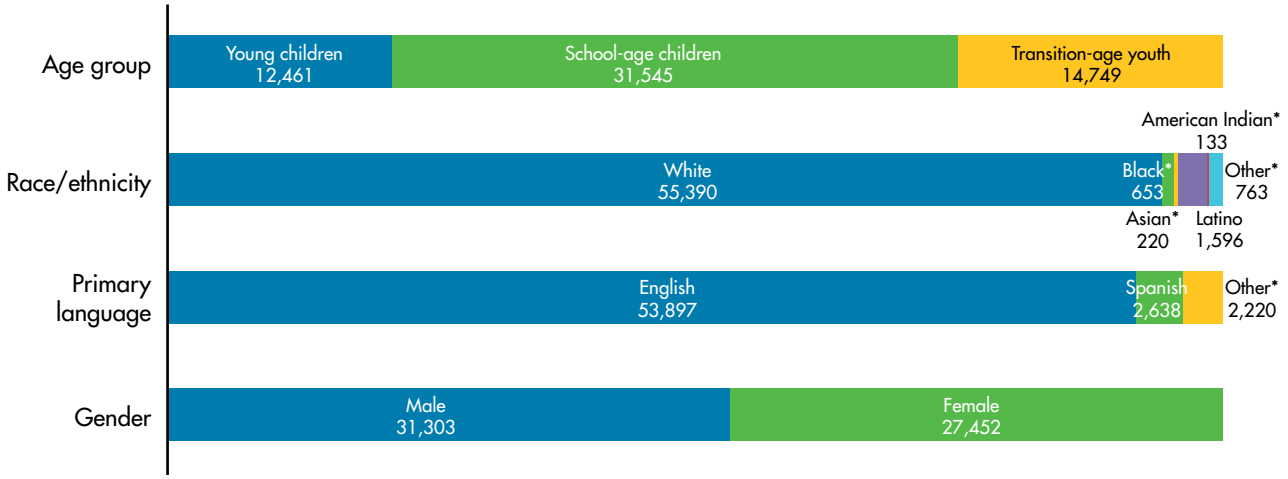
Poverty and income	Number	Percent
Total county population	182,655	
Number of all persons in poverty (2008)	11,796	7%
Number of children under the age of 18 in poverty (2008)	3,131	7%
Median household income, in dollars (2008)	$72,090	

Population of children by race	Number	Percent
Total population	58,755	
White	55,390	94%
Black	653	1%
Latino	1,596	3%
Asian	220	.3%
Other	763	1%
American Indian	n/a	

Population of children by age	Number	Percent
Total population	58,755	
Young children	12,461	21%
School-age children	31,545	54%
Transition-age youth	14,749	25%

Population of children by primary language	Number	Percent
Total population	58,755	
English	53,897	92%
Spanish	2,638	4%
Other	2,220	4%

Livingston County (n=58,755)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

INGHAM COUNTY

Poverty and income	Number	Percent
Total county population	278,316	
Number of all persons in poverty (2008)	47,203	18%
Number of children under the age of 18 in poverty (2008)	11,770	20%
Median household income, in dollars (2008)	$45,987	

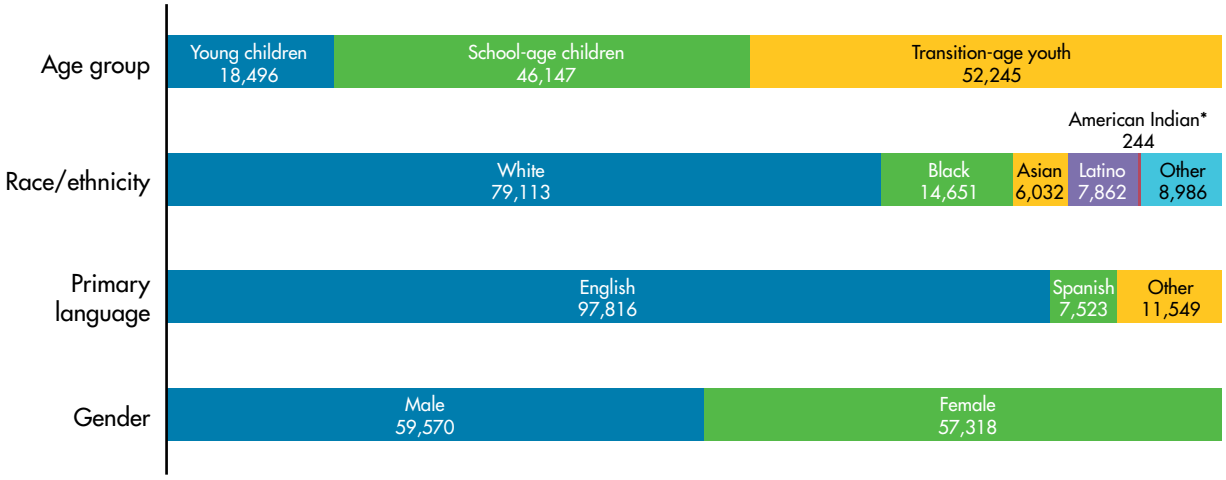
Population of children by race*	Number	Percent
Total population	116,888	
White	79,113	68%
Black	14,651	13%
Latino	7,862	7%
Asian	6,032	5%
Other	11,549	10%
American Indian	244	.2%

Population of children by age*	Number	Percent
Total population	116,888	
Young children	18,496	16%
School-age children	46,147	39%
Transition-age youth	52,245	45%

Population of children by primary language*	Number	Percent
Total population	116,888	
English	97,816	84%
Spanish	7,523	6%
Other	11,549	10%

* Data for Ingham County and Eaton County is grouped.

Eaton and Ingham Counties (n=116,888)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

HIAWATHA (area)*

Poverty and income	Number	Percent
Total county population	102,332	
Number of all persons in poverty (2008)	14,505	
Number of children under the age of 18 in poverty (2008)	3,986	
Median household income, in dollars (2008)	$38,782	

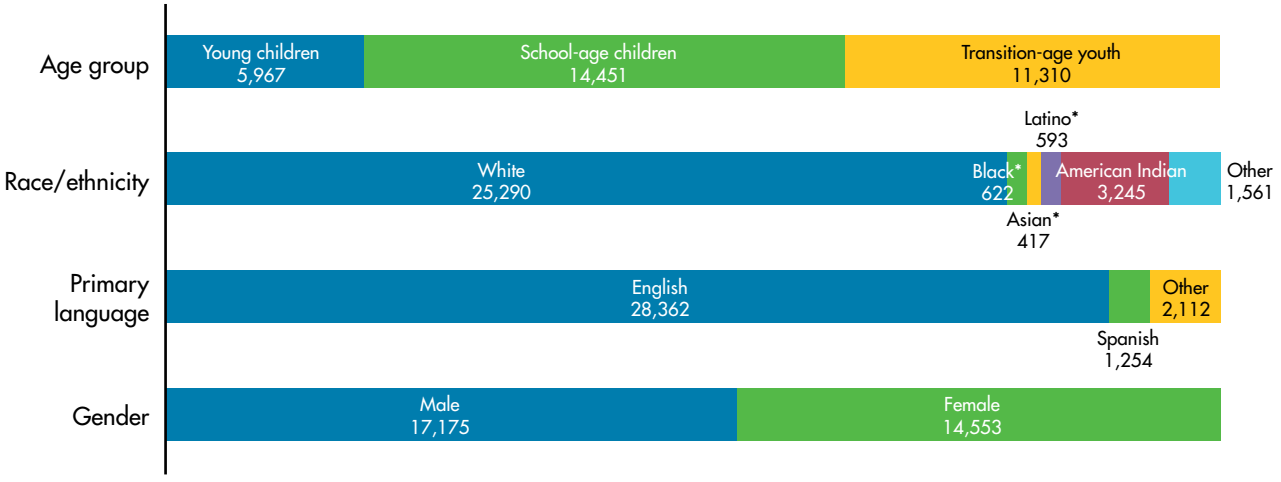
Population of children by race*	Number	Percent
Total population	31,728	
White	25,290	80%
Black	622	2%
Latino	593	2%
Asian	417	1%
Other	1,561	5%
American Indian	3,245	10%

Population of children by age*	Number	Percent
Total population	31,728	
Young children	5,967	19%
School-age children	14,451	46%
Transition-age youth	11,310	35%

Population of children by primary language*	Number	Percent
Total population	31,728	
English	28,290	89%
Spanish	1,254	4%
Other	2,112	7%

* The Hiawatha area includes Chippewa, Delta, Luce, Makinac, & Schoolcraft Counties. The data is grouped.

Schoolcraft, Chippewa, Makinac, Delta, Luce Counties (n=31,728)



* This estimate should be used with caution. It may be unreliable due to a small sample size.

Source: US Census Bureau/Small Area Income & Poverty Estimates. http://www.census.gov/cgi-bin/saipe/saipe.cgi

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