Ventura County Behavioral Health Children's Accelerated Access to Treatment and Services

Final Evaluation Report 202 0

VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Healthcare Agency

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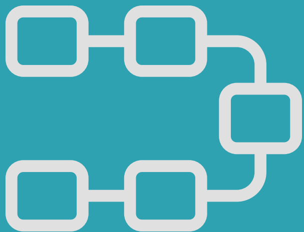
Children's Accelerated Access to Treatment and Services (CAATS) Innovation Program

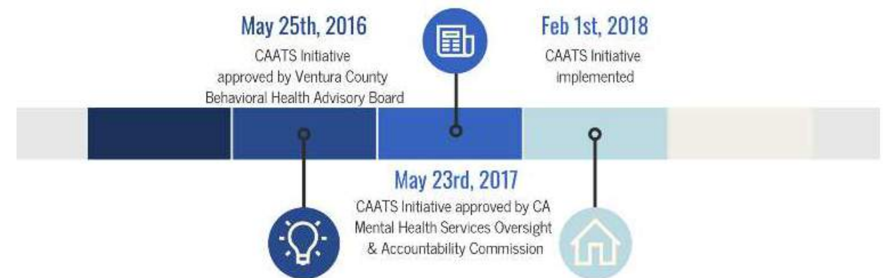
The CAATS Initiative facilitated systematic procedural changes within county agencies to ensure that the needs of youth in dependency are better and more efficiently addressed.

In 2016, Ventura County Behavioral Health (BH) designed the Children's Accelerated Access to Treatment and Services (CAATS) initiative to ensure that timely access to mental health services is provided to youth involved in the child welfare system. CAATS is funded with Mental Health Services Act (MHSA) Innovation monies and leveraged by EPSDT Medical dollars to serve youth in dependency of the Ventura County Child Welfare System. The CAATS initiative provides structures to improve (1) access, (2) quality, and (3) timeliness of mental health services, including psychotropic medication support, for youth in dependency.

CAATS has been an essential element in support of the county's larger child welfare system restructuring efforts, based on state mandates. Ventura County partner agencies have engaged in system mapping processes and organizational changes to more efficiently increase their collaborative efforts and implement practices to improve care and services to youth and families within the foster care system. CAATS is one of the processes that was created to make concrete shifts in service provision to better meet the needs of youth in dependency.



Milestone dates specific to the implementation of the innovative CAATS initiative are presented below. As a part of this initiative, BH first hired the License Vocation Nurse (LVN) position August 2017; followed by the incorporation of the accelerated time to service and universal assessments in February 2018; with The Child and Adolescent Needs and Strengths (CANS) assessment tool launching in April 2018.



CAATS Initiative Goals

In order to improve (1) access, (2) quality, and (3) timeliness of mental health services, the following four goals were established for the program:

Universal, Comprehensive Assessments: Research on adverse childhood experiences (ACES) suggests that removal from the home is a traumatic experience and should be addressed clinically. To respond to this need, comprehensive assessments are conducted for all children to assess their level of trauma.

Expedited care: To reduce the overall potential for negative outcomes, timely access to mental health services is critical. Additionally, reducing the delay in provision of services allows BH staff to participate in the case planning Child and Family Team meeting (CFT) that takes place 30 days after entry into the Child Welfare system.

Implementation of culturally-and trauma-informed care/assessments: Given that the removal from the home is a traumatic experience in itself, staff utilize a trauma informed care approach. This includes knowledge of culturally relevant treatment for developmental milestones.

Provide improved psychotropic medication administration, education, and compliance: Psychotropic medication management for youth in dependency requires much oversight and documentation at the county level as mandated by the state. Multiple individuals and departments (i.e., psychiatrists, public health nurses, behavioral health clinicians, probation officers and court officials) contribute to the approval, prescribing, and monitoring of symptoms and results.

Data Collection and Evaluation

A mixed methods approach including interviews with key stakeholders, surveys, and quantitative data analysis was utilized to evaluate the progress of the CAATS initiative in meeting its intended goals. The evaluation questions guiding the development of this report are presented below.

1. How long does it take youth in dependency to receive mental health services?
2. Did the referral rate to mental health services increase after the implementation of CAATS?
3. What is the level of trauma for youth in dependency in the county?
4. Does providing mental health intervention to all youth in dependency improve mental health outcomes?
5. How does the role of the LVN support the work conducted with the youth and families in dependency?
6. Are families satisfied with the services the LVN provides?

Core Data Metrics of the CAATS Initiative

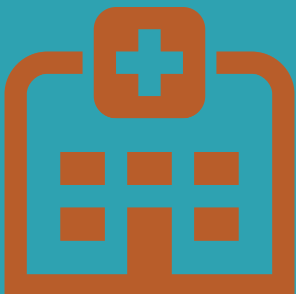
Elements Measured	Data Sources & Methods
Universal Assessments Conducted on all Youth Entering Dependency	Included in this analysis is the percent of eligible children entering dependency (via HSA) who were referred to BH. This metric assesses progress towards the goal of offering mental health assessments to every available child entering dependency.
Expedited Care	To assess the elapsed time between key points of services, as identified in the Accelerated Access to Treatment model, dates for each event were exported from AVATAR, BH's Electronic Health Recored database, and analyzed to calculate the number fo business days between each event.
Mental Health Symptoms and Outcomes	The CANS scores are used to assess needs and symptomology. Data were extracted from AVATAR and analyzed to identify changes from CANS intake to the subsequent interval administration of CANS assessments.
Licensed Vocational Nurse Position	To assess the value added by the LVN position, a multi-methods approach was utilized including key stakeholder interviews, surveys, and analysis of a sample of tasks including treatment reviews, CFT interfacing, JV220 activities, and case coordination.

Youth Mental Health Outcomes

Data outlined on the next series of pages address the following evaluation questions:

(1) What is the level of trauma for youth in dependency in the county?

(2) Does providing mental health intervention to all youth in dependency improve mental health outcomes?



Overview: Child and Adolescent Needs and Strengths Assessment (CANS)

In order to appropriately assess a child's trauma, BH clinicians utilize an evidence-based, validated tool that provides insights on a number of critical indicators needed to properly address a child's needs. This tool is known as the Child and Adolescent Needs and Strengths (CANS). In addition to using the CANS for preliminary needs assessments, subsequent administrations of the CANS help to inform clinicians about changes in the symptomology experienced by youth. The CANS is intended to be administered: (1) upon the youth's intake to CWS, (2) at regular intervals (i.e., every 6 months), (3) after any key events or major changes in the youth's plans and (4) at discharge. The six-month assessment is defined as any assessment that occurred 5-7 months (150 -210 days) after the intake assessment.

Methodology

CANS assessment data for this report were provided by the Human Services Agency and Behavioral Health and were exported via CWS/CMS and AVATAR, respectively. Of note, the sample sizes throughout this report vary because not every youth had all data available and not all types of data applied (e.g., not every youth had a case closure; the CANS may not be performed on all infants or newborns).

Overview of Assessment Process

The CANS is comprised of a series of items organized into domains and rated on a scale of 0-3 depending on assessor's knowledge of the severity of symptoms experienced by the youth. Items with a severity rating of 2 or 3 are considered "actionable needs" that can guide the clinician and the child's support staff in addressing the youth's key needs for intervention.

Evaluation Question:

What is the level of trauma for youth in dependency in the county?

Key Findings:

Traumatic Stress Symptoms: At intake, the most common traumatic stress symptoms with an actionable need were emotional and/or physical regulation, traumatic grief and separation, and time before treatment.

Behavioral/Emotional Needs: At intake, the most common behavioral/emotional needs with actionable need in youth were adjustment to trauma, anxiety and depression.

Level of Trauma Among Youth

Findings shown below reflect the percentage of youth who exhibited "actionable need" Behavioral/Emotional and Traumatic Stress Symptoms at the time of their initial assessment. An actionable need refers to the percentage of youth who require a specific service or treatment based on their level of trauma.

Traumatic Stress Symptoms at Intake (N=366-367)

Percent of Youth with Actionable Need

24%
emotional and/or physical dysregulation

Item describes the child/youth's difficulties with arousal regulation or expressing emotions and energy states.

17%
traumatic grief and separation

This item describes the level of traumatic grief the child/youth is experiencing due to death or loss/separation from significant caregivers, siblings, or other significant figures.

13%
time before treatment

This item identifies the amount of time that passed between the trauma and the beginning of treatment.

Behavioral/Emotional Needs at Intake (N=448-452)

Percent of Youth with Actionable Need

32%
adjustment to trauma

This item is used to describe the child/youth who is having difficulties adjusting to a traumatic experience, as defined by the child/youth.

21%
anxiety

This item rates symptoms associated excessive fear and anxiety and related behavioral disturbances.

15%
depression

Symptoms included in this item are irritable or depressed mood, social withdrawal, sleep disturbances, weight/eating disturbances, and loss of motivation, interest or pleasure in daily activities.

Evaluation Question:

Does providing mental health intervention to all youth in dependency improve mental health outcomes?

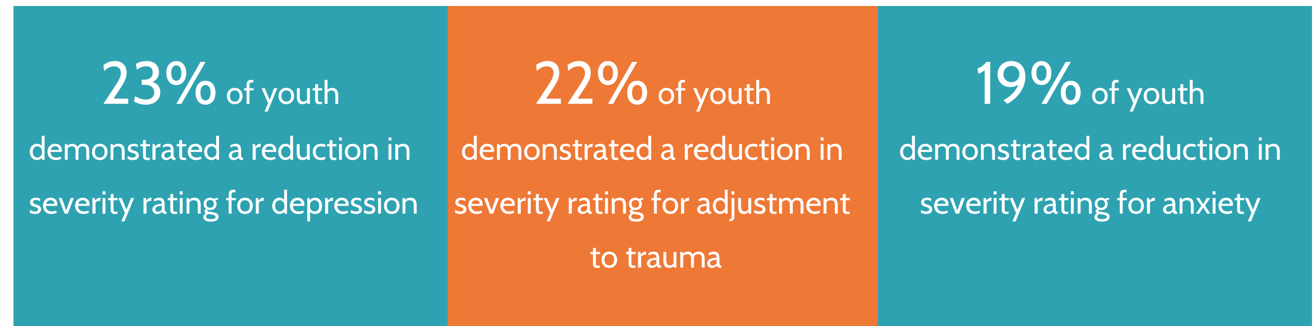
Key Findings:

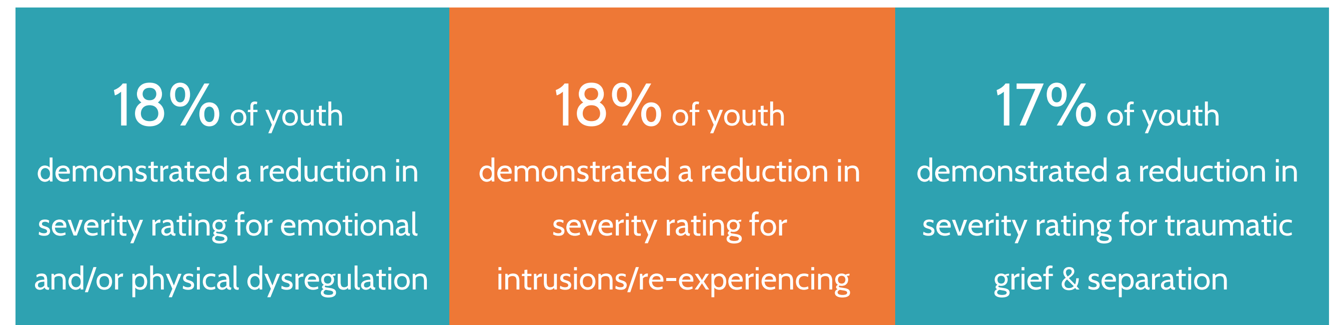
Approximately one in four youth who completed a 6-month follow up CANS demonstrated a reduction in severity rating for Depression. Another notable decrease was observed for Adjustment to Trauma.

About one in five (18%; N=18) showed a reduction in severity for Emotional and/or Physical Dysregulation, Intrusions/Re-Experiencing (18%; N=18), and Traumatic Grief and Separation (17%; N=17).

Data support that providing mental health services to youth in dependency leads to improved mental health outcomes.

Improvement in Mental Health Outcomes





Improvement in Mental Health Outcomes

Evaluation Question:

Does providing mental health intervention to all youth in dependency
improve mental health outcomes?

About the CANS Strengths Domain:

This domain differs from the others in the assessment, as it assesses the internal and external supports surrounding a youth, rather than symptoms. A youth's strengths can be used as protective factors or as part of a strengths-based approach to holistically build resiliency in youth.

Children are identified as having a need to develop strengths when the child lacks existing support in that area, or when the child has minimal existing support for building a strength. The table below displays the most common items from the Strengths domain that showed an improvement in strength at 6-month follow-up, compared to the baseline assessment.

Improvements in Strengths Domain: 6 month follow-up

41% of youth demonstrated an improvement in strength for the talents and interests item.

This item refers to hobbies, skills, artistic interests, and talents that are positive ways that young people can spend their time, and also give them pleasure and a positive sense of self.

33% of youth demonstrated an improvement in strength for the spiritual/religious item.

This item refers to the child/youth's experience of receiving comfort and support from religious or spiritual involvement and the presence of beliefs that could be useful to the child/youth

28% of youth demonstrated an improvement in strength for the natural supports item.

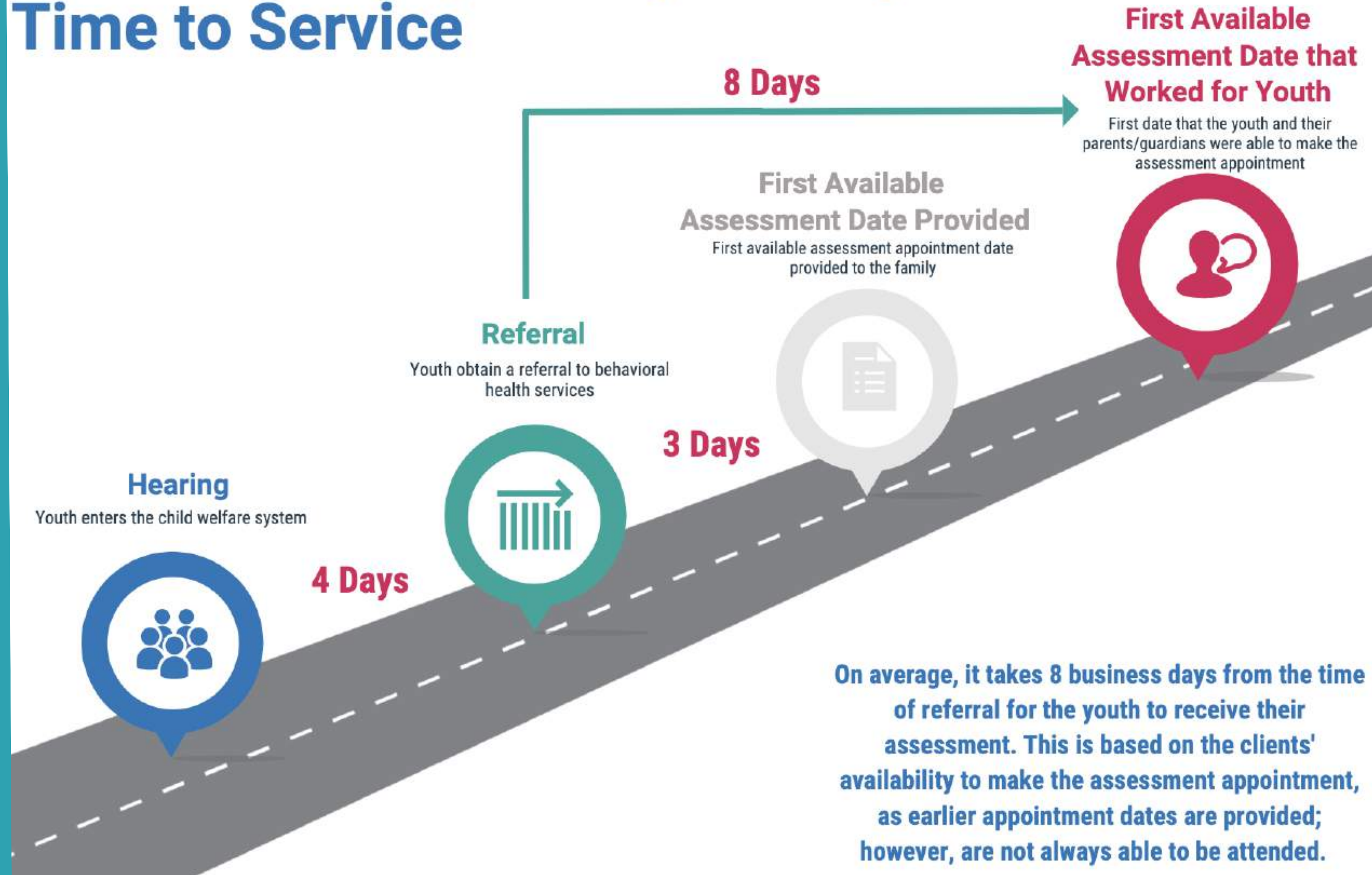
This item refers to unpaid helpers in the child/youth's natural environment. These include individuals who provide social support to the target child/youth and family.

27% of youth demonstrated an improvement in strength for the relationship permanence item.

This item refers to the stability of significant relationships in the child/youth's life. This likely includes family members but may also include other individuals.

Evaluation Question:

How long does it take for youth in dependency to receive mental health services?



Findings

As shown in the roadmap above, on average, youth are referred to behavioral health services 4 business days after entering the child welfare system. Once referred, the first available assessment appointment offered to youth and their families/guardian is generally within 3 business of the referral. However, it takes 8 business days for youth and their families to engage in the assessment given their availability. These data exceed the goal set by VCBH (i.e., obtain an assessment 10 days post referral). Data reflect start of the CAATS program through December 2019.

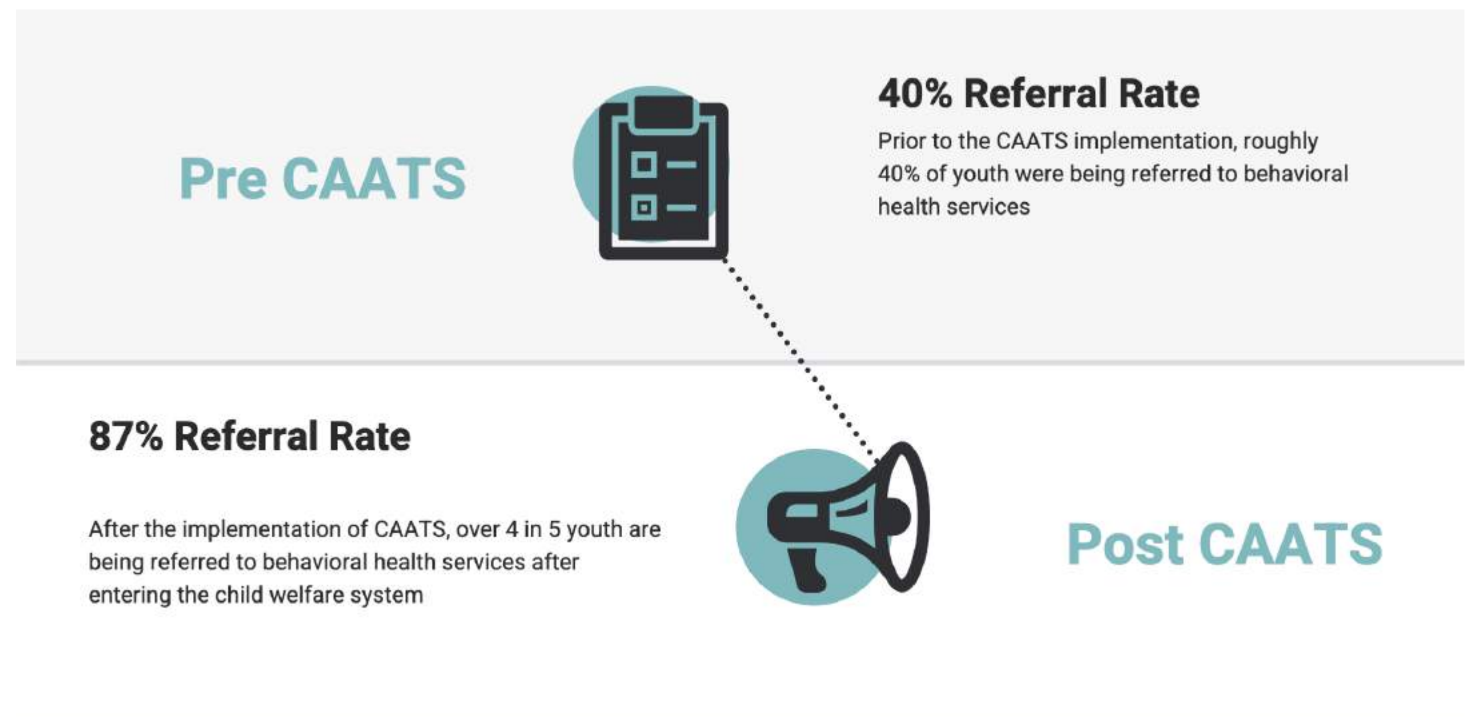
Referrals to Behavioral Health Services Pre- and Post- CAATS Implementation

Evaluation Question

What is the referral rate pre- and post- CAATS?

Findings

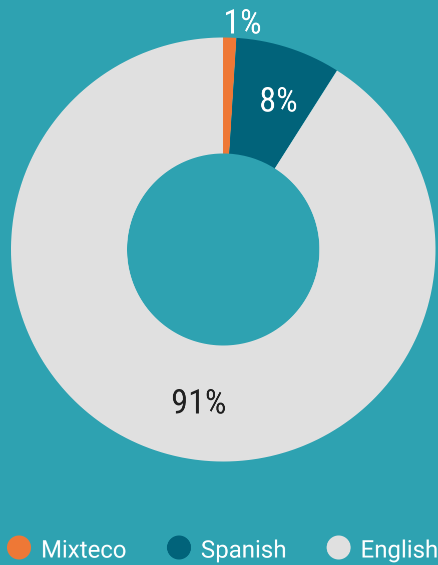
Since the beginning of the CAATS program through December 2019, over 4 in 5 youth received a referral to behavioral health services upon entering the Child Welfare System. This is a marked increase to the 40% referral rate prior to CAATS, showing the value the program has added to the system.

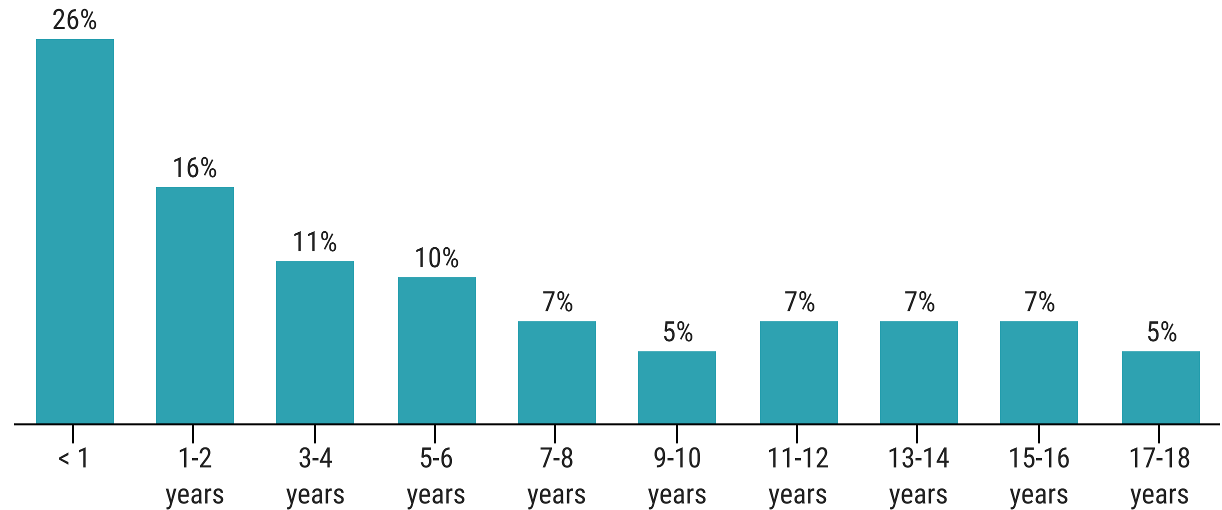


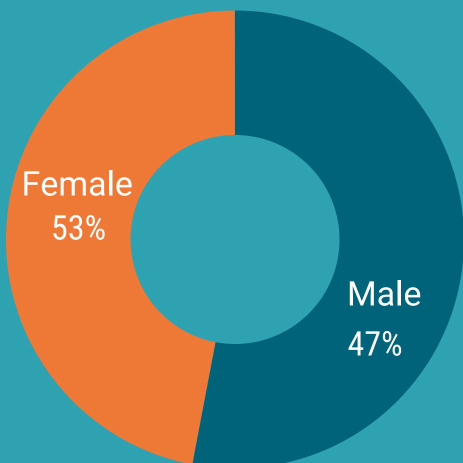
Note: Data utilized in this analysis include all cases pre- and post- CAATS and reflect both HSA and BH data files.

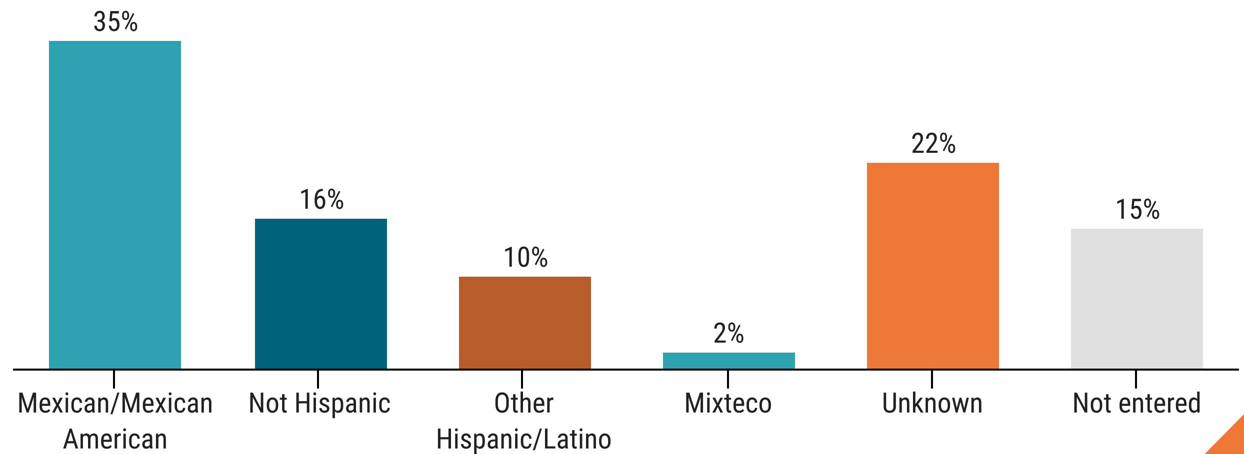
The referral time from hearing to behavioral health services has improved post-CAATS implementation. In the year before CAATS (i.e., January 2018 - January 2019) the average referral time was 51 business days; compared to 4 days post CAATS. However, the pre-CAATS referral time should be interpreted with caution, as the referral data were not cleaned for outliers or anomalous cases, as staff have been doing post CAATS. Other service metrics pre-CAATS were not able to be calculated due to differences in tracking the information post-CAATS.

Populations Served by CAATS









Licensed Vocational Nurse (LVN)

Evaluation questions and corresponding findings specific to the role of the LVN are presented on this page.

Evaluation Questions

How does the role of the LVN support the work conducted with the youth and families in dependency?

Are the families satisfied with the services that the LVN provides?

A critical element of the CAATS initiative was the inclusion of an LVN position. ***The LVN supports the work conducted with youth and families in dependency by serving as a resource and liaison between families and psychiatrists and clinicians to assist with managing medication needs.*** In order to assess the evaluation questions to the right, a mixed-methods (i.e., family surveys, surveys with staff members who work with the LVN, key stakeholder interviews) data collection approach was carried out. As illustrated in the summary of findings presented below, the LVN position was a valuable asset to both families and clinical staff. Those who engaged with the LVN had only positive things to say and were overwhelming satisfied with the services provided.

Staff provided several ways in which the LVN has contributed to elevating the system of support:

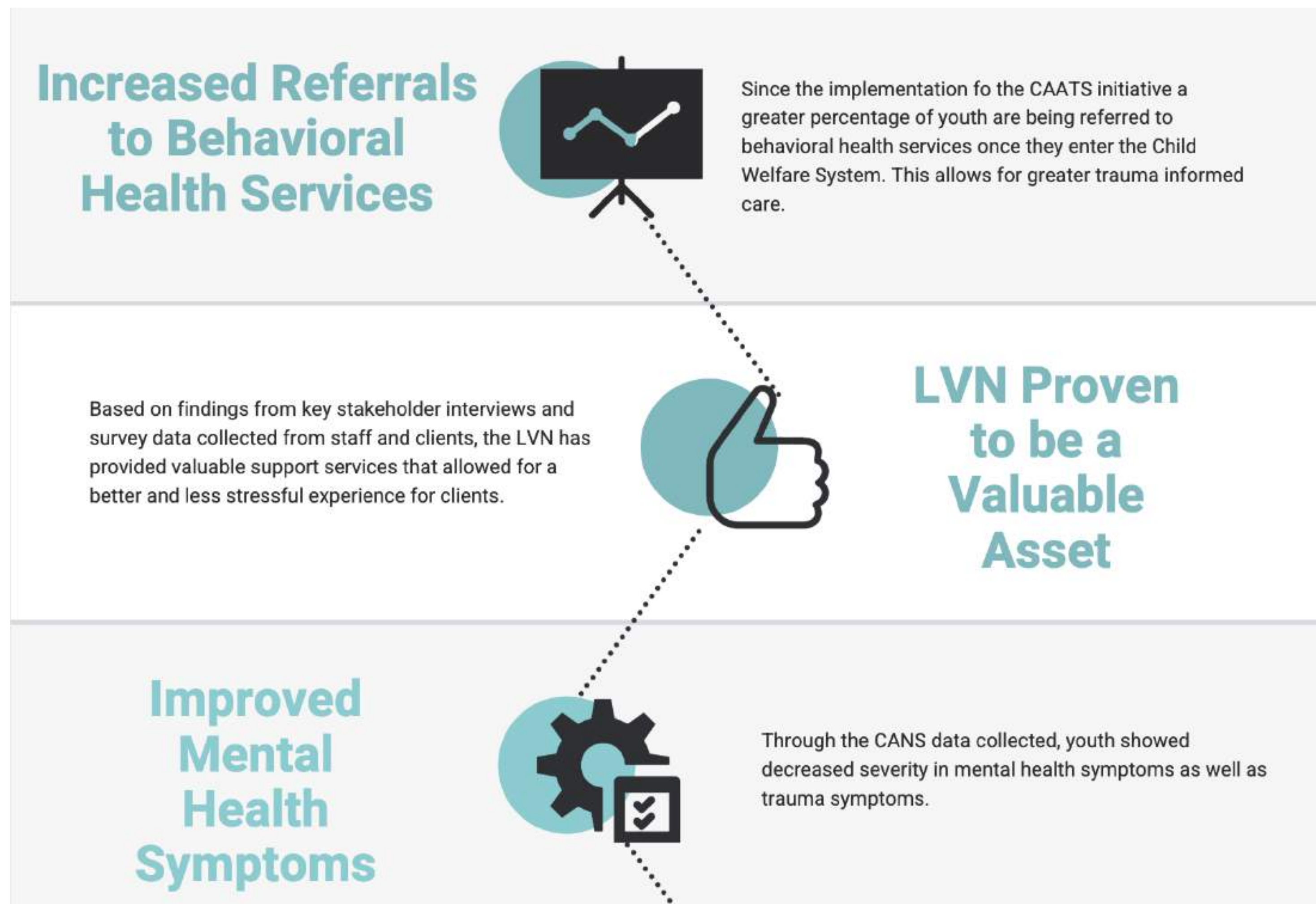
- Increased the quality of care for families and youth served
- Provides a level of support to staff that has enhanced the overall workflow
- The role of the LVN has filled gaps in the system resulting in increased coordination of paperwork within BH and across partner agencies; and better addressing the needs of families in relation to answering questions about medication or follow-up processes.
- Recommendations for improvement centered around creating greater awareness of the LVN role and the need for such a position

Of the family members who completed a survey about their experience with the LVN:

- 43% of respondents indicated interacting with the LVN at least once, and 31% interacted with the LVN several times
- Similar sentiments identified by staff and psychiatrists were reflected in the family survey findings. ***Overall, the LVN was perceived to be a valuable asset, as 100% of respondents believed the LVN to be "very helpful"***
- In open-ended responses, parents described how helpful the LVN was and how much they appreciated her support
- No recommendations for improvement were suggested

CAATS Highlights

The innovative CAATS program has prompted various systemic changes within BH and collaborative partners. Through a greater focus on trauma-informed care, timely access to services, increased partner agency collaboration, availability of support to navigate the system through the LVN, and the implementation of the CANS tool, several positive outcomes were experienced. Outlined below is a summary of primary successes that together translate to enhanced service provision for youth and families in the Child Welfare System.



Appendix A. CANS Scores Indicating Need at Initial Administration

Tables I to V: Description of Ratings	
Rating	**Description**
0	No current need; no need for action or intervention.
1	History or suspicion of problems; requires monitoring, watchful waiting, or preventive activities.
2	Problem is interfering with functioning; requires action or intervention to ensure that the need is addressed.
3	Problems are dangerous or disabling; requires immediate and/or intensive action.

Table I. Life Functioning (N= 450-452)

Item Name	Score=1		Score=2		Score=3		% of youth with actionable need
	N	%	N	%	N	%	
Family Functioning (N=452)	177	39%	152	34%	12	3%	**37%**
Social Functioning (N=452)	161	36%	67	15%	3	1%	**16%**
Living Situation (N=452)	217	48%	69	15%	4	1%	**16%**
School Achievement (N=452)	82	18%	42	9%	7	2%	**11%**
Communication (N=450)	89	20%	24	5%	7	2%	**7%**
Decision Making (N=452)	66	15%	28	6%	5	1%	**7%**
School Attendance (N=451)	55	12%	21	5%	9	2%	**7%**
Sleep (N=452)	92	20%	23	5%	4	1%	**6%**
School Behavior (N=452)	85	19%	19	4%	5	1%	**5%**
Recreational (N=449)	81	18%	16	4%	4	1%	**5%**
Developmental/Intellectual (N=452)	91	20%	19	4%	6	1%	**5%**
Medical/Physical (N=452)	87	19%	15	3%	4	1%	**4%**
Legal (N=450)	35	8%	17	4%	1	<1%	**4%**
Sexual Development (N=452)	33	7%	4	1%	5	1%	**2%**

Table II. Behavioral/Emotional Needs (N=448-452)							
Item Name	**Score=1**		**Score=2**		**Score=3**		**% of youth with actionable need**
	N	**%**	**N**	**%**	**N**	**%**	
Adjustment to Trauma (N=452)	186	41%	144	32%	2	<1%	**32%**
Anxiety (N=452)	192	42%	97	21%	--	--	**21%**
Depression (N=451)	189	42%	68	15%	--	--	**15%**
Anger Control (N=452)	109	24%	42	9%	2	<1%	**9%**
Impulsivity/Hyperactivity (N=452)	86	19%	35	8%	3	1%	**9%**
Attention/Concentration (N=448)	100	22%	30	7%	2	<1%	**7%**
Oppositional Behavior (N=451)	95	21%	31	7%	2	<1%	**7%**
Conduct (N=451)	52	12%	15	3%	1	<1%	**3%**
Substance Use (N=452)	33	7%	12	3%	1	<1%	**3%**
Autism Spectrum (N=449)	7	2%	3	1%	1	<1%	**1%**
Psychosis (N=452)	10	2%	2	<1%	--	--	**<1%**

Table III. Risk Behaviors (N=445-452)							
Item Name	**Score=1**		**Score=2**		**Score=3**		**% of youth with actionable need**
	N	**%**	**N**	**%**	**N**	**%**	
Victimization/Exploitation (N=446)	92	21%	14	3%	--	--	**3%**
Intentional Misbehavior (N=452)	35	8%	11	2%	--	--	**2%**
Runaway (N=452)	11	2%	9	2%	1	<1%	**2%**
Bullying Others (N=445)	39	9%	5	1%	--	--	**1%**
Delinquent Behavior (N=452)	18	4%	6	1%	--	--	**1%**
Sexually Reactive Behavior (N=448)	10	2%	4	1%	2	<1%	**1%**
Other Self-Harm (Recklessness) (N=452)	27	6%	5	1%	--	--	**1%**
Non-Suicidal Self-Injurious Behavior (N=452)	21	5%	1	<1%	2	<1%	**1%**
Danger to Others - triggers danger extension module (N=452)	19	4%	3	1%	--	--	**1%**
Sexual Aggression (N=452)	11	2%	1	<1%	1	<1%	**1%**
Suicide Risk (N=452)	37	8%	3	1%	--	--	**1%**
Fire Setting (N=445)	1	<1%	1	<1%	--	--	**--**

Table IV. Traumatic Stress (N=366-367)							
Item Name	**Score=1**		**Score=2**		**Score=3**		**% of youth with actionable need**
	N	**%**	**N**	**%**	**N**	**%**	
Emotional and/or Physical Dysregulation (N= 366)	185	51%	83	23%	2	1%	**24%**
Traumatic Grief & Separation (N=367)	207	56%	57	16%	--	--	**16%**
Time Before Treatment (N=367)	162	44%	34	9%	14	4%	**13%**
Hyperarousal (N=367)	113	31%	36	10%	---	--	**10%**
Intrusions/Re-Experiencing (N=367)	129	35%	31	8%	--	--	**8%**
Avoidance (N=367)	99	27%	20	5%	2	1%	**6%**
Numbing (N=367)	61	17%	12	3%	1	<1%	**3%**
Dissociation (N=366)	61	17%	2	1%	--	--	**1%**

Table V. Strengths (N=446-452)							
Item Name	**Score=0**		**Score=1**		**Score=2**		**% of youth with strength**
	N	**%**	**N**	**%**	**N**	**%**	
Family Strengths (N=452)	113	25%	190	42%	139	31%	**67%**
Relationship Permanence (N=450)	92	20%	165	37%	150	33%	**57%**
Interpersonal (N=452)	88	19%	139	31%	123	27%	**50%**
Natural Supports (N=452)	85	19%	136	30%	91	20%	**49%**
Resilience (N=452)	81	18%	128	28%	116	26%	**46%**
Optimism (N=451)	64	14%	109	24%	83	18%	**38%**
Resourcefulness (N=450)	56	12%	103	23%	88	20%	**35%**
Educational Setting (N=452)	55	12%	90	20%	70	15%	**32%**
Spiritual/Religious (N=452)	62	14%	55	12%	72	16%	**26%**
Community Life (N=452)	51	11%	69	15%	63	14%	**26%**
Talents and Interests (N=452)	49	11%	63	14%	90	20%	**25%**
Cultural Identity (N=452)	61	13%	54	12%	43	10%	**25%**
Vocational (N=446)	57	13%	26	6%	24	5%	**19%**

Table VI: Strengths Domain - Description of Ratings	
Rating	**Description**
0	Well-developed or centerpiece strength; may be used as a protective factor and a centerpiece of a strength-based plan.
1	Useful strength is evident but requires some effort to maximize the strength. Strength might be used and built upon in treatment.
2	Strengths have been identified but require significant strength building efforts before they can be effectively utilized as part of a plan.
3	An area in which no current strength is identified; efforts are needed to identify potential strengths.

Appendix B. Changes to severity ratings after 6 months

Table I. Life Functioning: Changes at 6-month follow-up (N=115-116)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	%	N	%
Family Functioning (N=116)	15	13%	**29**	**25%**
Living Situation (N=116)	19	16%	**27**	**23%**
Sleep (N=116)	17	15%	**23**	**20%**
School Achievement (N=116)	8	7%	**17**	**15%**
Sexual Development (N=116)	14	12%	**16**	**14%**
Recreational (N=116)	13	11%	**13**	**11%**
Decision Making (N=116)	11	9%	**10**	**9%**
Communication (N=115)	8	7%	**9**	**8%**
School Attendance (N=116)	14	12%	**9**	**8%**
Social Functioning (N=115)	6	5%	**9**	**8%**
Developmental/Intellectual (N=116)	4	3%	**9**	**8%**
Legal (N=115)	3	3%	**8**	**7%**
Medical/Physical (N=116)	6	5%	**8**	**7%**
School Behavior (N=116)	1	<1%	**5**	**6%**

Table II. Behavioral/Emotional Needs: Changes at 6-month follow-up (N=115-116)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	**%**	**N**	**%**
Depression (N=116)	14	12%	**27**	**23%**
Adjustment to Trauma (N=116)	15	13%	**25**	**22%**
Anxiety (N=116)	18	16%	**22**	**19%**
Oppositional Behavior (N=116)	12	10%	**9**	**8%**
Conduct (N=116)	6	5%	**8**	**7%**
Anger Control (N=116)	16	14%	**7**	**6%**
Impulsivity/Hyperactivity (N=116)	11	9%	**7**	**6%**
Attention/Concentration (N=115)	7	6%	**7**	**6%**
Substance Use (n=116)	2	2%	**1**	**1%**
Autism Spectrum (N=115)	1	1%	**--**	**--**
Psychosis (N=116)	--	--	**--**	**--**

Table III. Risk Behaviors: Changes at 6-month follow-up (N=113-116)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	%	**N**	**%**
Victimization/Exploitation (N=114)	4	4%	**11**	**10%**
Intentional Misbehavior (N=116)	4	3%	**6**	**5%**
Bullying Others (N=113)	4	4%	**5**	**4%**
Danger to Others - triggers danger extension module (N=116)	2	2%	**4**	**3%**
Delinquent Behavior (N=116)	2	2%	**3**	**3%**
Other Self-Harm (Recklessness) (N=116)	5	4%	**2**	**2%**
Suicide Risk (N=116)	1	1%	**2**	**2%**
Sexual Aggression (N=116)			**2**	**2%**
Runaway (N=116)	5	4%	**1**	**1%**
Non-Suicidal Self-Injurious Behavior (N=116)	4	3%	**1**	**1%**
Sexually Reactive Behavior (N=115)	1	1%	**1**	**1%**
Fire Setting (N=115)	1	1%	**--**	**--**

Table IV. Traumatic Stress: Changes at 6-month follow-up (N=100)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	**%**	**N**	**%**
Emotional and/or Physical Dysregulation (N=100)	10	10%	**18**	**18%**
Intrusions/Re-Experiencing (N=100)	3	3%	**18**	**18%**
Traumatic Grief & Separation (N=100)	8	8%	**17**	**17%**
Hyperarousal (N=100)	5	5%	**12**	**12%**
Time Before Treatment (N=100)	6	6%	**8**	**8%**
Avoidance (N=100)	9	9%	**5**	**5%**
Numbing (N=100)	5	5%	**4**	**4%**
Dissociation (N=100)	5	5%	**5**	**5%**

Table V. Strengths: Changes at 6-month follow-up (N=114-116)				
Item Name	Youth showing **weakening** in Strength		Youth showing **improvement** of strength	
	N	**%**	**N**	**%**
Talents and Interests (N=116)	13	11%	**48**	**41%**
Spiritual/Religious (N=116)	12	10%	**38**	**33%**
Natural Support (N=115)	12	10%	**32**	**28%**
Relationship Permanence (N=116)	10	9%	**31**	**27%**
Educational Setting (N=116)	10	9%	**31**	**27%**
Family Strengths (N=116)	8	7%	**27**	**24%**
Resilience (N=115)	7	6%	**25**	**22%**
Community Life (N=116)	9	8%	**24**	**21%**
Interpersonal (N=116)	8	7%	**24**	**21%**
Cultural Identity (N=59)	11	9%	**17**	**15%**
Optimism (N=115)	18	16%	**14**	**12%**
Resourcefulness (N=116)	15	13%	**12**	**10%**
Vocational (N=114)	14	12%	**7**	**6%**

Appendix C. Changes to severity ratings after 12 months

Table I. Life Functioning: Changes at 12-month follow-up (N=97-98)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	%	N	%
Family Functioning (N=98)	20	20%	**42**	**43%**
Living Situation (N=98)	14	14%	**40**	**41%**
Social Functioning (N=98)	14	14%	**34**	**35%**
School Achievement (N=98)	10	10%	**23**	**23%**
School Attendance (N=98)	12	12%	**20**	**20%**
Sleep (N=98)	14	14%	**18**	**18%**
Communication (N=98)	12	12%	**14**	**14%**
Legal (N=98)	2	2%	**13**	**13%**
School Behavior (N=98)	12	12%	**13**	**13%**
Recreational (N=97)	12	12%	**12**	**12%**
Decision Making (N=98)	18	18%	**10**	**10%**
Medical/Physical (N=98)	7	7%	**10**	**10%**
Sexual Development (N=98)	4	4%	**9**	**9%**
Developmental/Intellectual (N=98)	10	10%	**9**	**9%**

Table II. Behavioral/Emotional Needs: Changes at 12-month follow-up (N=97-98)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	**%**	**N**	**%**
Depression (N=98)	12	14%	**29**	**30%**
Adjustment to Trauma (N=98)	11	11%	**33**	**34%**
Anxiety (N=98)	13	13%	**30**	**31%**
Oppositional Behavior (N=98)	13	13%	**16**	**16%**
Conduct (N=98)	3	3%	**13**	**13%**
Attention/Concentration (N=97)	7	7%	**12**	**12%**
Anger Control (N=98)	16	16%	**11**	**11%**
Impulsivity/Hyperactivity (N=98)	8	8%	**10**	**10%**
Substance Use (N=98)	6	6%	**1**	**1%**
Autism Spectrum (N=98)	1	1%	**1**	**1%**
Psychosis (N=98)	--	--	**--**	**--**

Table III. Risk Behaviors: Changes at 12-month follow-up (N=97-98)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	**%**	**N**	**%**
Intentional Misbehavior (N=98)	7	7%	**9**	**9%**
Victimization/Exploitation (N=96)	5	5%	**8**	**8%**
Sexual Aggression (N=98)	1	1%	**6**	**6%**
Delinquent Behavior (N=98)	4	4%	**5**	**5%**
Non-Suicidal Self-Injurious Behavior (N=98)	5	5%	**5**	**5%**
Sexually Reactive Behavior (N=98)	2	2%	**5**	**5%**
Bullying Others (N=97)	2	2%	**5**	**5%**
Runaway (N=98)	4	4%	**3**	**3%**
Danger to Others - triggers danger extension module (N=98)	5	5%	**3**	**3%**
Other Self-Harm (Recklessness) (N=98)	8	8%	**2**	**2%**
Suicide Risk (N=98)	6	6%	**2**	**2%**
Fire Setting (N=97)	2	2%	**--**	**--**

Table IV. Traumatic Stress: Changes at 12-month follow-up (N=94)				
Item Name	Youth showing **increase** in score		Youth showing **decrease** in score	
	N	**%**	**N**	**%**
Emotional and/or Physical Dysregulation (N=94)	7	7%	**20**	**21%**
Hyperarousal (N=94)	14	15%	**18**	**19%**
Traumatic Grief & Separation (N=94)	13	14%	**17**	**18%**
Intrusions/Re-Experiencing (N=94)	7	7%	**14**	**15%**
Time Before Treatment (N=94)	8	9%	**13**	**14%**
Avoidance (N=94)	17	18%	**7**	**7%**
Numbing (N=94)	10	11%	**5**	**5%**
Dissociation (N=94)	9	10%	**5**	**5%**

Table V. Strengths: Changes at 12-month follow-up (N=98)				
Item Name	Youth showing **weakening** in Strength		Youth showing **improvement** of strength	
	N	**%**	**N**	**%**
Talents and Interests (N=98)	8	8%	**40**	**41%**
Educational Setting (N=98)	9	9%	**47**	**48%**
Optimism (N=98)	18	18%	**37**	**38%**
Natural Support (N=98)	11	11%	**36**	**37%**
Community Life (N=98)	10	10%	**36**	**37%**
Resourcefulness (N=98)	6	6%	**36**	**37%**
Resilience (N=98)	3	3%	**32**	**33%**
Family Strengths (N=98)	13	13%	**30**	**31%**
Interpersonal (N=98)	18	18%	**28**	**29%**
Cultural Identity (N=98)	12	12%	**26**	**27%**
Spiritual/Religious (N=98)	15	15%	**22**	**22%**
Relationship Permanence (N=98)	13	13%	**20**	**20%**
Vocational (N=98)	16	16%	**18**	**18%**

Text

APPENDIX D. Time to Service Metrics

Table VI. Youth in Dependency served by CAATS initiative **Feb 2018 -June 2018** (N=114)*			
Steps of the Accelerated Access Initiative:	Step 1: Hearing date to Referral date	Step 2: Referral date to assessment date	Overall: Hearing to Assessment
Number of youth	114	98	98
Median number of days	8	12	21
Mean number of days (Standard deviation)	19 (34)	8 (8)	24 (30)
Percent of clients seen within goal timeframe	37% of clients referred in 5 or fewer days	79% of clients assessed within 10 days of referral	58% of clients assessed within 15 days of hearing

Table VII. Youth in Dependency served by CAATS initiative **July 2018 - Dec 2018** (N=111)				
Steps of the Accelerated Access Initiative:	Step 1: Hearing date to Referral date	Referral date to first available assessment date*	Step 2: Referral date to assessment date	Overall: Hearing to assessment
Number of youth	111	46	88	88
Median number of days	5	2	9	15
Mean number of days (SD)	8 (20)	10 (24)	16 (20)	25 (32)
Percent of clients seen within goal timeframe	64% seen in 5 or fewer days	87% offered assessment date within 10 days of referral	58% assessed within 10 days of referral	52% assessed within 15 days of hearing

** Additional metric added*

Table VIII. Youth in Dependency served by CAATS initiative **Jan 2019 - June 2019** (N=111)				
Steps of the Accelerated Access Initiative:	Step 1: Hearing date to Referral date	Referral date to first available assessment date*	Step 2: Referral date to assessment date	Overall: Hearing to assessment
Number of youth	113	61	79	101
Median number of days	4	3	8	12
Mean number of days (SD)	4 (2)	5 (8)	12 (15)	14 (14)
Percent of clients seen within goal timeframe	72% seen in 5 or fewer days	95% offered assessment date within 10 days of referral	70% assessed within 10 days of referral	69% assessed within 15 days of hearing

** Additional metric added*

Table IX. Youth in Dependency served by CAATS initiative **July 2019 - Dec 2019** (N=162)				
Steps of the Accelerated Access Initiative:	Step 1: Hearing date to Referral date	Referral date to first available assessment date*	Step 2: Referral date to assessment date	Overall: Hearing to assessment
Number of youth	162	114	137	136
Median number of days	3	4	10	15
Mean number of days (SD)	3 (2)	9 (19)	16 (24)	20 (25)
Percent of clients seen within goal timeframe	86% seen in 5 or fewer days	82% offered assessment date within 10 days of referral	51% assessed within 10 days of referral	37% assessed within 15 days of hearing

** Additional metric added*