

**The Evaluation of the Second Year of the Illinois Screening,
Assessment and Support Services (SASS) Program during
Fiscal Year 2006
July 1, 2005 through June 30, 2006**

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I. EXECUTIVE SUMMARY

In State Fiscal Year 2005, Illinois expanded the Screening, Assessment and Support Services (SASS) program to include all children and adolescents who are Medicaid eligible and those seeking public funding. The State of Illinois contracted for an evaluation of this program through Northwestern University's Mental Health Services and Policy Program. As required by a Memorandum of Understanding, Northwestern University undertook an evaluation of the SASS program for the fiscal year ending June 30, 2005. The contract for this evaluation was renewed for the 2006 Fiscal Year. The second year evaluation continues to utilize a multi-method approach to understanding the implementation and impact of the SASS program from multiple perspectives. Among the indicators evaluated include the penetration of SASS services statewide, the utilization of services within episodes of care, the decision-making in regards to referrals to SASS, admission to psychiatric hospitals, the outcomes associated with SASS participation, and the satisfaction of multiple partners with the SASS process. In FY06, a survey of youth was included to understand their perspective on SASS services.

The evaluation combined utilization data reported by SASS workers, billing data reported to the Illinois Department of Healthcare and Family Services (HFS) and survey data collected from the following partners: parents and other caregivers, youth, SASS program directors and agency directors, hospitals, and other (non-SASS) community behavioral healthcare providers. Decision analysis and outcomes data were collected through the use of the Childhood Severity of Psychiatric Illness (CSPI) which was completed by SASS workers at the initiation of screening and the end of the SASS episode of care. This year, version 2.0 of the CSPI was used which expands the assessment of youth to 34 items. All SASS workers were trained in the reliable use of the CSPI and certified through the use of test case vignettes to ensure the accuracy of these data.

The results of the present evaluation in aggregate demonstrate that the provision of SASS services under The Children's Mental Health Act of 2003 continues to meet the needs of children in crisis. SASS was a successful program in FY05 and on many performance indicators SASS demonstrated significant improvement in FY06. *SASS was able to reach the target population of children and families in crisis due to emotional or behavioral problems.* Statewide, services were provided in a timely fashion to more than 19,000 children and adolescents. *SASS decision making was clinically rational.* In fact, the consistency of the decision-making appears improved from the first year. More than 82% of decisions fit the decision support model. This is an impressive rate for a large public system. There were no large gender or age disparities in the services provided by SASS, although, the threshold for referral to CARES and SASS is lower for Caucasian children and youth than for African American and Hispanic children. *SASS was effective.* An episode of SASS care is associated with significant clinical and functional improvement, particularly a significant reduction in suicide risk and violence. While overall findings suggest that intensive community services are associated with better outcomes, it was clearly the case that children and youth who fit the decision support criteria for psychiatric hospital admission had better outcomes when hospitalized than when served in the community. Equally important, however, children and youth who did not meet the decision support criteria for hospital admission became worse when hospitalized. *In terms of satisfaction, most partners are satisfied with the CARES line and the*

process of receiving a SASS referral. In particular, youth and parents and other caregivers reported high levels of satisfaction with this service. Consistent with FY05 findings, community providers and hospitals remained the least satisfied system partners. All partners viewed SASS as respectful and culturally sensitive.

In sum, evaluation data support that the CARES line and the provision of SASS services to all Medicaid eligible children and adolescents and those seeking public funding is an effective system to address the acute needs of children and youth in crisis:

- A substantial, and increased, number of children and adolescents have been served.
- Parents and youth are generally pleased with the services.
- SASS providers feel that they are able to deliver a high quality product.
- Other system partners (e.g., hospitals, community behavioral health providers) are generally satisfied with SASS.
- Decision-making with regard to the use of intensive community services and psychiatric hospitalization appears to be clinically sound and improved in FY06 from FY05.
- Child outcomes are generally good. Intensive community interventions appear to be particularly effective at reducing symptoms and risk behaviors and improving functioning.

There are some areas for improvement. These can be summarized as follows:

- Non-SASS providers who also serve children and adolescents do not consistently feel included in the SASS service delivery process.
- Some SASS providers continue to have concerns about the structure and functioning of the business model and some have continued to struggle in their shift to a fee-for-service model. This problem is mostly identified by agency directors, whereas program directors reported significant improvements from FY05 to FY06.
- Variation across providers in terms of both decision-making and outcomes suggest that different approaches to delivering services in the SASS model exist.
- There continues to be a substantial number of children and youth readmitted to the hospital.

While the evaluation effort this year has attempted to pull together data from multiple sources and address the most pressing questions with regard to understanding the impact of SASS on children and families, a number of questions remain unanswered. Among the questions that should be addressed through future evaluation efforts are the following:

- What factors influence hospital readmission?
- What packages of services are most effective with which youth?
- Is it possible to implement a prospective decision support application with the CSPI that can be used in the field?
- Can we better understand racial and cultural factors?
- Is it possible to increase the inclusion of non-SASS providers to create a seamless transition from SASS to non-crisis outpatient services?

The results of the present evaluation indicate that SASS is an effective program. It appears that the SASS program improved from FY05 to FY06 in terms of its penetration and decision-making. There continue to be a number of opportunities for continued improvement within the program. Suggested FY07 priorities include improving communication and collaboration with all child-serving partners, assisting those SASS providers who continue to struggle with the transformation to a fee-for-service environment, and addressing performance variability among providers.

II. BACKGROUND

The extension of the Screening, Assessment and Support Services (SASS) program to serve all children and youth covered by Medicaid was an outcome of the Children's Mental Health Act of 2003. In early 2001, a group of advocates and educators pressed for the creation of the Children's Mental Health Task Force. This task force was created in June, 2002. In April of 2003, the task force published its final report: Children's Mental Health: An Urgent Priority for Illinois. Part of the impact of this report was legislation to improve mental health services for all publicly-funded children. The Children's Mental Health Act of 2003 (IL PA 93-0495) was signed into law by Governor Blagojevich in August of 2003.

One of the requirements of the Children's Mental Health Act was for the Illinois Department of Healthcare and Family Services (HFS) to implement pre-admission psychiatric hospital screening and assessment procedures for Medicaid eligible youth. This mandate led HFS to partner with the Departments of Children and Family Services and Human Services, which were already providing pre-admission screening services, to develop a protocol to expand SASS to all publicly funded children.

On July 1, 2004, HFS, working in collaboration with the Illinois Departments of Children and Family Services (DCFS) and Human Services (DHS), expanded the availability of the SASS program to all children who were covered by Medicaid, who were deemed presumptively eligible for Medicaid, or those who were unfunded within the Department of Human Services target populations. SASS had previously been operated state-wide as two separate programs, one managed by the Department of Children and Family Services and the other operated by the Department of Human Services through its Division of Mental Health. The expansion required that all SASS providers respond to a Request for Proposal to bid on the provision of these services. In July of 2004, 44 SASS primary contractors began offering services state-wide, each SASS responsible for a specific geography (i.e., area of the state). Some of these providers subcontract with other agencies to provide sufficient geographic coverage of their service areas, resulting in a total of 50 SASS providers.

As a component of the expansion of SASS, a central phone intake and referral process was created called the Crisis and Referral Entry Service (CARES). The CARES line takes calls from anyone wishing to refer a child or youth for a SASS assessment. The CARES line staff perform a simple screening process to ensure the appropriateness of the referral. If the child or youth meets a defined level of acuity, the CARES staff then refers that individual to the SASS program consistent with the child's geographical location. For all referred children and youth, SASS programs provide screening, crisis intervention and support services. Thus, SASS workers will perform an assessment to determine if they could stabilize the child or youth in the community through intensive community services instead of admitting him/her to a psychiatric hospital. If the child/youth is hospitalized, the SASS agency provides ongoing monitoring and discharge planning services and helps in the transition back to the community. If the child/youth is not hospitalized, then the SASS agency provides community stabilization services to ensure that the needs of the child and family are met. The duration of SASS services is up to 90 days; however, SASS programs can request an extension if it is indicated by the clinical circumstances of the case.

The Mental Health Services and Policy Program (MHSP) was selected to perform the second year evaluation of the SASS program primarily because of its decade-long experience evaluating and monitoring the SASS program provided by DCFS. In addition, John S. Lyons, Ph.D., the Director of MHSP, is the developer of the Childhood Severity of Psychiatric Illness (CSPI), which is the decision support/outcomes monitoring tool selected to be used within the SASS program. In FY06, SASS providers adopted version 2.0 of the CSPI. In part through the use of the CSPI over a number of years to support clinically driven decisions regarding the use of intensive community support or psychiatric hospital admissions, DCFS was able to reduce and practically eliminate racial disparities in psychiatric hospital admission. Also, DCFS has been able to decrease its use of SASS services over the past several years through its effective implementation of a foster care stabilization program called System of Care (SOC).

The evaluation process was organized with two levels of collaboration. The evaluation Executive Committee was comprised of Dr. Lyons and Lynn Steiner (Projector Coordinator) from Northwestern University and representatives of Healthcare and Family Services (Stephanie Hanco, Shawn Cole, June Jones and Frank Kopel), Children and Family Services (Jane Hastings and Matt Burgess), and Human Services (Dessie Trohalides, Patricia Roy, M.D., and Amy Starin). This committee provided direction to the evaluation efforts and facilitated access to information in support of the evaluation.

The Evaluation Advisory Committee includes all members of the Executive Committee and representatives of the various partners affected by the SASS program. The membership of this committee includes the following individuals:

Bryan Austin	DCFS Youth Advisory Board
Terry Carmichael	Community Behavioral Healthcare Association
Heather Eagleton-Helmy	Illinois Association of Rehabilitation Facilities
Gaylord Gieseke	Voices for Children, Children's Mental Health Partnership
Scott Leon	Loyola University, Department of Psychology
Kim Miller	Parent Representative
Patrick Phelan	Children's Home Association of Illinois
Rita Thorpe	Leyden Family Services
Penny Weedon	Robert Young Center
Linda Weiss	Coles County Mental Health Center

The Advisory Committee reviewed all surveys and reports and gave feedback to the evaluators regarding methods, measures, and dissemination strategies.

III. DATA AND METHODS

The evaluation approach was multi-method and involved the convergence of data from multiple sources. Three primary sources were used. HFS data from the claims database were used to establish baseline data and estimate service use patterns. Claims data has the advantage that SASS programs and hospitals are presumably highly motivated to submit information consistently to HFS in order to secure payment for services. Claims data has the disadvantage that providers have the provision allowing them to submit claims from up to 12 months from the original date of services. Thus the use of claims data to fully evaluate SASS service provision may underestimate the intensity, frequency and duration of SASS interventions.

The second data source used for the evaluation was screening and assessment data reported by SASS agencies to Northwestern University's Mental Health Services and Policy Program (MHSPP); these data were used to evaluate decision-making and outcomes. Screening and assessment data has the advantage that it contains information specific to the child and family and allows for a more detailed understanding of the performance of the services. These data have the disadvantage that some SASS providers might be less motivated to submit these data as no clear financial incentives exist for their completion and submission. To optimize reliability, all SASS workers are required to receive training in the use of the assessment instrument and become certified by demonstrating their reliability on a test case vignette. Statewide, 167 SASS workers were certified in the reliable use of the Childhood Severity of Psychiatric Illness (CSPI). Their average reliability was 0.80, which is evidence of very good reliability.

SASS agencies use the CSPI as a decision support and outcomes measure. A copy of the CSPI-2 manual can be found in Appendix A. One of the uses of the CSPI is to model decision making with regard to community stabilization. The basic structure of the CSPI is composed of 34 items and each item has anchored four point rating scales. However, those anchored definitions are designed to translate into the following four action levels:

- 0 No evidence, no need for action. There is no reason to believe this is a need at this time.
- 1 Watchful waiting, prevention. There is a history of problems or there is suspicion of problems.
- 2 Action. The need is interfering in the child's, family's, or community's functioning and/or well being and it must be addressed.
- 3 Immediate or intensive action. This need is dangerous or disabling.

Based on this measurement model, it is possible to identify which children and adolescents may be in need of a secure psychiatric hospital admission. Specifically, the following seven items significantly contribute to the likelihood that a child or youth would not be able to be stabilized in the community:

- Psychosis
- Depression
- Impulse/Attention Deficit

- Suicide Risk
- Danger to Others
- Judgment
- Anger Control

Detailed definitions of these items can be found in the CSPI-2 manual in Appendix A. It is important to note that the CSPI is a decision support tool, not an expert system. There certainly are children whose circumstances cannot be addressed in the community and may necessitate psychiatric hospital admission who do not fit the above decision model. Likewise, there will be children who fit the above criteria but for whom circumstances allow them to be treated in the community with intensive services.

The third data source included survey results used to assess the multiple perspectives of the various partners in the SASS program. Hospital representatives, SASS program directors and their agency directors, and community mental health providers who do not provide SASS services were surveyed directly. Consistent with federal and state confidentiality requirements, youth, parents and caregivers were recruited by the SASS worker to complete surveys. All data collection, storage, and analyses were compliant with guidelines.

IV. UTILIZATION OF SASS SERVICES

Over the second year of the SASS implementation, a total of 13,590 CARES calls relating to SASS were registered on the web-based system. This system was not operational until late November, 2005, so no data are available for CARES calls that occurred between July 1, 2005, and the initiation of the web-based system. The volume of CARES calls by month was as follows:

November, 2005	380 (incomplete month)
December, 2005	1461
January, 2006	1982
February, 2006	1987
March, 2006	2195
April, 2006	1921
May, 2006	2178
June, 2006	1576

In FY06, a total of 19,298 initial screenings were documented. This number represents a substantial increase (26.7%) from the 15,226 reported in FY05. Of these, 12,008 children and youth were admitted into a psychiatric hospital (compared to 9,884 hospital admissions in FY05). This shows a decrease in the hospitalization rate from FY05 to FY06 (65% v. 62%).

Several limitations must be considered in interpreting these basic utilization numbers. First, although the evaluation team strived to ensure that all SASS workers reported all episodes of service to Northwestern University, it is possible that some episodes went unreported. To improve the accuracy of data on the number of episodes of SASS care, a web-based data management system was implemented that links SASS data directly to eligibility data collected by HFS and CARES. The introduction of the website likely increased compliance with the reports of screenings as information came directly from CARES and the SASS programs used the website for case management activities. Thus it is possible that the reported increase may reflect somewhat improved 'data capture' of provided services rather than an actual increase in the numbers of screenings and hospitalizations. In order to ensure that the numbers were as precise as possible, regular monthly reports on the numbers of screenings reported were given to all providers and they had the opportunity to correct any counts that appeared incorrect.

Table 1 presents screenings by region. Not surprisingly, Cook County saw the greatest number of SASS screenings with more than 7,800, and Southern saw the fewest with slightly more than 1,700. Central and Northern Regions had comparable volume of services. Notably, the community stabilization rate was lower in Cook County (29.3%) than in other regions. Central Region had the highest rate of community stabilization (48.5%) compared to other regions.

Table 1. FY06 SASS Utilization by Region, for Screens Performed 07/01/05 through 6/30/06.

Region	Total	Community Stabilization	%	Psychiatric Hospitalization	%
Statewide	19,298	7,290	37.8	12,008	62.2
Cook County	7,865	2,308	29.3	5,557	70.7
Central	5,332	2,584	48.5	2,748	51.5
Northern	4,340	1,715	39.5	2,625	60.5
Southern	1,761	683	38.8	1,078	61.2

Table 2 presents the distribution of screenings and screening outcomes broken out by gender, age, and race. There are about 1,000 fewer screenings represented in this table because gender, age, and race were sometimes missing from reports submitted by SASS workers. Missing data were not included. There were slightly more boys served than girls overall but there did not appear to be any differences in rates of hospitalization between boys and girls. About two-thirds of all SASS referrals were followed by a psychiatric hospital admission.

Table 2. FY06 SASS Utilization by Gender, Age and Race, for Screens Performed 07/01/05 through 06/30/06.

	Total	%	Community Stabilization	%	Psychiatric Hospitalization	%
GENDER						
Male	9,195	50.8	3,509	38.2	5,686	61.8
Female	8,896	49.2	3,284	36.9	5,612	63.1
AGE						
< 5	174	1.0	92	52.9	82	47.1
6 – 12	5,097	28.2	2,166	42.5	2,931	57.5
13-15	6,990	38.6	2,670	38.2	4,320	61.8
16 >	5,827	32.2	1,864	32.0	3,963	68.0
RACE						
Black	4,988	38.9	1,775	35.6	3,213	64.4
Hispanic	1,541	12.0	596	38.7	945	61.3
Asian	48	.4	17	35.4	31	64.6
White	5,869	45.8	2,428	41.4	3,441	58.6
American Indian/Eskimo	12	.1	4	33.3	8	66.7
Other	358	2.8	138	38.5	220	61.5

The majority of SASS screenings involved adolescents. Only a small percentage of referrals to SASS were for children under five years old (1%). This represents a decline from the first year. The largest age group was 13 to 15 years old (39%). However, about one

quarter (28%) of all SASS referrals were for children aged 6 to 12. The likelihood of psychiatric hospital admission increased with age, from 47% for children 5 and under (again a reduction from the first year) to 68% of youth 16 years or older. This finding is consistent with other findings that adolescents have behavior problems that present greater risk and thus sometimes require more intensive levels of care. The decline in the number of very young children referred to SASS and an increase in the rate of community stabilization of these children is a positive sign.

There was a small increase in the percent of Hispanic youth served. Caucasian children (46%) remained the most common racial group served (down from 49% in the first year), although a substantial percentage of children were African American (39%). Hispanic youth accounted for 12% of the total population served. There was a tendency for African American children to be hospitalized more frequently than Caucasian children; however, this appears to be the result of African American children being assessed as having higher risk symptoms and behaviors at SASS screening. Thus, while there continues to be a racial disparity in hospitalization rates it may reflect an actual racial disparity in the threshold for referring children and youth to SASS services rather than a hospital admission threshold difference. In other words, it appears that African American and Hispanic children and youth are seen at a point when they present with more symptoms and higher levels of risk behaviors than do White children. This suggests challenges in the process of detection and referral from the community to SASS rather than a problem with how CARES or SASS serves African American and Hispanic children and youth.

Table 3 presents screenings by participating SASS agencies and their subcontracting agencies. Subcontracting agencies are reported under the agency that holds the contract with the State of Illinois. In addition, by each agency name there is an indicator of whether or not its LAN (e.g., service area) contains psychiatric hospital beds for adults and for children and adolescents. This is an important indicator in that it is generally easier to obtain a psychiatric hospital admission if the hospital serves the geographic area in which the child and family live. In addition, parental and caregiver involvement during the hospital stay is easier when the hospital is closer to home. Also, many children and families appear at emergency rooms when in crisis, so the potential for providing community stabilization services decreases when the child and family have already presented at a hospital setting. The role of hospital availability on admission rates both in terms of location and bed availability requires further study.

In Table 3, substantial variation can be seen across the 50 agencies which contract and subcontract to provide SASS services. One Cook County provider served more than 1,000 children and adolescents through fiscal year 2006 (FY06); of these, 33.1% were stabilized in the community. In contrast, five agencies served ten or fewer children. Of the 35 children served by these five agencies, 21 (60%) were stabilized in the community.

Claims Data Summary Statistics

In FY06, it is possible to begin an analysis of claims data in that the 12 month window for billing has expired for much of the first year. Therefore, the following analyses of claims data are based on claims made during FY05.

A. Eligibility for SASS Services

During FY05, there were 9,661 unique recipients and 10,335 SASS episodes; 8,990 (93.05%) recipients had 1 episode, 668 (6.91%) recipients had 2 episodes, and 3 (0.03%) recipients had 3 episodes. A new episode began when there was a gap (≥ 2 days) between the beginning date and the last ending date and when the eligibility had a value of "MH" (mental health, the code used to identify a SASS client). Twelve percent of episodes extend past 91 days. Table 4 describes the frequency of time span per episode and per recipient.

Table 4: Frequency table of time spans per episode and per recipient

Time Span (days)	# of Episodes	Cumulative %	# of Recipients	Cumulative %
< 91	61	0	55	0
91	9,045	88	7,952	83
92 ~ 120	356	92	283	86
121	468	96	360	90
122 ~ 150	127	97	95	91
151	82	98	69	91
152 ~ 181	166	99	103	92
182	8	99	452	97
182 ~ 319	72	100	292	100
Total	10,335	100	9,661	100

B. Hospital Admissions

In FY05, there were fewer hospital admissions than in FY04 and FY03 (7,114 v. 12,602 and 11,647) but a greater percentage of readmissions in FY05 compared to FY04 (28.6% v. 24.0%) while both years had a lower percentage of readmissions compared to FY03 (32.0%). Table 5 compares admissions, length of stay and readmissions across fiscal years 2003, 2004 and 2005.

For the period 7/1/04 - 5/30/05 there were 5,079 unique recipients with 7,114 admissions with an average length of stay (LOS) of 11.74 days. Of these, 1,438 unique recipients were readmitted with same diagnosis related group (DRG) code cited, resulting in a total of 2,035 readmissions during the time period with an average of 41.42 days elapsed between admissions.

For the period 7/1/03 - 6/30/04 there were 12,602 admissions with an average LOS of 11.68 days. There were 1,756 unique recipients readmitted with the same DRG code cited, resulting in a total of 3,026 readmissions during the time period, with an average of 55.32 days elapsed between admissions.

For the time period 7/1/02 – 6/30/03 there were 11,647 admissions with an average LOS of 11.58 days. There were 2,150 unique recipients readmitted with the same DRG code cited, resulting in a total of 3,724 readmissions during the time period, with an average of 57.07 days elapsed between admissions.

Table 5. Summary of the hospital admission and average LOS, readmission and days elapsed between admissions for the three years. (Note: FY 05 does not contain full data)

Time Period	Admissions ¹	Average LOS	Readmissions ²	Days Elapsed Between Admissions	Recipient Readmitted
7/1/04 - 5/30/05 [^]	7,114	11.74	2,035	41.42	1,438
7/1/03 - 6/30/04	12,602	11.68	3,026	55.32	1,756
7/1/02 – 6/30/03	11,647	11.58	3,724	57.07	2,150

¹Admissions are defined as paid claims with a bill type frequency code of ‘1’ or ‘2’ which denote the beginning of an inpatient stay.

²Readmissions are defined as a subsequent admission for a recipient for the same DRG code.

[^]Beginning of current SASS program.

C. Service Utilization

Of a total of 9,661 unique recipients in Table 4, above, 8,591 unique recipients received 139,227 non-inpatient services, 5,079 unique recipients had 7,114 hospital admissions, and 4,965 recipients received both hospital and non-inpatient services. Analyses of diagnosis codes and service types by unique recipients and by SASS episodes (i.e., some clients had multiple episodes) were conducted and the results appear in the four tables below.

Table 6 displays diagnosis by unique recipients. The most common diagnoses among unique recipients are psychoses (68%), followed by childhood mental disorders (13%) and personality and impulse disorders (8%). It appears that the diagnostic categories used in the HFS claims database do not correspond consistently with CSPI clinical assessments. The observation of a higher rate of psychosis diagnosis in the HFS data versus the ratings of actionable psychosis in the CSPI requires further investigation.

Table 6. Distribution of Diagnostic Related Group codes of the 7,114 hospital admissions for the 5,079 recipients.

Diagnosis Related Group code	Frequency	Percent
Psychoses	4,846	68.12
Childhood mental disorders	915	12.86
Disorders of personality & impulse control	561	7.89
Depressive neuroses	441	6.2
Neuroses except depressive	270	3.8
Organic disturbances & mental retardation	42	0.59
Acute disturbances of psychosocial dysfunction	29	0.41
Other mental disorder diagnoses	9	0.13
O.R. procedure w/principal diagnosis of mental illness	1	0.01
<i>Total</i>	7,114	100.00

Table 7 lists the types of services received by unique recipients. For unique recipients, the most frequent services received included case management (38%), therapy/counseling (21%), and screening and assessment services (24%).

Table 7. Distribution of procedures for the 8,591 unique recipients receiving 139,227 NIPS*

Procedure	Frequency	Percent
Case management	52,315	37.58
Therapy/counseling	29,871	21.45
Mental health assessment/Psychological evaluation	20,008	14.37
Crisis intervention	13,520	9.71
Crisis intervention – pre-hospitalization screening	11,676	8.39
Treatment plan development, review, modification	5,255	3.77
Therapeutic behavior services	3,948	2.84
Psychotropic medication monitoring	1,150	0.83
Intensive family-based services	435	0.31
Psychotropic medication training	353	0.25
Skills training and development	247	0.18
Assertive community treatment	181	0.13
Mental health intensive outpatient	80	0.06
Mental health day treatment	66	0.05
Activity therapy	61	0.04
Psychotropic medication administration (T1052)	37	0.03
Psychotropic medication administration (T1502)	24	0.02
<i>Total</i>	139,227	100

* Non-Institutional Provider System

Of 10,335 episodes from Table 4, 9,168 episodes received 127,585 non-inpatient services, 5,407 episodes resulted in 6,838 hospital admissions, and 5,269 episodes resulted in both non-inpatient services and hospital admissions.

Table 8 displays diagnosis by episode (not recipient) while Table 9 lists the types of services received per episode (not recipient). When analyzed by episode rather than by individual, the findings are comparable. Similar to the diagnosis breakdown noted in Table 6, the most common diagnoses in Table 8 are psychoses, childhood mental disorders and disorders of personality and impulse control.

Table 8. Distribution of Diagnostic Related Group codes for the total of 6,838 hospital admissions for 5,407 episodes.

Diagnosis Related Group code	Frequency	Percent
Psychoses	4,660	68.15
Childhood mental disorders	891	13.03
Disorders of personality & impulse control	534	7.81
Depressive neuroses	430	6.29
Neuroses except depressive	253	3.7
Organic disturbances & mental retardation	35	0.51
Acute disturbances of psychosocial dysfunction	26	0.38
Other mental disorder diagnoses	8	0.12
O.R. procedure w/principal diagnosis of mental illness	1	0.01
<i>Total</i>	6,838	100.00

Table 9. Distribution of NIPS* for the total of 127,585 non-inpatient services for 9,168 episodes.

Procedure	Frequency	Percent
Case management	47,268	37.05

Therapy/counseling	27,213	21.33
Mental health assessment/Psychological evaluation	18,787	14.73
Crisis intervention	12,548	9.84
Crisis intervention – pre-hospitalization screening	10,873	8.52
Treatment plan development, review, modification	4,929	3.86
Therapeutic behavior services	3,540	2.77
Psychotropic medication monitoring	1,059	0.83
Intensive family-based services	416	0.33
Psychotropic medication training	313	0.25
Skills training and development	205	0.16
Assertive community treatment	179	0.14
Mental health intensive outpatient	79	0.06
Mental health day treatment	61	0.05
Activity therapy	57	0.04
Psychotropic medication administration (T1052)	35	0.03
Psychotropic medication administration (T1502)	23	0.02
<i>Total</i>	127,585	100

* Non-Institutional Provider System

According to Table 9, the highest percentage of services provided are for case management (about 37%), therapy/counseling (about 21%) and screening and assessment (about 23%), comparable with the numbers for recipients in Table 7. These services are the core services of the SASS program which shows that SASS is doing what it is supposed to be doing.

Table 10. Number of psychiatric hospitalizations per client from 7/1/04 to 5/30/05.

Hospitalizations	Frequency	Percent
1	3,846	75.72
2	797	15.69
3	256	5.04
4	92	1.81
5	42	0.83
6	28	0.55
7	10	0.20
8	2	0.04
9	4	0.08
10	1	0.02
14	1	0.02

Table 10 shows the readmission rate during this period: 24.28% of children and youth were readmitted to the hospital during the follow along period. The majority of these (15.69%) were readmitted once. Another 256 children and youth (5.04%) were readmitted twice, while 3.55% were readmitted three or more times. Thus, the recidivism rate is 2.428 per 1,000 children and youth.

D. Predicting Hospital Length of Stay

Hospital length of stay (LOS) was determined using the SASS reported hospital admission and discharge dates. Unfortunately, the compliance with these data elements in the website has not been consistent. In particular, discharge dates were often absent, resulting in a substantial amount of missing data. However, there is little reason to believe that a systematic bias exists in what data is missing; therefore, it is still possible to analyze the relationship of predictor variables to LOS. Based on the results of a multilevel regression analysis (HLM), length of stay is based on the following youth variables:

- Age: older youth have shorter LOS
- Suicide: more suicidal youth have shorter LOS
- Other self-harm: youth involved in reckless behavior have longer LOS
- Family Functioning: youth with greater family problems have longer LOS
- DCFS status: youth in DCFS have longer LOS

Despite the importance of relevant clinical variables in determining LOS at the youth level, the analyses also revealed that the hospital continues to play a significant role in predicting LOS. Hospital accounts for approximately 8% of the variance in LOS. Interestingly, this 8% figure is almost identical to the percent variance accounted for by practice pattern variations in other arenas such as therapist outcomes and academic achievement in the schools (across classrooms). The importance of DCFS as a predictor variable varies across hospitals. Therefore, at some hospitals the youth's DCFS status does not predict LOS while at others it has a significant impact. This suggests some combination of variation in DCFS offices with regard to their ability to work effectively with hospitals and/or SASS programs or SASS program/hospital variations in their ability to work with DCFS. In other words, it may be that some case workers and supervisors are better at facilitating shorter lengths of stay. This suggests a DCFS practice pattern variation rather than a hospital practice pattern variation.

The data on suicide predicting shorter stays is consistent with a large body of earlier research. Suicidality not complicated by other factors often passes quickly and safety planning can be put in place to ensure a child or youth's safety following hospital discharge. Recklessness, as assessed by the Other Self Harm item does not share this pattern of rapid remediation.

IV. DECISION ANALYSIS

A. CARES ACUITY SCREEN

Based on 13,590 calls into the CARES line using the web-based system, one or more of the following characteristics (current/recent) of youth were obtained. In order of frequency, they are:

<u>CARES Acuity Screen Item</u>	<u>Yes*</u>
Has the youth acted aggressively towards others or animals, or intimidated others or destroyed property, set fires?	40.7%
Has the youth spoken about harming him/herself or said he/she wished he/she were dead?	39.3%
(If the youth has a plan for self harm) Is there a way he/she could follow through on the plan?	38.2%
Has he/she said he/she wants or intends to severely harm someone?	26.4%
Has the youth made any current attempts to harm self?	18.5%
Does he/she have a history of harming others?	18.0%
Is the youth running away?	15.6%
Has he/she tried to harm themselves?	14.0%
Is the youth using drugs?	11.7%
Is the youth living situation currently in jeopardy	10.8%
Is the youth using alcohol?	8.7%
Is he/she hearing voices or seeing things that are not really there?	8.6%
Are they saying or doing things that don't make sense to you?	7.1%
Has the youth severely hurt someone?	4.1%
Is he/she involved in a gang?	3.8%
Has the youth engaged in increased sexual activity or dangerous sexual activity?	3.4%
Does he/she think people are after him/her or are plotting against him/her?	2.8%
Has the youth been sexually aggressive toward anyone?	2.2%
Is the youth involved in prostitution?++	0.8%

* The percentage of youth that fit this criterion.

++ Question discontinued in FY07.

Over 40% of children and youth screened by CARES and referred to SASS acted aggressively toward others, and 39% expressed the desire to harm themselves.

B. SASS DECISION ANALYSIS

Decision Tree Modeling regarding the use of community stabilization versus hospitalization

Figure 1 presents the results of an Optimal Data Analysis (ODA) for youth undergoing an initial SASS screening. This analysis was performed by Scott Leon, Ph.D., of Loyola University. The ODA approach maximizes the percent accuracy of predicting a categorical dependent variable. In this case, CSPI data were used to predict whether a youth was provided intensive community stabilization services only or was admitted to the psychiatric hospital during an episode of care.

One of the unique characteristics of ODA is that it allows predictor variables, in this case items of the CSPI, to split anywhere along their distributions to optimize prediction. In other words, the analysis found that for one item the distinction between a 0 and a 1, 2, 3 is most relevant, whereas for another item the distinction between a 0, 1 and a 2, 3 is more relevant, while for a third item the important distinction is between a 0, 1, 2 and a 3 rating. Items are entered into the tree based on their ability to distinguish youth on the primary dependent variable (i.e., community stabilization versus hospitalization).

Judgment is the first item entered, followed by Suicide Risk. On the left side of the decision tree, if a youth does not have an actionable Judgment need, then Suicide Risk breaks out into three groups (0,1), 2 or 3. The left hand branch is a youth who does not have an actionable Judgment or an actionable Suicide Risk need. The next item is Danger to Others. If a youth is not dangerous to others, then the final item on the branch is Psychosis. If the youth also does not have an actionable level of Psychosis, the tree ends at Node A. Review of the legend for Figure 1 on the following page reports that 80% of youth in this branch are served through community stabilization. However, if a youth does have actionable needs with regard to Psychosis, the decision shifts to favoring hospital admission in 65% of the cases (Node B).

On the right side of the decision tree, if a youth has 'actionable' Judgment needs, the next question is "Is he/she suicidal?" If the youth has acute Suicide Risk, then the final item in the decision tree is Anxiety. A youth who has actionable Judgment, acute Suicide Risk and actionable Anxiety is likely to be hospitalized 75% of the time. In the absence of Anxiety, these youth are only admitted to the hospital 48% of the time.

Tracing each branch of the decision tree from the top to the decision node provides 22 distinct profiles of youth based on characteristics assessed by the CSPI. In half of these nodes, the decision favors community stabilization. In the other half of the nodes, the decision favors psychiatric hospital admission.

Some nodes are more clear cut than others in their decision implications. For example, those in Node D (actionable Psychosis and Danger to Others) are admitted into the hospital 85% of the time. Those in Node S (recent suicide but not acute suicide or judgment needs) are mostly served through community stabilization (92%).

Figure 1.

ODA Community Stabilization versus Hospital Admission Decision Tree

CSPI Options: 0, 1, 2, 3/Shaded box indicates decision to hospitalize.

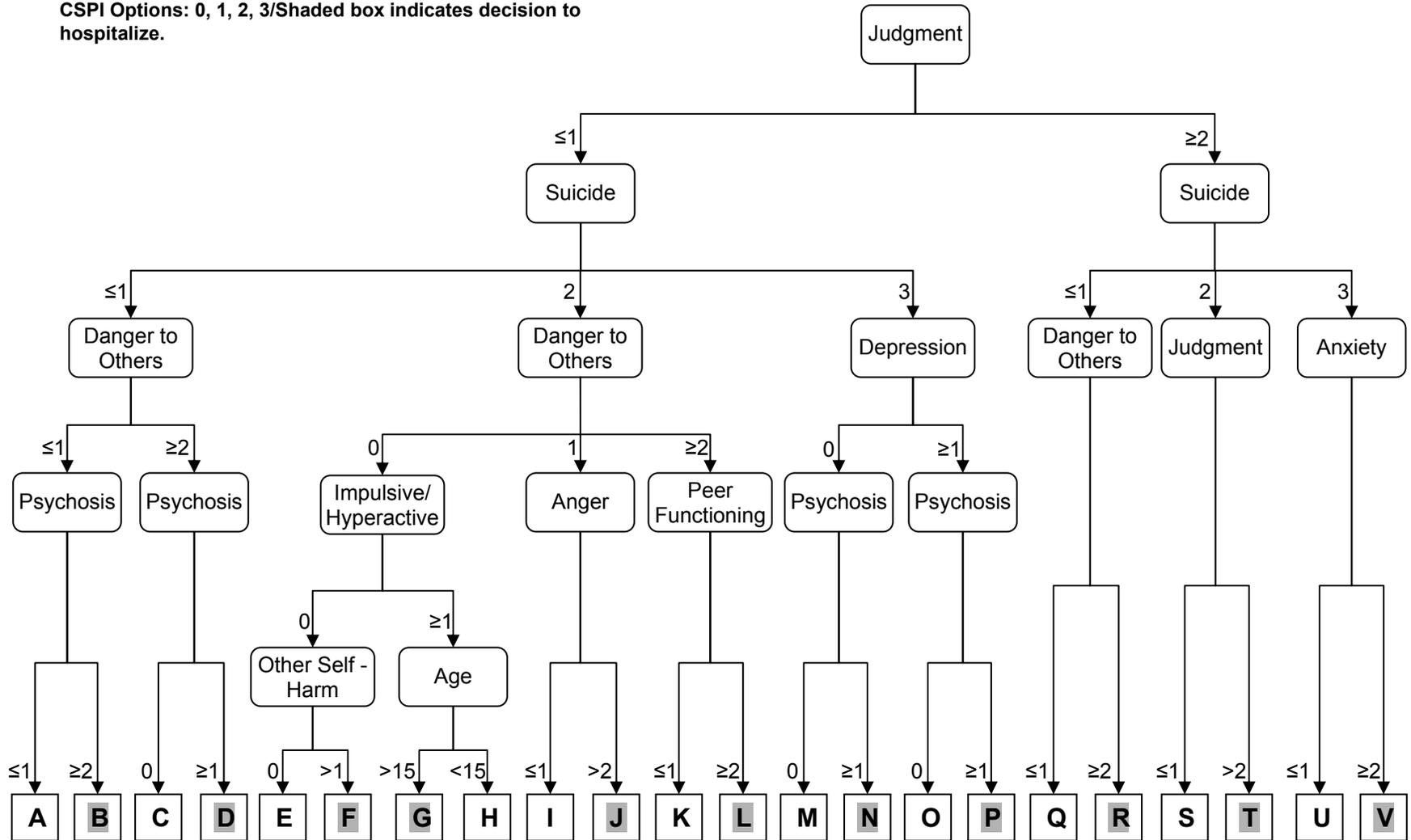


Figure 1 Legend. Decision Accuracies for Various Decision Endpoints: FY04-FY06 Sample

<u>Decision Node</u>	<u>Prediction</u>	<u>Accuracy</u>
A	Community	80%
B	Hospital	65%
C	Community	36%
D	Hospital	85%
E	Community	88%
F	Hospital	45%
G	Hospital	61%
H	Community	65%
I	Community	62%
J	Hospital	62%
K	Community	66%
L	Hospital	61%
M	Community	85%
N	Hospital	44%
O	Community	80%
P	Hospital	50%
Q	Community	75%
R	Hospital	60%
S	Community	92%
T	Hospital	30%
U	Community	52%
V	Hospital	75%

Review of the decision tree reveals a fairly consistent logic behind the decision making of SASS workers. Perhaps the most intriguing implication of the ODA analysis is contained in not which items *are included* as important to the branching logic but rather which items *are not*. It appears that caregiver capacity has little impact on the decision to serve children and youth in the community. This is somewhat surprising in that the opportunity to utilize intensive community treatment should be informed, at least somewhat, by caregiver needs.

VI. OUTCOMES

There are a variety of ways in which the CSPI can be used as an outcome monitoring tool. The standard method is to sum the items within domains (e.g., symptoms, risk behaviors, functioning) and study change over time on these scale scores. Table 12 presents the overall analysis of change for all children and adolescents for whom both a completed CSPI at screening and at termination of the SASS episode of care were submitted to Northwestern University during last fiscal year. As can be seen from Table 12, SASS involvement was associated with significant improvement overall. All of these improvements were statistically significant and clinically meaningful. Careful review of these tables indicates a substantial amount of missing data for these analyses. This is primarily due to three causes. First, SASS workers were not required to submit a second CSPI if they only saw the child one time. Second, open cases at the end of the fiscal year did not include a final CSPI. Finally, some SASS workers failed to submit CSPI data on their closed cases.

Table 12. FY05 SASS Outcomes by Provider, from Terminate CSPIs Received 07/01/05 through 06/30/06.

SASS Provider	Total # of Terminate CSPIs ^A	# Clients with Screening & Terminate CSPIs qualifying for this report**	CSPI Risk Behaviors (max=30)*		Behavioral/Emotional Symptoms (max=30)*		Functioning Problems (max=30)*		Caregiver Needs & Strengths (max=30)*		Mean Risk+Symp+Func+ Needs (max=30)*	
			Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination
Total	4959	2240	8.25	5.08	10.89	7.84	9.13	6.67	4.54	4.24	8.16	5.86
Ada S. McKinley Community Services, Inc.	110	50	7.84	6.04	9.96	7.91	7.88	5.86	5.75	2.21	7.58	5.27
Ben Gordon Center	12	8	8.51	5.69	12.06	9.03	8.71	10.19	2.86	2.33	8.35	6.22
Bridgeway	12	4	11.11	3.06	11.67	5.83	6.50	6.50	4.50	3.50	8.44	4.72
Catholic Charities Diocese	36	15	9.56	5.95	11.93	7.70	12.26	9.41	6.67	7.71	10.22	7.69
Center for Children's Services	43	12	8.49	5.07	9.50	10.18	7.42	6.70	3.46	6.36	7.22	7.39
Children's Home Association of Illinois	173	72	7.65	5.34	9.99	7.94	9.14	7.06	3.93	4.18	7.56	6.11
Coles County Mental Health Association, Inc.	68	40	7.47	4.78	10.83	8.31	8.00	8.36	5.21	5.79	7.88	6.71
Community Care Options	442	171	8.17	4.81	10.59	7.68	8.52	6.38	3.47	3.92	7.59	5.60
Community Counseling Center of Chicago	639	209	7.73	4.45	9.72	6.98	8.19	5.41	3.46	3.15	7.26	4.84
Community Counseling Ctr of Northern Madison Cty	52	0										
Community Mental Health Council	55	20	11.75	9.54	16.67	12.78	11.00	13.33	3.60	8.22	10.43	10.67
Comprehensive Mental Health Center	35	17	8.06	4.65	13.06	8.07	9.73	6.05	2.00	2.25	7.82	5.34
Crosspoint Human Services	55	3	9.26	7.04	8.52	9.63	4.44	7.44	3.33	0.00	6.39	6.03
DuPage County Health Department	197	87	7.93	6.11	9.65	8.73	9.06	7.67	5.59	5.90	7.94	6.96
Egyptian Public and Mental Health Department	49	32	8.11	4.34	10.39	6.68	9.01	7.07	5.19	4.19	8.29	5.62
Family Counseling Center, Inc.	43	35	5.71	4.13	8.92	6.38	5.57	6.19	4.46	4.17	6.23	5.22
Family Service Association of Greater Elgin Area	97	54	7.96	5.48	9.26	7.89	7.62	6.39	2.62	3.53	6.59	5.59
Franklin-Williamson Human Service, Inc.	21	11	6.57	4.34	10.61	7.37	5.82	5.90	2.91	3.00	6.48	4.95
Grand Prairie Services	209	92	7.74	3.78	11.30	6.11	8.39	4.26	2.26	1.39	7.22	3.67
Heartland Human Services	19	7	8.65	1.30	9.57	5.37	11.50	5.56	0.67	6.00	8.22	4.56
--Community Resource Center	36	17	6.88	5.44	9.18	9.07	6.42	4.77	4.62	8.04	7.13	7.23
Helen Wheeler Center for Community Mental Health	67	45	8.85	6.85	12.81	10.78	10.17	7.80	6.50	6.39	9.64	7.80
Heritage Behavioral Health Center, Inc	137	91	7.22	2.93	10.56	5.02	9.13	3.95	4.88	2.98	7.95	3.69
--DelVitt County Human Resource Center	0	0										
Human Support Services	0	0										
--Human Service Center	18	12	9.01	2.59	11.67	4.54	9.72	4.36	3.33	6.20	8.36	3.87
^A Received by Illinoisoutcomes.com by 7/31/06 [*] Higher CSPI scores indicate greater severity ^{**} Only includes clients w/ both initial screening and termination CSPI; at least 75% of items in each domain must be completed to be included here ⁺ Refers to initial screening for "episode" of SASS services ending in termination of interest. "Episode" must be between 3-120 days												

Table 12. FY05 SASS Outcomes by Provider, from Terminate CSPIs Received 07/01/05 through 06/30/06 (continued)

SASS Provider	Total # of Terminate CSPIs ^A	# Clients with Screening & Terminate CSPIs qualifying for this report**	CSPI Risk Behaviors (max=30)*		Behavioral/Emotional Symptoms (max=30)*		Functioning Problems (max=30)*		Caregiver Needs & Strengths (max=30)*		Mean Risk+Symp+Func+ Needs (max=30)*	
			Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination	Initial Screening+	Termination
Institute for Human Resources	2	2	7.22	3.89	8.89	3.33	8.33	4.50	0.00	2.00	6.11	4.18
Jane Addams Family Counseling Ctr of Stephenson C	55	32	8.65	4.60	12.99	7.41	12.45	7.82	6.43	3.63	10.19	5.56
Janet Wattles Center, Inc.	3	2	11.67	7.22	12.78	13.33	5.83	7.50	1.00	0.00	7.82	7.01
Jewish Children's Bureau	74	47	7.26	5.27	9.80	7.73	8.20	7.66	3.51	5.15	7.20	6.48
Kenneth W. Young Centers	194	115	9.66	5.76	12.09	8.19	8.39	6.27	2.08	2.31	7.99	5.64
Kids Hope United/ Hudelson Region	100	59	8.33	6.17	10.64	8.93	7.97	5.88	3.78	3.94	7.64	6.18
Lake County Health Department and Community Health	174	105	8.71	5.18	12.58	8.40	9.68	7.22	4.89	2.98	8.90	5.96
Leyden Family Service and Mental Health Center	542	134	8.38	4.82	10.44	7.41	10.14	6.84	4.62	5.58	8.27	5.82
Lutheran Social Service of Illinois	127	58	10.29	4.60	12.13	7.46	10.76	5.54	5.30	2.28	9.54	4.89
Macoupin County Community Mental Health Ctr	74	47	9.13	4.42	12.11	7.02	10.36	6.59	7.07	6.04	9.63	5.98
McHenry County Mental Health Board	129	63	9.74	5.72	12.31	8.72	12.55	8.29	7.90	5.56	10.65	7.02
Mental Health Centers of Central Illinois	251	156	7.02	5.79	10.55	9.76	8.83	8.09	4.34	4.56	7.70	7.01
--Christian County Mental Health	23	12	8.82	4.82	12.80	9.89	12.33	9.79	7.00	7.40	9.91	7.37
Metropolitan Family Services	30	0										
Mount Sinai Hospital	6	0										
--Mujeres Latinas en Accion	11	1	1.11	1.11	16.67	16.67	3.33	3.33	0.00	0.00	7.78	7.78
North Central Behavioral Health Systems	66	42	9.74	5.15	12.34	8.30	11.59	7.82	5.90	4.96	10.08	6.47
Robert Young Center	105	36	11.20	6.79	14.60	9.22	12.51	9.91	5.70	4.88	10.96	7.54
Schuyler County Mental Health Services	11	10	6.78	2.56	10.68	6.18	7.33	6.17	5.11	3.78	7.70	4.85
--Cass County Mental Health Center	2	0										
--Morgan Scott Mental Health	0	0										
Sinnissippi Centers, Inc.	159	91	9.28	5.44	10.06	7.15	10.37	5.98	8.09	7.81	9.44	6.66
Southeastern Illinois Counseling Centers, Inc.	42	31	6.05	3.15	9.26	5.69	8.20	4.47	5.95	5.10	7.45	4.61
Southern Illinois Regional Social Services	51	36	5.83	4.75	8.59	7.10	8.70	8.74	5.59	6.39	7.13	6.85
Transitions of Western Illinois	103	57	8.76	6.01	11.45	8.87	8.12	7.01	3.93	3.62	8.11	6.40
^ Received by Illinoisoutcomes.com by 7/31/06												
* Higher CSPI scores indicate greater severity												
** Only includes clients w/ both initial screening and termination CSPI; at least 75% of items in each domain must be completed to be included here												
+ Refers to initial screening for "episode" of SASS services ending in termination of interest. "Episode" must be between 3-120 days												

Table 13 presents CSPI outcomes data using a different method. In this approach, the percentage of youth with each level of action for each item is reported at initiation of and transition from SASS services. The percentage of youth with ‘actionable’ needs (i.e., ratings of ‘2’ or ‘3’) can be compared over the episode of care, thereby indicating the specific needs that the SASS program has impact upon. For example, 43% (i.e., 20% + 23%) of youth presenting at the initial screen had an actionable need regarding Suicide Risk. At transition from SASS, only 7% (i.e., 5% + 2%) continued to have this level of need. For the majority of youth served, suicidality was resolved to at least a ‘watchful waiting/prevention’ level.

Review of Table 13 suggests that the primary impact of SASS services involves the reduction of risk behaviors. At their transition from SASS, youth were less likely to have an actionable level for nearly all risk behaviors. For behavioral and emotional needs, however, the pattern is different. For these issues, SASS generally helped stabilize youth but did not resolve their actionable behavioral health needs. In other words, the movement was from ‘3’ (i.e. dangerous/ disabling) to ‘2’ (i.e., actionable). Thus youth served by SASS have sustained needs for ongoing behavioral health treatment beyond their episode of care in SASS. Impulsivity/ Hyperactivity (31%), Anger Control (31%), Oppositional Behavior (29%) and Depression (27%) were the most common sustained needs following SASS. Functioning improved for most youth served. Interestingly, Caregiver Needs were relatively unaffected by the SASS intervention.

Table 13. Percentage of children and youth rated at each of four levels of severity of need on the Childhood Severity of Psychiatric Illness (CSPI) at Initial Screening and Termination of SASS involvement.

CSPI item	Initial Screening				Transition			
	0	1	2	3	0	1	2	3
<i>Risk Behaviors</i>								
Suicide Risk	36	22	20	23	51	42	5	2
Self Mutilation	67	17	13	3	74	23	3	0
Other Self Harm	57	22	16	5	65	29	5	1
Danger to Others	39	28	20	13	50	40	9	1
Sexual Aggression	91	5	3	1	92	6	2	0
Runaway	64	17	8	11	69	22	6	3
Judgment	13	29	38	20	15	53	27	5
Fire-setting	88	7	4	1	92	7	1	0
Social Behavior	32	34	21	14	39	44	14	4
<i>Behavioral/Emotional Symptoms</i>								
Psychosis	75	14	6	5	81	15	4	1
Impulse/Hyper	19	28	36	17	25	44	27	4
Depression	14	30	41	16	20	53	25	2
Anxiety	40	33	23	5	47	42	11	1
Oppositional	25	26	33	16	26	44	25	4
Conduct	48	27	19	7	56	32	10	2
Adjustment to Trauma	41	28	23	8	47	35	15	3
Anger Control	16	28	39	18	20	49	26	5
Substance Use	69	17	10	5	70	21	7	3
<i>Functioning Problems</i>								
Living Situation	26	31	35	9	34	42	19	5
Community	57	28	13	2	68	24	6	1
School	22	27	30	21	31	41	20	9
Peer Functioning	26	32	32	10	32	46	19	4
Developmental	74	19	6	1	77	17	5	1
Medical Compliance	75	10	9	7	77	14	6	3
<i>Juvenile Justice Risk</i>								
Juvenile Justice Status	81	9	8	2	81	11	6	2
Community Safety	82	12	5	2	85	12	3	1
Delinquency	79	13	7	2	81	14	4	1
<i>Child Protection</i>								
Abuse/Neglect	80	13	5	2	85	11	3	1
Domestic Violence	83	14	2	1	86	13	1	0
<i>Caregiver Needs & Strengths</i>								
Health	78	15	6	1	77	16	6	1
Supervision	53	30	14	2	55	32	12	1
Involvement	59	34	6	2	58	34	6	1
Social Resources	60	26	12	2	62	27	9	1
Residential Stability	80	14	5	2	82	14	3	1

VII. PARTNER PERSPECTIVES

The SASS program is designed to operate within the fabric of the children's mental health service system. In fact, one of the stated goals of the program is to improve the coordination of services within the system. As such, SASS services touch many people, and understanding the impact of the current SASS program should include some attention given to the perspectives of these various system partners. For the evaluation of the first year of the current SASS program, four perspectives were identified: parents/caregivers, SASS agencies/ programs, hospitals, and community behavioral health providers. For the second year, youth were also surveyed. This section of the evaluation presents the results of surveys designed to assess the experience of each of these partners within the first year of SASS. Clearly, other important perspectives exist, including the SASS worker's perspective, school's perspective, etc., but time and resources limit the ability to sample all perspectives annually.

Consumer Perspective---Youth and Parents/Caregivers

Method

SASS providers received parent and youth satisfaction surveys in March 2006 which they handed out to consumers. Surveys were in English and Spanish, for parents/caregivers and for youth under 12 and 12 and older. Surveys were accepted until May 1st. Results of these surveys follow.

Findings

Parent Survey Responses

Surveys were distributed to 2,654 parents and 234 were returned for a response rate of 9%. This is a relatively low response rate but one to be expected given the method used. Multiple mailings to parents would be too much of a burden for agencies and NU direct contact with families would be a violation of HIPAA regulations. Of the surveys returned, 220 were English and 14 were Spanish. There were 67 responses from the Central Region; 61 from Cook; 38 from Northern; and 58 from Southern. The largest group of respondents -- almost half (48.3%) -- had children who received services 1-3 months ago. The most frequent age group served overall was 10-14 year olds (46.3%) followed by 15-17 year olds (37.9%). Overall about half the children served were male and half were female, but for the Spanish surveys, more females were served (64.3%). There were also differences in race. The majority of those filling out Spanish surveys (64.3%) chose "Other" with over half writing in "Hispanic." Overall, about 40% of the sample identified themselves as White, about 47% as Black, and almost 12% as "Other."

In this report, those who answered the English survey are referred to as "English-speakers" and those who answered the Spanish survey as "Spanish-speakers." Language and race/ethnicity overlapped but not completely. Only about 18% of the full sample identified themselves as of Hispanic origin compared to almost 93% of Spanish-speakers. Over 92% of English-speakers, but no Spanish-speakers, said English was their primary language. On the other hand, 64.3% of Spanish-speakers said Spanish was their primary language (vs. 8.7% of English-speakers). Respondents were asked about their relationship to the child: 66.1% of the sample (but over 85% of Spanish-speakers) were

biological parents. Over 12% of English-speakers, but none of the Spanish-speakers, were adoptive parents.

Respondents were asked a series of questions about their satisfaction with elements of the SASS program. Spanish-speakers tended to rate items more positively than English-speakers. Overall, most respondents gave favorable ratings. The lowest rated items in Getting SASS Services still had over 85% “good” or “excellent” responses. Positive responses in Appropriateness and Sensitivity were slightly higher. One item – the SASS worker’s ability to speak the language – was rated 99.1% “good” or “excellent.” Compared to the other categories, Outcomes fared less well in consumer satisfaction, which was also true in FY05. It appears that agencies are doing well as reported by parents in *coordinating current services* and *linking to new ones* (new items). Finally, in Global Satisfaction, satisfaction was high, but overall quality of services received higher positive ratings than parents’ satisfaction with the outcome of services. It appears that parents give SASS programs credit for good faith efforts to help even if that help is not always effective.

Parent Comments

Parents were given the opportunity to give specific suggestions on how to improve SASS, to describe any aspects of SASS services that they thought were good, or to make any comments in general. Comments could be grouped into 12 themes:

Category	Number of responses
Pleased with SASS services	42
Praise for SASS workers	33
Need for longer service period	11
Challenges with SASS staff	9
Negative experience with SASS	7
Desiring more services	6
Expressing gratitude in learning how to better handle child	5
Wanting better communication with SASS about their child	4
Issues with slow response by staff	3
Needing more workers or staff	2
Too early to assess since services were ongoing	2
None/no comment	5

Statewide, every region received positive remarks from parents regarding overall services and specific caseworkers within agencies, and every region had requests for longer service periods beyond 90 days. There were also a few region-specific differences. The Northern region received the most positive responses from parents regarding SASS services and praise for SASS workers. The Central region received the most responses about the need for improved communication and more intensive services. Cook County received the majority of comments from parents wanting longer service periods. Almost half of the comments about challenges with SASS staff came from the Southern region.

Comparison to FY05

Looking at the survey responses overall, *there has been an improvement in parent satisfaction this year, with an increase in good or excellent responses on every item in every category, with a substantial increase in some cases.*

Youth Survey Responses

This year the SASS youth population was surveyed for the first time. Four survey versions – two age-related (under 12 and 12 and older), both in English and Spanish – were created and reviewed. These surveys shared common questions (for comparison) but targeted specific age-groups. The under 12 survey could be taken independently by the older youth in that age group; for the younger youth, parents were instructed to read the questions and write down the youth's answers. Surveys were sent out to 2804 youth and 249 were returned for a response rate of 9%. Of the 249, 241 were English and 8 were Spanish (all 12 and older); 175 were youth 12 and over and 74 were youth under 12. The only demographic information asked of respondents was age. Slightly less than half of all youth responding to the survey were in the 10-14 age range.

Respondents were then asked a series of questions about their satisfaction with elements of the SASS program. As with the parent survey, Spanish-speakers tended to rate items more positively than English-speakers. In general, youth involved in SASS have had positive experiences with the program. The majority believe that the SASS worker was nice and helpful; they were involved in treatment decisions; and they are doing better now than when they first entered SASS. Overall, older youth are more likely to be involved in making decisions about their treatment than younger youth. Older youth are also more likely to feel more positive about their interactions with the SASS worker and to feel that they are doing better since starting the program, whereas younger youth do not appear to be as clear about what they have gained from the program. Both groups rate their overall satisfaction with the program at about the same high level.

Youth Comments

There were a number of open-ended questions on the survey. Youth 12 and over were able to provide a description of what happened if they thought the SASS worker was disrespectful. They were also able to give comments about how they were doing now compared to when they began the program, in addition to their rating. Both groups were asked to describe what they liked and did not like about their experiences in SASS. And then both were given the opportunity to provide more feedback at the end of the survey.

Youth 12 and over

Youth were asked to tell us what happened if they did not think the SASS worker was respectful: only 15 youth (out of 158 respondents) responded to this question and only five of those thought the worker was not respectful. They were then asked how they are doing now compared to before they met with SASS. The most common response was they felt better. Next they were asked what they liked most about their experience in SASS. Frequent responses included having someone to talk to and positive comments about the SASS worker. Youth were also asked what they liked least about their experience in SASS. Almost half of the 117 responses to this question were nothing or

N/A (56). Finally, they were given space for additional comments about their SASS experience. Most gave positive feedback or noted nothing or N/A.

Youth under 12

Youth were asked what they liked most about their experience in SASS. Most responded they liked the SASS workers. Next they were asked what they did not like about their experience in SASS. The most common answer was disliking nothing. Finally, youth were given space for additional comments about their SASS experience. Comment categories included no comments and satisfied with SASS program.

All Youth

Overall, youth expressed common experiences and feelings about their involvement in SASS that crossed age lines. They had similar likes of the program (e.g., the SASS worker, having someone to talk to, and the activities) regardless of age, and similar dislikes of the program, when this was expressed (the majority of respondents of all ages disliked nothing; other dislikes included having to talk; the doctor/hospital; and needing more time in SASS). When it came to additional comments, youth in the 12 and over age group were more likely to write in comments, but youth of all ages tended to give positive feedback about their experiences in the program.

Summary

It is clear from parent and youth survey results that, in general, both groups found that their involvement with SASS was a positive experience and that they were helped. Given the small sample size, findings must be qualified; however, there appears to be a strong trend that consumers of SASS services believe that the program is effective.

SASS Program Perspective

Method

Informational letters and SASS provider satisfaction surveys were sent out to the chief executive officer (CEO)/executive director and the program director of 52 SASS agencies and subcontractors in mid-February 2006.

Findings

Survey Responses

Thirty-one CEO/executive directors and 36 program directors returned completed surveys, for a response rate of 60% and 69% respectively (an increase from the FY05 rate of 54% and 60%, respectively). There were surveys from all regions (3 from Cook; 7 from Northern; and 10 each from Central and Southern). For both categories of respondents, the median number of full-time SASS workers was 3. The median number of part-time SASS workers in agencies was reported as 0 by CEOs and .25 by program directors. The median number of SASS referrals to the agency in the last full month was reported as 12 by CEOs and 33 by program directors.

Overall, CEOs and program directors were generally satisfied with the responsiveness of the CARES line and the timeliness and completeness of referrals. CEOs were concerned about their ability to recruit SASS workers and program directors were less satisfied with

the appropriateness of CARES referrals. Both were concerned about the clarity of rules for SASS. Not surprisingly, CEOs were dissatisfied with the speed and amount of reimbursement from the state, while program directors were dissatisfied with their ability to recruit and retain good staff and the financial viability of the program. This finding is consistent with FY05 results. The majority of CEOs and program directors continue to see the fit between the SASS business model and clinical model as a poor or fair fit. They also see an increased burden of the Northwestern evaluation, likely due to the introduction of the SASS websystem in November 2005. However, the majority rated support for training and technical assistance and the evaluation team's responsiveness to their concerns as good or excellent, and program directors were generally satisfied with SASS outcomes. Respondents believe their agencies are providing quality services, and most are satisfied with the SASS program overall.

This year there were new questions for program directors relating to coordination of and linkage to services, and to the new SASS websystem. Providers are still adjusting to use of the website, which requires completion of various forms online rather than on paper; in addition, the website moved certain processes (such as transfer of clients between SASS providers) from paper to online, and providers are still becoming familiar with this new way of working.

Comparison to FY05

Looking at the survey responses overall, *there has been an improvement in CEO/Executive Director and Program Director satisfaction this year.* All categories showed some improvement and most survey items also showed improvement. Overall satisfaction was high, with both CEOs and program directors satisfied with the overall quality of services the agency provides and with the SASS program generally.

Hospital Perspective

Method

A list of 225 hospitals was identified and hospitals with contact e-mail addresses received an introductory e-mail confirming contact names and letting the person know they would be contacted in a week. Surveys were conducted by phone starting April 3rd and ended the first week of May. Results of these surveys follow.

Findings

Survey Responses

The evaluation team was able to contact 140 hospitals, for a response rate of 63%. This was lower than last year's response rate of 79%. Of these, 60 felt they did not have experience with SASS, serving kids or emergencies, and 80 provided interviews (two people were unknowingly interviewed from the same hospital for 81 responses). Of the 80 hospitals, 36 were from Cook County; 20 were from the Central Region; and 12 each from the Northern and Southern Regions. Compared to last year, a smaller percentage of hospitals in the survey admitted children (29% v. 63%), though the actual number of hospitals was about the same (23 v. 22). Most respondents fell into five general categories: nursing staff; clinical directors; coordinators/managers; social workers; and therapists/clinicians.

General findings

CARES

Respondents were asked a series of questions about their experiences with CARES. Almost 39% said they had frequent or very frequent contact with CARES; about 26% had somewhat frequent contact, while 35% had infrequent or no contact. Almost 75% of respondents were satisfied or extremely satisfied with their ability to access CARES. Almost 80% of respondents rated their satisfaction with CARES as good or excellent.

In addition to ratings, respondents were asked about their likes and dislikes of CARES. Responses are shown in the table below.

Hospital likes and dislikes about CARES

Likes	#	%	Dislikes*	#	%
CARES quick response	23	20.7	Nothing (i.e., no dislikes)	24	22.4
Positive feedback on CARES staff	13	11.7	General inconvenience to call CARES	12	11.2
CARES service provision	11	9.9	Not responsive enough	10	9.3
Helped hospital’s clinical operations	9	8.1	Adds time to assessment process	7	6.5
Helped clients	7	6.3	Asks too many/unnecessary questions	6	5.6
Easy to contact and access	7	6.3	Having payment tied to the call to CARES	5	4.7
Liked CARES overall	7	6.3	Lack of follow-up with hospital/ SASS	5	4.7
Informative	4	3.6	Complaints about staff	5	4.7
Has improved	4	3.6	Staff poorly trained/educated	4	3.7
Speedy dispatch of workers	3	2.7	Confusion with client’s insurance	3	2.8
SASS-related comments	5	4.5	No clear guidelines	3	2.8
No opinion	13	11.7	SASS-related comments	3	2.8
Nothing	5	4.5	No answer	11	10.3

* The remainder of comments did not fall into specific categories.

There were also many suggestions on how to improve CARES, including speedier response to calls and eliminating CARES; many respondents also answered that they had no suggestions.

SASS

Respondents were also asked questions about their experience with SASS. Eighty-five percent of respondents had frequent/daily contact with SASS; almost 10% had occasional contact; and the remaining 5% had little or no contact with SASS. The most often mentioned types of contact were calling CARES; talking to or meeting with the SASS worker; discharge planning/attending staffings; and follow-up services. Respondents were also asked about their satisfaction with the timeliness of the SASS response and proposed reasonable response times. Over 66% of respondents were satisfied or extremely satisfied with SASS response time. Slightly more than 19% were neutral and slightly more than 14% were dissatisfied or extremely dissatisfied. About half thought response time from SASS should be 60 minutes or less; a little over 30% felt a reasonable response rate was between 60 minutes and four hours; and 9% said between 12 and 24 hours. Respondents were asked their opinion of the overall quality of the SASS program: about 80% thought the SASS program was good or excellent.

Respondents were also asked what they liked and disliked about the SASS program. The largest group of responses was no suggestions for improvement. Next was a speedier response and increasing the number of SASS staff.

Hospital likes and dislikes about SASS

Likes*	#	%	Dislikes*	#	%
Services provided	22	16.8	Nothing	24	21.6
SASS is helpful	17	13.0	Increased wait time	13	11.7
SASS workers/ program	14	10.7	Lack of responsibility/involvement/ availability of SASS worker	9	8.1
Continuity of care	7	5.3	No need for CARES or SASS	6	5.4
Good communication	7	5.3	Response time	6	5.4
Does the assessment	7	5.3	Inconsistencies among agencies	5	4.5
Provides follow-up	7	5.3	Lack of follow-up	5	4.5
Focus on kids	6	4.6	Non-SASS kids not receiving same quality of care as SASS kids	5	4.5
Good teamwork	6	4.6	Increased work for hospital	5	4.5
The idea of the program	5	3.8	SASS refuses to hospitalize child	5	4.5
Community/at-home care	4	3.1	Lack of communication	3	2.7
Discharge plan	4	3.1	Discharge box is linked to payment	3	2.7
Response time	4	3.1	N/A	6	5.4
Thorough	3	2.3	No answer given	4	3.6
Saves hospital time	3	2.3			
N/A	5	3.8			

*The remainder of comments did not fall into specific categories.

In addition to their opinions on CARES and SASS, respondents were asked about the impact of changes in the SASS program since July 1, 2004 on the children and families they serve and on their clinical operations. Almost a third of respondents thought that the changes had no impact on children and families. About 29% of respondents thought there was a positive impact as a result of the changes. About a quarter of respondents thought there was a negative impact. Thirty-eight percent of respondents said the changes in the SASS program had no impact on their clinical operations. Almost 17% described positive impacts while about a quarter of respondents described negative impacts.

Impact of the SASS program on children and families served by the hospital and on the hospital's clinical operations

Impact on Children and Families*	#	%	Impact on Clinical Operations*	#	%
No impact	30	29.7	No impact	35	38.0
Increased wait time/delayed access to services	9	8.9	Increased wait time/treatment delays	6	6.5
Better care/continuity of care	8	7.9	Time consuming/administrative burden	5	5.4
Uninsured can now receive/guaranteed services	5	5.0	Had to learn new policies/procedures	4	4.3
More resources/services accessible/available	5	5.0	Decrease in hospital staff time/ involvement/ resources	3	3.3
Helpful to/positive experience for families	4	4.0	SASS provides helpful services	3	3.3
Burdensome to families	3	3.0	More lengthy evaluation process	3	3.3
Can't answer	13	12.9	Can't answer	8	8.7

*The remainder of comments did not fall into specific categories.

New this year, respondents were asked to list the types of kids their hospital best served as well as the types of kids their hospital is less well-equipped to serve. About 26% stated that they were best able to serve children with mental illness/psychiatric issues. Almost 12% best serve children with a dual diagnosis, and about 9% handle children with medical/medically complex or chronic medical needs. On the other hand, hospitals also acknowledged that there were some types of children they were not able to serve well. About 13% listed mental illness/psychiatric treatment and children 5 and under as groups they were less well-equipped to serve. Ten percent of hospitals are less able to serve dual disorder children or children in general (age 6-12). And almost 9% of hospitals stated that they can serve all children.

Findings by Region

CARES

Cook region was most likely to have frequent or very frequent contact with CARES, while the Southern Region was most likely to have infrequent contact with CARES. While the Central Region was most satisfied with the ease of accessing the CARES line, no respondents in either the Northern or the Southern Regions were dissatisfied. All respondents in the Northern region thought the quality of CARES was good or excellent, while only slightly more than half of respondents in the Southern Region thought so.

There were also differences in the likes, dislikes, and suggestions regarding CARES.

Top 3 Likes, dislikes and suggestions regarding CARES, by region

Top 3	Central	Cook	Northern	Southern
Likes	Quick response	Quick response	Quick response	Helps hospital's clinical operations
	Services that CARES provides	Positive characteristics of CARES staff	Services that CARES provides	SASS-related comments
	Helps clients	Can't answer/no opinion	Likes CARES overall	Quick response
Dislikes	Nothing	Nothing	Nothing	Nothing
	General inconvenience of calling CARES	N/A/can't answer	General inconvenience of calling CARES	General inconvenience of calling CARES
	Poorly trained/educated staff	Lack of follow-up with hospital & SASS	Not responsive enough	Not responsive enough
Suggestions	None	None	None	None
	Can't answer/no opinion	Can't answer/no opinion	Speedier response to calls	Eliminate CARES
	Improve payment procedures	Eliminate CARES	Can't answer/no opinion	Make CARES line easier to use

SASS

There were also regional differences regarding SASS. Cook was the least satisfied with the timeliness of the SASS response (58.4% satisfied or extremely satisfied compared to 70-75% for the other regions). For the majority of respondents in all regions except Northern, 60 minutes or less was the preferred response time of SASS. Only a third of Northern Region respondents thought this was necessary. Finally, satisfaction with SASS overall was high and similar to ratings for CARES. All Northern Region respondents rated the quality of SASS as good or excellent; the other regions' ratings ranged from 70-85%.

There were regional similarities and differences among hospitals regarding likes and dislikes.

Top 3 Likes, dislikes and suggestions regarding SASS, by region

Top 3	Central	Cook	Northern	Southern
Likes	Services provided by the program	Helpful	Services provided by the program	Services provided by the program
	Focus on kids	Services provided by the program	Helpful	SASS workers/program
	Continuity of care	SASS workers/program	Does the assessment	Helpful
Dislikes	Nothing	Nothing	Nothing	Nothing
	No need for CARES or SASS	Lack of responsibility/ involvement/ availability of SASS worker	Increased wait time	Increased wait time
	Increased wait time	Increased wait time	Concerns about non-SASS kids receiving same quality of care as SASS kids	Attitude problems
Suggestions	None	None	None	None
	Decrease response time	Decrease response time	Needs more SASS workers	N/A
	Needs more SASS workers	Increase responsibility/ involvement/ availability of SASS worker	Better training for workers	Decrease response time

Next the differences in the impact of the SASS program on children and families and clinical operations were assessed.

Top 3 Impacts on children and families and hospital clinical operations, by region

Top 3	Central	Cook	Northern	Southern
Impacts on Children & Families	None	None	None	None
	Better care/continuity of care	Increased wait time/delayed	Can't answer	Can't answer

		access to services		
	More available/accessible resources/services	Can't answer	Uninsured can now receive/are guaranteed services	Uninsured can now receive/are guaranteed services
Impacts on Hospital Clinical Operations	None	None	None	None
	Time consuming/administrative burden	Can't answer	Can't answer	Increased wait time/delayed access to services
	More lengthy evaluation process	Had to learn new policies & procedures	Improved discharge planning	Had to learn new policies & procedures

Finally, there were some regional trends in the ability of hospitals to serve different types of kids. The Southern Region had the highest percentage of hospitals that could serve all types of kids (almost 29%) compared to Cook, which had the lowest (about 7%). All regions had hospitals which specialized in mental illness/psychiatric issues but this too varied, from 33.3% (Northern) to 21.4% (Southern). There were also regional differences in children that hospitals were less equipped to handle. Twenty percent of Southern Region hospitals reported being ill-equipped to handle mental illness/psychiatric treatment (compared to about 7% of Cook hospitals). Across regions, hospitals reported not being able to serve various ages of children: for children 5 and under, from 20% of Southern hospitals to about 9% of Cook hospitals; for children ages 6-12, it was 13% for Northern, down to 9% for Cook; the same pattern was evident for serving adolescents. Another population that cut across regions serving children with dual disorders – 9-10% of hospitals in every region thought they were ill-equipped to handle this population.

Findings by Hospital Type

The following facilities were surveyed: 37 general hospitals without psychiatric units; 20 general hospitals with psychiatric units; 17 general hospitals with child and adolescent (C&A) units; and 6 psychiatric hospitals with child and adolescent units were surveyed. Overall, it appears that the hospitals that access CARES the most (psychiatric hospitals in Cook County) are least satisfied with CARES. Hospitals that do not use CARES as much, such as general hospitals without psychiatric units, tend to feel more neutral about CARES or less satisfied than general hospitals with psychiatric or C&A units. General hospitals without psychiatric units were more likely to say they did not have an opinion or could not answer when asked what they liked about CARES. A similar pattern occurred for SASS satisfaction. Psychiatric hospitals with C&A units were the least satisfied of all hospital types with the timeliness of the SASS response and the overall quality of SASS. They were also more likely to propose a quicker response rate than the other hospital types. Interestingly, general hospitals with C&A units were most likely to be satisfied with SASS' response and with SASS overall.

There were also differences in impact on children and families and hospital clinical operations.

Top 3 Impacts on children and families and hospital clinical operations, by hospital type

Top 3	General hospital w/C&A unit	General hospital w/o psych unit	General hospital w/psych unit	Psychiatric hospital w/C&A unit
Impacts on Children & Families	None	None	None	Increased wait time/delayed access to care
	More availability/access to resources/services	Can't answer	Can't answer	Burdensome to families
	Better care/continuity of care	Better care/continuity of care	Increased wait time/delayed access to care	None
Impacts on Hospital Clinical Operations	None	None	None	Increased wait time/delayed access to care
	Time consuming/administrative burden	Increased wait time/delayed access to care	Can't answer	More lengthy evaluation process
	Can't answer	Can't answer	Had to learn new policies & procedures	Reimbursement concerns

Comparison to FY05

Compared to FY05, there has been great improvement in overall satisfaction with the quality of CARES (from 52% good or excellent to almost 80%), which brings it to the level of satisfaction with SASS, up from last year. Satisfaction with the quality of SASS has also improved, from 66% good or excellent to about 80%. However, satisfaction with the timeliness of the SASS response has decreased from 71% satisfied or extremely satisfied in FY05 to about 66% this year. Similar feedback about CARES continues to be mentioned this year, including positive feedback about CARES workers; the need for a speedier response; and eliminating the line. Fewer respondents this year reported nothing to like about CARES, and there were fewer complaints about CARES staff qualifications. More respondents this year noted an inconvenience of calling CARES and CARES not being responsive enough. Feedback similar to last year also appeared with SASS, including positive feedback about the SASS workers and the program; liking the follow-up services and discharge planning; liking the idea of the program; and noting increased wait time. More respondents noted that there was nothing they disliked about the program and more complained about the lack of involvement/availability of the SASS worker and response time. Respondents continued to comment on liking the services SASS provides and thinking SASS is helpful. About the same amount of respondents this year as last year thought that SASS workers needed better training.

Regarding impact of the program on children and families, more respondents this year said that there was no impact or they could not say. About the same number as last year noted increased wait times while fewer noted confusion for families. New this year, respondents expressed a belief that the uninsured are now guaranteed services and noted better care or continuity of care. More respondents this year noted that the SASS program

has not had an impact on clinical operations. Although about the same number as last year thought the program was time consuming and an administrative burden, there were fewer concerns about increased cost, reimbursement issues.

Summary

In general, hospital representatives are satisfied with CARES and SASS. Hospitals in the Central and Northern Regions appear to be most satisfied with the program. By hospital type, psychiatric hospitals continue to be less satisfied with CARES and SASS than other hospital types. This year general hospitals with C&A units tended to be most satisfied with CARES and SASS, which is a change from last year. It is possible that SASS staff have been able to build relationships with these hospitals, resulting in those hospitals seeing the benefits of the SASS program and staff.

Community Provider Perspective

Method

Community Mental Health Providers (CMHPs) were identified and surveys were sent April 1st to each agency's Executive Director. Results of these surveys follow.

Findings

Survey Responses

Surveys were mailed out to 67 executive directors of CMHPs; two were undeliverable and 31 returned, for a response rate of almost 48% (compared to 52% in FY05). There were surveys from all regions. The median number of full-time therapists/counselors was seven and for part-time it was three. The median number of contacts with CARES was four calls in the last full month.

Overall, CMHPs were satisfied with CARES' responsiveness to their agency but less so with the clarity of rules for SASS services and the responsiveness of the State to any concerns about CARES or SASS. New this year was a question about services available for 18 to 20-year olds, and overwhelmingly they were unhappy with service availability. Respondents generally felt that SASS workers were sensitive to the child's needs and spoke in the family's language; that children, families and the agency's own staff were treated with respect; and that the SASS workers were able to perform assessments (new question this year). CMHPs felt less included in the planning process. They generally thought that SASS services made a positive impact on the child's safety, but only half of respondents were satisfied with other outcomes. Most were satisfied overall with CARES and SASS.

Comments

Respondents had an opportunity to give specific suggestions on how to improve SASS, to describe any aspects of SASS services that they thought were good, or to make general comments. Communication/coordination was the most common response, followed by lack of resources. Other categories included dissatisfaction with SASS agencies; training issues; quality of/discrepancies with information collected; dissatisfaction with CARES; unhappy with billing/ reimbursement; and did not receive/have not recently received

SASS referrals. There were a few regional differences; for example, only respondents from the Southern Region commented on issues with data quality and discrepancies.

Comparison to FY05

Overall satisfaction improved on many measures from FY05 to FY06. Two items worsened (timeliness/completeness of CARES referrals and involvement in care planning) and one stayed about the same (overall quality of the interactions with CARES).

Summary

Community mental health providers have been the least satisfied of all the SASS partners we have surveyed in the last two years. This year, satisfaction with SASS has improved, though areas of dissatisfaction have remained.

VIII. SUMMARY AND RECOMMENDATION

Summary

The totality of the evaluation data presented above suggests that the CARES line and the SASS program for all Medicaid eligible children and adolescents continue to be a success. The SASS program was successful in FY05 and, on many performance indicators, was even more effective in FY06:

- A substantial number of children and adolescents have been served. This number has increased during FY06.
- Parents and youth are generally pleased with the services.
- SASS providers feel that they are able to deliver a high-quality product.
- Other system partners are generally satisfied with SASS.
- Decision-making with regard to the use of intensive community services and psychiatric hospitalization appears to be rational and this rationality is improved from last year.
- Outcomes are generally good. Intensive community interventions appear to be particularly effective at reducing symptoms and risk behaviors and improving functioning.

There do appear to be some areas for continued improvement. These can be summarized as follows:

- Non-SASS providers who also serve children and adolescents do not always feel included in the SASS service delivery process.
- SASS providers have some concerns about the structure and functioning of the business model and some have continued to struggle in their shift to a fee-for-service model. This problem is mostly identified by agency directors whereas program directors reported significant improvements from FY05 to FY06.
- Variation across providers in terms of both decision-making and outcomes suggests that the SASS model still has not been consistently implemented across the state.

SASS in the context of the child serving system

Understanding the role and effectiveness of SASS must ultimately be done within the larger context of the child service system. While the focus of the present evaluation is within the episode of care for children and youth served by SASS, there are some findings that have relevance for a more contextual understanding of SASS services.

There is a body of research that suggests that the threshold for psychiatric hospitalization is lower for rural children and youth than for those living in urban areas. The explanation of these findings is that services are often less available in rural areas; this results in the hospital becoming the only viable service option in some cases. In the present evaluation, the opposite effect was observed. In Illinois, the rate of low risk

admissions is actually higher in urban areas where community services are likely more readily accessible. The possible explanation of this effect is that SASS comes with services in rural areas. That is, SASS workers can provide mobile community stabilization services even in areas that do not have other service options. This feature appears to mediate the rural effect reported elsewhere.

The continuing higher threshold for African American and Hispanic youth into SASS suggests that racial disparities may exist in community services in Illinois. There is little evidence that SASS as a program suffers racial disparities once a referral is made; however, the referral into SASS does appear to be affected by a youth's race. The solution to this problem is far broader than the SASS program and requires a comprehensive approach to the identification and referral of behavioral health challenges in all communities in Illinois.

Although they are not included in this present evaluation, several completed ad hoc analyses demonstrate that the child or youth's living arrangement has an impact on SASS's ability to provide stabilization services. Specifically, youth in residential treatment appear to actually have a somewhat lower threshold into the hospital relative to those living in the community. This finding is counter-intuitive in that one could reasonably expect that residential treatment providers should be better able to handle behavioral challenges. However, there are a number of programmatic and economic factors that actually favor hospitalization. Therefore, it appears that these issues may over-ride good clinical decision-making. These issues require further investigation.

One service context factor for which there is no current information is the relationship between SASS service experiences and connections with other community mental health providers. That question will be a focus of future exploration as a primary goal of SASS should be reintegration of a child or youth with other community-based services regardless of whether community stabilization or hospitalization services were used during the SASS episodes.

Recommendations

While the evaluation effort this year has attempted to pull together data from multiple sources and address the most pressing questions with regard to understanding the impact of SASS on children and families, a number of questions remain unanswered. Among the topics that should be addressed through future evaluation efforts are the factors that influence hospital readmission, which service packages that are most effective with certain youths, the possibility of implementing a prospective decision support application with the CSPI, and better understanding of racial and cultural factors.

The results of the present evaluation indicate that SASS continues to be an effective program with a number of addressable issues identified that, if resolved, could lead it to be an even more effective program. Suggested FY07 priorities include improving communication and collaboration between all child-serving partners, and ensuring that all SASS providers understand and implement the fee-for-service business model in a fashion that supports the clinical model.

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Appendix A

10/20/2005

CHILDHOOD SEVERITY OF PSYCHIATRIC ILLNESS

Manual
Version 2.0

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Buddin Praed Foundation

A large number of individuals have collaborated in the development of the second version of the Childhood Severity of Psychiatric Illness tool. The CSPI-2 was developed based on work done using the Childhood Severity of Psychiatric Illness (CSPI) in collaboration with the New Jersey Division of Behavioral Healthcare as a component of the Division of Children's Behavioral Health Services. Along with the various Child and Adolescent Needs and Strengths (CANS) versions for mental health, developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CSPI is an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Buddin Praed Foundation to ensure that it remains free to use. For specific permission to use please contact Melanie Lyons of the Foundation. For more information on the **CSPI** contact:

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CHILDHOOD SEVERITY OF PSYCHIATRIC ILLNESS (CSPI)

The CSPI is a decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis that threatens their safety or well-being or the safety of the community. It is intended to be completed by the individuals who are directly involved with the crisis assessment. The form serves as both a decision support tool and as documentation of the identified needs of the child served along with the decisions made with regard to treatment and placement at the time of the crisis.

This tool is designed from a communication theory perspective. As such, the indicators are selected to represent the key information needed in order to decide the best intervention strategy for a child during a time of crisis. For each indicator, four levels are anchored in order to translate the indicator into a level of action. For the CSPI, these four levels can be generally translated into the following:

- 0** indicates no evidence or no reason to believe that the rated item requires any action.
- 1** indicates a need for watchful waiting, monitoring or possibly preventive action.
- 2** indicates a need for action. Some strategy is needed to address the problem/need.
- 3** indicates a need for immediate or intensive action. This level indicates an immediate safety concern or a priority for intervention.

In order to enhance the reliability of the CSPI, anchor points have been designed to facilitate the translation of levels of each indicator into the four action levels described above. It should be noted that these anchor points represent guidelines. Since it is not feasible to exhaustively define all circumstances that might fit a particular level, the assessor may use some clinical judgment to determine the rating when no clear choice is obvious. This judgment should be guided by a decision on the appropriate level of action required for the specific indicator.

A primary goal of this tool is to further communication with both the individual child and family and for the children's initiative system of care. As such, consistency and reliability in the use of this tool is important. Therefore, formal training is required prior to any staff completing this tool based on an actual crisis assessment.

Please note that a 24 hour window is used for the symptoms and risks. This window is just to remind the rater that the interest is in describing the child or adolescent's immediate needs in these regard. The use of the word 'history' in many of the ratings of '1' refers to lifetime history. In other words, if a youth attempted suicide five years ago but is not actively suicidal, a rating of '1' would be appropriate.

Definitions of Coding Criteria

RISK BEHAVIORS

<i>Check</i>	SUICIDE RISK <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History but no recent ideation or gesture.
2	Recent ideation or gesture but not in past 24 hours.
3	Current ideation and intent OR command hallucinations that involve self-harm.

<i>Check</i>	SELF-MUTILATION <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History of self-mutilation.
2	Engaged in self mutilation that does not require medical attention.
3	Engaged in self mutilation that requires medical attention.

<i>Check</i>	OTHER SELF HARM <i>Please rate the highest level from the past 24 hours</i>
0	No evidence of behaviors other than suicide or self-mutilation that place the child at risk of physical harm.
1	History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
2	Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3	Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk taking behavior.

<i>Check</i>	DANGER TO OTHERS <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History of homicidal ideation, physically harmful aggression or fire setting that has put self or others in danger of harm.
2	Recent homicidal ideation, physically harmful aggression, or dangerous fire setting but not in past 24 hours.
3	Acute homicidal ideation with a plan or physically harmful aggression OR command hallucinations that involve the harm of others. Or, child set a fire that placed others at significant risk of harm.

<i>Check</i>	SEXUAL AGGRESSION <i>Please rate the highest level from the past 24 hours</i>
0	No evidence of any history of sexually aggressive behavior. No sexual activity with younger children, non-consenting others, or children not able to understand consent.
1	History of sexually aggressive behavior (but not in past year) but child has not engaged in sexually aggressive behavior for the past year OR sexually inappropriate behavior in the past year that troubles others such as harassing talk or excessive masturbation.
2	Child is engaged in sexually aggressive behavior in the past year but not in the past 24 hours.
3	Child has engaged in sexually aggressive behavior in the past 24 hours.

<i>Check</i>	RUNAWAY <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History of runaway from home or other settings involving at least one overnight absence, at least 30 days ago.
2	Recent runaway behavior or ideation but not in past 7 days.
3	Acute threat to runaway as manifest by either recent attempts OR significant ideation about running away OR child is currently a runaway.

<i>Check</i>	JUDGMENT <i>Please rate the highest level from the past 24 hours</i>
0	No evidence of problems with judgment or poor decision making that result harm to development and/or well-being.
1	History of problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being. For example, a child who has a history of hanging out with other children who shoplift.
2	Problems with judgment in which the child makes decisions that are in some way harmful to his/her development and/or well-being.
3	Problems with judgment that place the child at risk of significant physical harm.

<i>Check</i>	FIRESETTING <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History of fire setting but not in the past six months.
2	Recent fire setting behavior (in past six months) but not of the type that has endangered the lives of others (e.g. playing with matches) OR repeated fire-setting behavior over a period of at least two years even if not in the past six months
3	Acute threat of fire setting. Set fire that endangered the lives of others (e.g. attempting to burn down a house).

<i>Check</i>	SOCIAL BEHAVIOR <i>Please rate the highest level from the past 24 hours</i>
0	No evidence of problematic social behavior.
1	Mild level of problematic social behavior. This might include occasional inappropriate social behavior. Comments to strangers or unusual behavior in social settings might be included in this level.
2	Moderate level of problematic social behavior. For example, frequent cursing in public would be rated here.
3	Severe level of problematic social behavior. Child's social behavior places him/her at risk for serious sanctions (e.g. suspension, expulsion from school, loss of foster home) For example, threatening others would be rated here.

BEHAVIORAL/EMOTIONAL SYMPTOMS

<i>Check</i>	PSYCHOSIS <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or suspicion of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
2	Clear evidence of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
3	Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder which places the child or others at risk of physical harm.

<i>Check</i>	IMPULSE/HYPERACTIVITY <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	Some problems with impulsive, distractible or hyperactive behavior that places the child at risk of future functioning difficulties.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's ability to function in at least one domain.
3	Clear evidence of a dangerous level of impulsive behavior that can place the child at risk of physical harm.

<i>Check</i>	DEPRESSION <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or suspicion of depression or mild to moderate depression associated with a recent negative life event with minimal impact on life domain functioning.
2	Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain. This may include significant withdrawal, avoidance, or elective mutism.
3	Clear evidence of a disabling level of depression that makes it virtually impossible for the child to function in any life domain.

<i>Check</i>	ANXIETY <i>Please rate based on the past 24 hours</i>
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

<i>Check</i>	OPPOSITIONAL <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures.
2	Clear evidence of oppositional and/or defiant behavior towards authority figures, which is currently interfering with the child's functioning in at least one life domain. Behavior causes emotional harm to others.
3	Clear evidence of a dangerous level of oppositional behavior involving harm or threat of physical harm to others.

<i>Check</i>	CONDUCT <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or suspicion of problems associated with antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property or animals.
2	Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals.
3	Evidence of a severe level of conduct problems as described above that places the child or community at significant risk of physical harm due to these behaviors.

<i>Check</i>	ADJUSTMENT TO TRAUMA <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or suspicion of problems associated with traumatic life events.
2	Clear evidence of adjustment problems associated with traumatic life event/s. Adjustment is interfering with child's functioning in at least one life domain.
3	Clear evidence of symptoms of Post Traumatic Stress Disorder, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts of trauma experience.

<i>Check</i>	ANGER CONTROL <i>Please rate based on the past 24 hours</i>
0	No evidence of any significant anger control problems.
1	Some problems with controlling anger. Child may sometimes become verbally aggressive when frustrated. Peers and family may be aware of and may attempt to avoid stimulating angry outbursts.
2	Moderate anger control problems. Child's temper has gotten him/her in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.
3	Severe anger control problems. Child's temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

<i>Check</i>	SUBSTANCE USE <i>Please rate the highest level from the past 24 hours</i>
0	No evidence
1	History or suspicion of substance use.
2	Clear evidence of substance abuse that interferes with functioning in any life domain.
3	Child requires detoxification OR is addicted to alcohol and/or drugs. Include here a child/youth who is intoxicated at the time of the assessment (i.e., currently under the influence).

FUNCTIONING PROBLEMS

<i>Check</i>	LIVING SITUATION <i>Please rate the highest level from the past 30 days</i>
0	No evidence of problem with functioning in home-like settings.
1	Mild problems with functioning at home. Caregivers concerned about child's behavior at home.
2	Moderate to severe problems with functioning at home. Child has difficulties maintaining his/her behavior in this setting creating significant problems for others in the home.
3	Profound problems with functioning at home. Child is at immediate risk of being removed from home due to his/her behaviors.

<i>Check</i>	COMMUNITY <i>Please rate the highest level from the past 30 days</i>
0	No evidence of problems with functioning in the community.
1	Mild problems with functioning in the community. Child's behavior has raised the concerns of some community members and/or institutions.
2	Moderate to severe problems with functioning in the community. Child has difficulties maintaining his/her behavior to avoid sanctions from community members and/or institutions.
3	Profound problems with functioning in the community. Child is at immediate risk of being removed from the community.

<i>Check</i>	SCHOOL <i>Please rate the highest level from the past 30 days</i>
0	Child is performing well in school.
1	Child is performing adequately in school although some problems may exist.
2	Child is experiencing moderate problems with school attendance, behavior, and/or achievement.
3	Child is experiencing severe problems in school with school attendance, behavior, and/or achievement.

<i>Check</i>	PEER FUNCTIONING <i>Please rate the highest level from the past 30 days</i>
0	Child has healthy peer relationships.
1	Child is having some minor problems with his/her peers.
2	Child is having some moderate problems with his/her peers. This may include a limited number of peers or difficulties maintaining same age friendships.
3	Child is experiencing severe disruptions in his/her peers. This may include have very little social contact with peers or primary affiliation with a negative peer group (e.g. gang member)

<i>Check</i>	DEVELOPMENTAL <i>Please rate the highest level from the past 30 days</i>
0	Child has no developmental problems.
1	Child has some problems with physical immaturity or there are concerns about possible developmental delay. Child may have low IQ.
2	Child has developmental delays or mild mental retardation.
3	Child has severe and pervasive developmental delays or profound mental retardation.

<i>Check</i>	MEDICATION COMPLIANCE <i>Please rate the highest level from the past 30 days</i>
0	Child takes psychotropic medications as prescribed and without problems or child is not currently on any psychotropic medication.
1	Child will take psychotropic medications routinely, but who sometimes needs reminders to maintain compliance. Also, a history of medication noncompliance but no current problems would be rated here.
2	Child is somewhat non-compliant. The child may be resistant to taking psychotropic medications or may tend to overuse his or her medications. He/she might comply with prescription plans for periods of time (1-2 weeks) but generally does not sustain taking medication in prescribed dose or schedule.
3	Child and caregivers are not compliant with prescribed medications or child abuses prescription medication.

JUVENILE JUSTICE

<i>Check</i>	JUVENILE JUSTICE STATUS <i>Please rate the highest level from the past 30 days</i>
0	No current involvement
1	Status offense: Juvenile/Family conflict, in-county runaway, truancy, petty offenses.
2	Moderate juvenile delinquency: offenses against persons, offenses against property.
3	Felony criminal activity: serious offenses against persons or property (e.g. robbery, aggravated assault, possession with intent to distribute CDS, 1 st or 2 nd degree offenses.

<i>Check</i>	COMMUNITY SAFETY <i>Please rate the highest level from the past 30 days</i>
0	No evidence of any risk to the community from the child’s behavior.
1	Child has a history of presenting a significant physical risk to community members or a mild to moderate risk of other negative outcomes.
2	Child’s current behavior represents a moderate risk of physical danger or a significant risk of other negative outcomes.
3	Child’s current behavior represents a significant risk of physical danger to members of the community.

<i>Check</i>	DELINQUENCY <i>Please rate the highest level from the past 30 days</i>
0	No evidence
1	History of delinquency but no acts of delinquency in past 30 days.
2	Recent acts of delinquency.
3	Severe acts of delinquency that places others at risk of significant loss or injury or place child at risk of adult sanctions.

CHILD PROTECTION

<i>Check</i>	ABUSE OR NEGELCT <i>Please rate the highest level from the past 24 hours</i>
0	No evidence the child is at risk for physical or sexual abuse with current caregivers.
1	Child has a history of abuse with current caregivers but he/she is not currently at risk.
2	Child is at risk of abuse or neglect, must contact DYFS Protective Services.
3	Child at immediate risk of abuse or neglect and requires immediate protection.

***All referents are legally required to report suspected child abuse or neglect to DCFS.**

<i>Check</i>	DOMESTIC VIOLENCE <i>Please rate the highest level from the past 24 hours</i>
0	No evidence of domestic violence in family or household.
1	Child has a history of exposure to domestic violence but no current violence in the household.
2	Child is exposed to domestic violence in the household. DYFS Protective Services must be called.
3	Child is in danger due to domestic violence in the household. Child requires immediate protection.

CAREGIVER NEEDS & STRENGTHS

<i>Check</i>	HEALTH <i>Please rate the highest level from the past 24 hours</i>
0	Caregiver is generally healthy.
1	Caregiver is in recovery from medical, physical, mental health, or substance use problems or has mild or controlled health problems that have the potential to complicate parenting.
2	Caregiver has medical, physical, mental health, or substance use problems that interfere with their parenting role.
3	Caregiver has medical, physical, mental health, and/or substance use problems that make it impossible for them to parent at this time.

<i>Check</i>	SUPERVISION <i>Please rate the highest level from the past 24 hours</i>
0	Caregiver has good monitoring and discipline skills.
1	Caregiver provides generally adequate supervision. May require occasional help or technical assistance.
2	Caregiver reports difficulties monitoring and/or disciplining child. Caregiver requires assistance to improve supervision skills.
3	Caregiver is absent or requires considerable help to monitor or discipline the child. Caregiver requires immediate and continuing assistance. Child at risk of harm to self due to absence of supervision.

<i>Check</i>	INVOLVEMENT <i>Please rate the highest level from the past 24 hours</i>
0	Caregiver is able to act as an effective advocate for child.
1	Caregiver has history of seeking help for their children. Caregiver is open to receiving support, education, and information
2	Caregiver does not wish to participate in services and/or interventions intended to assist their child.
3	Caregiver wishes for child to be removed from their care.

<i>Check</i>	SOCIAL RESOURCES <i>Please rate the highest level from the past 24 hours</i>
0	Caregiver has significant family, friend or social network that actively helps family and child.
1	Caregiver has some family, friend, or social network that actively help with family and child.
2	Caregiver has some family friend, or social network that may be able to help with family and child
3	Caregiver has no family, friend, or social network that may be able to help with family and child.

<i>Check</i>	RESIDENTIAL STABILITY <i>Please rate the highest level from the past 24 hours</i>
0	Caregiver has stable housing for the foreseeable future
1	Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2	Caregiver has moved multiple times in the past year. Housing is unstable.
3	Caregiver has experienced periods of homelessness in the past six months.

Appendix B: Individual Comments from the Satisfaction Surveys

SASS CEO/Executive Director Comments: pp. 59-69

SASS Program Director Comments: pp. 70-83

SASS Community Mental Health Provider Survey Comments: pp. 84-87

SASS Hospital Survey Comments: pp. 88-117

SASS Parent Survey Comments: pp. 118-124

SASS Youth Survey Comments: pp. 125-157

**FY06 SASS CEO/Executive Director Comments
April, 2006**

Note: All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed.

Key to comments:

Barriers refers to the question: What are the barriers if your agency does not have a stated commitment to developing services for young adults (18 to 20-year olds)?

Primary Problems refers to the question: What are the three primary problems you encounter when trying to coordinate between child & adolescent and adult services?

Easiest Things refers to the question: What are the three easiest things to coordinate between child & adolescent and adult services?

Other Comments refers to the statement: Please include any other comments regarding providing SASS services to the 18 to 20-year old population here or in the box below.

Suggestions refers to the questions: What specific suggestions would you make to improve SASS services and/or what aspects of SASS are particularly problematic? What aspects of SASS are particularly excellent?

CENTRAL REGION

ED#3

Barriers:

No comments

Primary Problems:

- 1. Lack of adult services/long waiting lists/agencies not accepting referrals*
- 2. Adult services not geared toward 18 year olds*
- 3. Roadblocks with ICG clients-no placements available and what is available is not appropriate it*

Easiest Things:

- 1. Agencies are receptive (just don't have appropriate resources or programming)*

Other comments:

No comment.

Suggestions:

Work should be continued to steam-line the process. The web-based system is particularly cumbersome. Problems still exist with some community hospitals and physicians. For example, the hospital (psychiatrist) in our community has begun to secure admission prior to screening. Many of the program requirements are not fiscally supported in a fee-for-service system. However, many areas have demonstrated drastic improvement over the last year.

ED#4

Barriers:

Funding

Young adults are mobile and not interested in services

Primary Problems:

- 1. Available information regarding adult services*
- 2. Clarifying the programs with parents*

Easiest Things:

No comments

Other comments:

Some of the problem has been that the 18-20 yr old clients are not interested in active services

Suggestions:

The assessment program is excellent in making decision regarding safety. A problematic areas is parents who want service but refuse to sign consent to participate.

ED#16 (DUPLICATE OF ED#4)

ED#5*Barriers:*

No comments

Primary Problems:

- 1. Transportation in a small community with county so spread out*
- 2. Services in our area to outreach to-“Big Bro./Big Sisters” etc.*
- 3. Parent’s mental illnesses*

Easiest Things:

- 1. Counseling sessions*
- 2. Schools ability to help*

Other comments:

Services are not available to insurance holders even though insurance does not pay for SASS services. SASS services are not available unless medicare card!!

Suggestions:

Let services be available for people with insurance. Insurance doesn’t pay for SASS.

ED#11*Barriers:*

No comments

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

- Our SASS receivable is over 120 days*
- It is difficult to sort out SASS pmts from other public aid pmts.*
- Too much double work having to enter everything in your software and our software.*
- We should not have to do a cost report and other reporting for a fee for service program.*

ED#12*Barriers:*

No comments

Primary Problems:

- 1. Young adults willingness to follow through with services*

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

No comments

ED#13*Barriers:*

No comments

Primary Problems:

- 1. 18-20 y/o range refusal of services more frequent*
- 2. SASS therapist doesn’t help keep adults on caseload and after 3 months 20y/o clients would be reassigned.*
- 3. After hours staff frequently told by CARES staff that SAS does not include 18-20y/o*

Easiest Things:

- 1. Referral or adult services, crisis, and psychiatric services which can be mixed milieu or independently*
- 2. Crisis services are openly accessible to any person in need regardless of age*

3. no comments

Other comments:

I CARES workers often time give conflicting report if eligible or not. Personally somewhat confusing as 18 is legal age for adulthood and census.

Suggestions:

- 1. CAES workers often give conflicting information regarding 18-20 y/o eligibility*
- 2. CARES workers questions the "professional" judgments of the caller by asking inane questions that do not relate to information that is being given.*
- 3. The process is cumbersome, confusing, and conflictive and delays a process that is of critical importance.*
- 4. We have found nothing excellent about SASS-our agency provided excellent crisis intervention to all consumers. SASS has just made service to children/adolescents DIFFICULT.*
- 5. Another major problem is receiving the money for services rendered. The process is designed so that approx 50% rejected for various reasons. Upon review of rejections NO CAUSE can be found to justify the rejection in 85-90% of the cases.*

ED#14

Barriers:

How even 18-20y/o are not interested in the program

Primary Problems:

- 1. Explaining programs*
- 2. Obtaining consents*

Easiest Things:

No comments

Other comments:

Difficult

Suggestions:

No comments

ED#15

Barriers:

We have a commitment to servicing this age group and do so to the best of our availability. It is just not stated anywhere like in our mission statement if that what you are looking for. We serve all age groups and don't single them out.

Primary Problems:

- 1. Schools who have Children in specialized services who say the student needs residential placement. If they need it, why aren't they in it? DCFS plays a role here.*

Easiest Things:

- 1. In house referrals*

Other comments:

DCFS takes little responsibility for the 18 to 20 y/os who might need residential placement. Older adolescents don't seem to get the care they need.

Suggestions:

No comments

ED#22

Barriers:

No comments

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

No comments

ED32

Barriers:

Very little resources, nor expertise/competence with this population as well as the “funding silos” - “adult world”.

Primary Problems:

Unknown service systems

Easiest Things:

Unknown – clinical staff reported on this

Other comments:

No comments

Suggestions:

No suggestions

COOK

ED#6

Barriers:

No comments

Primary Problems:

- 1. Lack of program design to this age “adult”*
- 2. Need for family involvement with an “adult”*
- 3. Planning for transitions needs to begin earlier*

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

Some of the information requested from Illinois Outcomes is available from other sources (CARES). In a fee for service environment this non-billable service is distracting and costly. Staff also concerned about SSN and Mother’s maiden name being sent to IL outcomes. The entire model of fee for service (which was implemented much too abruptly by the state, resulting in financial distress for agencies) is in many ways antithetical to SASS and had resulted in increased volume served (which does look good statistically) but impacted negatively on quality of service.

ED#18

Barriers:

Currently we are a child focus agency.

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

Expand SASS coverage to all 18-21 year olds.

ICG compensation model is currently inadequate.

Too early to know if increased rates will be adequately cover costs.

ED#25

Barriers:

No comments

Primary Problems:

- 1. Interface between ROCS & DPA billing is not always clear*
- 2. Youth may be unfunded and service may not be available (particularly for youth from other areas)*

3. *Adult services are not as familiar w/SASS so continuity of care is less than coordinated Easiest Things:*

1. *It is helpful when an organization serves both adult and C&A population*

Other comments:

No comments

Suggestions:

- Lack of funding for administrative functions that are from SASS (i.e. entering demographic data/ web based CSPI).

- Still no payment for non-medicaid physician services (though we were told in Oct. 2005 that it would happen!)

- DHS/DCFS/HFS do not appear to be working together for the sake of the children. Still making decision on their own and still not working in partnership with stakeholders.

- SASS is a really great program when not micro-managed by the state.

NORTHERN REGION

ED#7

Barriers:

We already offer adult mental health services. The SASS staff could use more training on treating transitional youth. The adult services are more office based, not as intense. Transportation can be a barrier. Adult clinicians may see young clients are not as needy as out chronic MH population

Primary Problems:

1. *Intensity in Adult MH is less.*

2. *Case management services are given to the most severe/chronic cases due to limited funds available.*

3. *There are no adult flex funds to provide needed items and services*

Easiest Things:

1. *It is an internal referral and we know what adult services are available and who to contact*

2. *There are more psychiatric services available*

3. *The client is transferred to adult services so opening paperwork does not have to be repeated.*

Other comments:

Transition planning needs to begin around age 16 and extend past 21 for many clients

Suggestions:

1. For most clients, 90 days of service is inadequate to work with the multiple problems and areas of low functioning clients present. 2. We need to be paid for psychiatric services. It has been over 1.5 years and there is still no payment mechanism. 3. SASS is more time consuming to manage with double checking approvals, RIN #'s, reconciling billing etc., and reimbursement doesn't consider this overhead. The fact that services have been expanded to more youth is good.

ED#9

Barriers:

No comments

Primary Problems:

1. *Client & parent follow through.*

2. *Identifying funding source once SASS funding ends.*

Easiest Things:

1. *We provide both programs for adults & children/adolescents*

2. *Coordination between child and adult team works well. no comments*

Other comments:

No comments

Suggestions:

1. *The influx of emails is difficult to organize.*

2. *SASS manual does not address all issues that may arise from a clinical perspective*

3. *No clear point person for questions/consultation*

ED#17

Barriers:

No comments

Primary Problems:

- 1. Some services have lower outreach*
- 2. Wait for services*
- 3. Changes in rights @ age 19*

Easiest Things:

- 1. Accessibility to LCM*
- 2. Psychiatric Care*
- 3. Intra-agency services*

Other comments:

No comments

Suggestions:

No comments

ED#27

Barriers:

No comments

Primary Problems:

- 1. Lack of concrete services to address multi-faced needs of young, in particular housing issues.*
- 2. Some of the adult services are not as custom designed to meet the needs of youth/young adults and/or MISA clients.*

Easiest Things:

- 1. Access is a huge benefit, as SCI has all the services in-house.*
- 2. SCI housing addictions services in house is an additional huge benefit – MISA services protocol are TX in place.*

Other comments:

No comments

Suggestions:

- 1. Lack of inpatient psychiatric hospitals near our facility. Huge barriers to clients. Closest inpatient psychiatric hospital is 65 miles and beyond.*
- 2. Need for a wider continuum services for SASS youth, such as after school programs, day treatment programs, etc.*
- 3. Need for expanded funding to enhance follow-up outpatient services for youth who have completed SASS.*

ED#28

Barriers:

- 1. Lack of cooperation/collaboration with adult providers.*

Primary Problems:

- 1. Adult providers are reluctant to serve the “SASS” population of youth.*
- 2. Adult providers don’t know how to bill Medicaid.*

Easiest Things:

No comments

Other comments:

In Access to SASS Section:

The timeliness and completeness from CARES – The rules change every day.

The clarity of rules for SASS – I want to know if they are assigning a temporary RIN #.

In Evaluation of SASS Section:

Support for training and technical assistance – Trainings always the states agenda..

The responsiveness of the evaluation team to your concerns -- Feedback?? When can we expect more given the amount of unreimbursed time that it takes to give the data.

In Global Satisfaction of SASS Section:

The disconnect between the business model and best practices for this type of services is VERY disturbing.

Suggestions:

- Youths should be screened if at all possible by the SASS agency where the client resides not where the client presents.*
- 90 day time frame seems capricious and not tailored to meet the needs of the youth and family.*
- Offer an expanded array of non-medical services to families. It only takes money.*

ED#29

Barriers:

No comments

Primary Problems:

- 1. If there is a need for a change in therapy, there is often a few weeks wait to get if.*

Easiest Things:

- 1. All therapists are in the same building.*
- 2. Many child and adolescent therapists*

Other comments:

No comments

Suggestions:

No suggestions

ED#31

Barriers:

No comments

Primary Problems:

- 1. Lack of linkage to services & follow-up*
- 2. Lack of response to coordinate or collaborate services*
- 3. Lack of transportation services from the school district*

Easiest Things:

- 1. Outpatient therapy*
- 2. Hospitalization*

Other comments:

No comments

Suggestions:

Our collaborative work with provider agency's & competent SASS therapists make our program excellent.

Problematic – Concerns regarding additional data entry responsibilities required of SASS agencies without billing compensation.

SOUTHERN REGION

ED# 1

Barriers:

Payment for residential services which is usually the need Consumer sees program as children's program

Primary Problems:

- 1. Availability of services and resources*
- 2. Cooperation of consumer*
- 3. Lack of MISA expertise and/or substance abuse services*

Easiest Things:

- 1. Voluntary substance abuse treatment*
- 2. Availability of PSR and case management within our catchments area*

Other comments:

No comments

Suggestions:

Better assessment via the CARES line
Professional accountability for referrals (hospitals)
Streamline Illinois outcomes process

ED#2*Barriers:*

No comments

Primary Problems:

1. *Schedule availability*
2. *Co-operation from Clients*
3. *no comments*

Easiest Things:

1. *Group services*

Other comments:

No comments

Suggestions:

No comments

ED#8*Barriers:*

We are a child welfare agency and this the only program we have at agency that is in this age group

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

Note in Evaluation of SASS Section-“Poor-Results to slow in regards to staff passing the test”

The biggest problems we have is finding resources for children and adult DD clients. Services to this population are almost nonexistent. The hospitals for this group are in Chicago. This area needs development.

FRD meeting is a gripe session. How about using the time for something more productive such as giving FRD’s training on things such as ADHD, bipolar, etc.

Thanks!

ED#19*Barriers:*

The 18-20 year olds fall under adult behavioral health. This is a completely separate system even within own agency. There is no programming to meet the specific needs of this population.

Primary Problems:

1. *Lack of recognition of transition needs*
2. *Lack of formal policy and procedures to facilitate this coordination*
3. *Difference in views of client accountability—what we do for clients as opposed to what we expect they do for themselves.*

Easiest Things:

1. *Substance abuse services can be provided in either adult or adolescent services when 18-21 y/o*
2. *Arranging psychiatric services*
3. *no comments*

Other comments:

No comments

Suggestions:

1. *For transfers from one provide to another there is a lag time for 3 business days. The accepting agency is reluctant, if not unwilling, to provide services until authorized for payment.*

2. *If a child is hospitalized within the 90 days—there needs to be a 90 day extension from date of re-admit.*

3. *Staff have commented about the ease of the web-based system.*

ED#20*Barriers:*

No comments

Primary Problems:

1. *We do not have psychiatric services*
2. *Adults may choose not to participate*

Easiest Things:

1. *We have child & adolescent services on site.*
2. *Adult Mental Health can offer medication, client transitional subsidy and other capacity grant services.*

Other comments:

No comments

Suggestions:

1. *Combine HSI & SASS websites*
2. *Increase funding to cover cost of services*
3. *Eliminate the requirement for family resource development for rural providers*
4. *Eliminate current length of stay requirement—90 days. Base length of stay on clinical appropriateness.*
5. *Issuing a RFP in A C&A LAN is unnecessary- Just renew with existing providers.*

ED#21*Barriers:*

Adequate funding. There is not enough funding in children's service to begin with much less add this burden. The state needs to commit the funds for this age group.

More specific training needs to occur.

Primary Problems:

1. *Speed of access to adult services*
2. *Lack of familiarity with each systems documentation*
3. *Lack of case management in adult outpatient service*

Easiest Things:

1. *We have both systems so there is easy access to staff consultation.*
2. *We can access psychiatric services due to proximity*
3. *Easy "handoff" from crisis staff.*

Other comments:

Could use separate funding and RFP process.

Suggestions:

CSPI process has many flaws and shouldn't be used for rating agencies. Consider looking at other options.

ED#23*Barriers:*

No comments

Primary Problems:

1. *18-21 y/o sometime don't function at adult level therefore sometimes don't follow through w/out parents*
2. *Often don't have resources to make it to outpatient services....like transportation.*

Easiest Things:

1. *We have adult services in-house, so very easy transition*
2. *No waiting list for adult services*
3. *SASS assessment can be used for outpatient services as well.*

Other comments:

No comments

Suggestions:

No comments.

ED#24*Barriers:*

These Pts are very difficult to link to services, parental support is frequently lacks. This age group requires constant case management.

Primary Problems:

- 1. None because my agency served both populations.*
- 2. Adult services is for not well equipped to handle this age group, because they are not compliant.*

Easiest Things:

- 1. Case management*
- 2. Multi-disciplinary staffing between the two departments.*
- 3. no comments*

Other comments:

1. Residential placement because majority of them lack parental support. 2. Medication compliance—need intensive case management

Suggestions:

The extension of SASS services needs to be re-evaluated because it is difficult to stabilize many cases in a short time period of three months.

*The SASS services should be extended to 6 months to allow family enough time to work with stabilization
The time requirement for clients to see psychiatrist is limited.*

ED#26

Barriers:

No comments

Primary Problems:

- 1. Difference in time frames*
- 2. Paperwork*

Easiest Things:

- 1. Provision of services once they start*
- 2. Transition out of hospitalization*

Other comments:

No comments

Suggestions:

-Keep looking at amount of time and travel and no-shows—doesn't fit well with the business model.

ED#30

Barriers: No comments

Primary Problems:

- 1. Available resources*
- 2. Tx compliance (client)*

Easiest Things:

- 1. Transfer process*
- 2. Identification of needs, strengths & preference*
- 3. Scheduling*

Other comments:

Lack of client willingness to receive services.

Suggestions:

No suggestions

MISSING REGION

ED#10

Barriers:

No comments

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

We are no longer a direct provider or work with CARES. Program demands made were too costly for a small county. We do only minimal billable service for a few referred children.

Suggestions:

No comments.

FY06 SASS Program Director Comments
April, 2006

Note: All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed.

Key to comments:

Barriers refers to the question: What are the barriers if your agency does not have a stated commitment to developing services for young adults (18 to 20-year olds)?

Primary Problems refers to the question: What are the three primary problems you encounter when trying to coordinate between child & adolescent and adult services?

Easiest Things refers to the question: What are the three easiest things to coordinate between child & adolescent and adult services?

Other Comments refers to the statement: Please include any other comments regarding providing SASS services to the 18 to 20-year old population here or in the box below.

Suggestions refers to the questions: What specific suggestions would you make to improve SASS services and/or what aspects of SASS are particularly problematic? What aspects of SASS are particularly excellent?

CENTRAL REGION

PD#2

Barriers:

No comments

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

No suggestions

PD#3

Barriers:

1. *lack of income, resources and manpower*

Primary Problems

1. *Local mental health will not open until SASS eligibility ends*
2. *Lack of services that are comparable to C/A services w/the same requirements*
3. *Lack of living stability makes coordinating services very difficult*

Easiest Things:

1. *Oftentimes the same community mental health providers for C/A are the adult providers*

Other comments:

No comments

Suggestions:

Particularly problematic:

Lack of psychiatric resources to meet SASS client's medication needs both during and following SASS sessions.

Particularly excellent:

The impact on keeping children/adolescents and young adults safe.

There has been significant support from state dependents and the ability for SASS providers to be involved in the evolution of SASS.

PD#9

Barriers:

No comments

Primary Problems:

- 1. No SASS-like program for children & adolescents with private insurance (which does not pay for intensive home based services).*
- 2. Sometimes the SASS clinician would like to keep the child in program 120, but schedules will not allow it so the therapeutic relationship must be reestablished with a new clinician.*

Easiest Things:

- 1. We have an excellent access to services system so we have no problems in this area.*

Other comments:

Adult in-pt. units are not familiar (used to) doing the case coordination activities involved w/SASS, which makes it more difficult to monitor & coordinate discharge.

Suggestions:

- 1) Expand SASS to 129 days to allow more time to assist these families. Do not include hospital time in the SASS time.*
- 2) Eliminate the 1 month only extension rule. Some SASS consumers quickly present with issues after discharge from SASS.*
- 3) Travel time is not reimbursed but is considerable in large geographic areas.*
- 4) Services are provided in the community & at an intensity level that these families need. This is what makes SASS great.*
- 5) The Family Resource Developer is a wonderful addition to SASS, but supervision of this person is time consuming. The FRD has too many mandatory meetings (monthly & quarterly) which takes her away from working with families. FRD meetings should be no more than quarterly.*

PD#11

Barriers:

No comments

Primary Problems:

- 1. All due to a lack in available services /long waiting lists etc.*

Easiest Things:

- 1. Adult providers are receptive to working with us.*

Other comments:

This population should be served with other young adults in an additional service system directed specifically at this population (in addition to SASS services). The C&A and adult systems are both inappropriate for these youth at times.

Suggestions:

There have been dramatic improvements over the last year and a half. Only minor issues seem to exist at this point.

PD#19

Barriers:

No comments

Primary Problems:

No comments

Easiest Things:

- 1. Linkage to services has not been a problem*

Other comments:

No comments

Suggestions:

No suggestions

PD#21

Barriers:

No comments

Primary Problems:

- 1. SASS clients in 18-20 yr range declining/refuse services more frequently.*
- 2. SASS therapist doesn't ... adults ... so after 3 mos they have to start over with a new therapist.*
- 3. After ..., staff remembering that 18-20 yr old can still qualify for SASS/CARES*
- 4. CARES telling out staff that 18-20 yr olds do not meet the requirement.*

Easiest Things:

- 1. Usually they refuse SASS services & can be referred to adult services only.*
- 2. They both can easily access psychiatric services.*
- 3. Both can readily access ... services with our agency*

Other comments: No comments

Suggestions:

- 1. It would be helpful to provide a link on the Northwestern website to the HIS website where we have to do entry for hospital monitoring. Possibly on page 5 where you indicate the child was hospitalized.*
- 2. SASS is a billing nightmare for those agencies that subcontract.*
- 3. The CARES staff is not always consistent when they tell our staff regarding guidelines on eligibility when we call.*
- 4. CARES staff should not be able to override our assessment or that of a DR. who is recommending hospitalization given they are not providing any face to face assessment of the child. This is a huge liability for CARES I would imagine, should they decline SASS services and the child harm themselves.*
- 5. We've lost hundreds of dollars in billing due to the problems with SASS and the subcontract.*
- 6. It is a huge hassle to transfer a case to another county for 5-14 days just so they can monitor hospitalization and then send it back to us when they are discharged.*
- 7. There have been problems with the HIS website and have not been able to get an answer as to how to correct it.*
- 8. Under this new SASS system there are MAMY children that we are not allowed to categorize under the SASS services but who are in need of the level of intensity and frequency of services that SASS provided. We used to have more discretion at who we could put in the SASS program and offer the SASS services.*
- 9. CARES still has problems understanding the difficulties facing the subcontractors. At times they would not give us any info on the child they wanted us to screen, saying that they had already given that info to the head contract agency and that they can only make that referral one time and refused to give out the info again.*
- 10. It is extremely time consuming to enter the data necessary on the Northwestern website*
- 11. Northwestern staff have been very helpful in responding to our problems when we email them.*

PD#22

Barriers:

No demonstrated need to develop same

Primary Problems:

No comments

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

No suggestions

PD#24

Barriers:

Client refusal, if any barriers

Primary Problems:

- 1. 18-20 client referral for services offered*
- 2. Services (adult) that are appropriate for the age and draw interest in the client (too many "old" people)*

Easiest Things:

- 1. Psychiatric Services*
- 2. Psychotherapeutic Services*
- 3. Medical/Dental/Life Skills training services*

Other comments

The majority of this referred population do not want services – they value their independence which they seem to equate to doing everything alone.

Suggestions:

- 1. The "90 day services" does not seem long enough for the acuity level of the SASS family. Just as you are establishing a trust rapport with the client parent you are referring them to long-term therapeutic services.*
 - 2. The "clumping" of incoming referrals, 4 or 5 within a 30-40 minute time frame is problematic for the 90 minute response time – it is not cost effective to have more crisis staff available because the follow-up case load does not justify a larger SASS employee team. This becomes a high burn-out part of the job*
 - 3. Excellent = the FRD position!!!*
 - 4. Excellent = All the built in benchmark in the overall SASS program.*
 - 5. Excellent = The support of the 3 state agencies to provider concerns.*
 - 6. Illinois outcomes is too time consuming and a staffing problem. The time limits for entry here and in HS of I are too restrictive. This part of the SASS program is not cost effective for the provider.*
- No suggestions*

PD#25

Barriers: No comments

Primary Problems:

- 1. Youth don't meet criteria for adult services*
- 2. Lack of residential resources for young adult*
- 3. Lack of curriculum for young adult population needs*

Easiest Things:

- 1. Case management*
- 2. Medical services*
- 3. Out patient therapy*

Other comments:

Difficulty in engaging this age group to meet their needs

Suggestions:

No suggestions

PD#31

Barriers:

It's not something we've seen a huge need for in our area.

Primary Problems:

- 1. Most children and adolescents in SASS program LZ have eligible dx, not target dx. The adult services are beginning to focus more on target dx for which some won't qualify.*

Easiest Things:

- 1. Our agency has both available*

Other comments:

No comments

Suggestions:

Billing:

Although it has improved, we are still experiencing some problems with rejections and now suspended billings. The biggest problem area is that nothing is saved within the system(we are using internet billing). All tracking must be done manually and the manner in which billings are adjudicated (debits, credits, reductions, payments versus non-payments) makes no sense. Our situation is complicated by sub-contracting.

Initial Referrals:

We continue to get a number of referrals that appear to be inappropriate for a variety of reasons. I'm not sure how this is happening unless callers to the CARES line are giving different information than we receive at time of assessment. I suspect this accounts for some but not all of the problems.

Suggestion:

*- Billing through ROCS as was done in the past would be extremely helpful. (or perhaps this could be considered when/if ROCS switched to HCPCS coding)
- Some means of matching CARES referral info to actual assessment info might be helpful to determine what problems, if any, exist in this process. Perhaps there needs to be a clear distinction between emergency and non emergency screens and other types of services beyond mental health crisis might be needed.*

PD#33

Barriers:

We do not experience barriers for this population that are unique from other populations. We serve all at out agency.

Primary Problems:

- 1. We don't have transition issues, per se, as all populations see our clinicians.*

Easiest Things:

No comments

Other comments:

In Financial Aspects of SASS Section:

?SASS program does not seem to add services we don't do anyway at our agency

In Outcomes of SASS Section:

Impact of SASS services on parent's ability to help manage their child's behavior. -- We perceive that SASS does not add to what a qualified and competent clinician should be doing, anyway.

Questionable use of State resources, to implement the process.

Suggestions:

It is difficult for us to understand how a centralized CARES line system is a clinical benefit and a fiscally wise process. This may be in part to our setting. (Centralization of funded programs away from our own agency and professionally trained staff – LCPCs – has previously impeded service access, in our experience.)

Lastly, it seems to us that if a primary goal of SASS is deflection of unnecessary and/or inappropriate admissions, perhaps it would be better to spend time/money on staff training in appropriate deflection/philosophy rather than a CARES line system. Thank you!

PD#36

Barriers:

Living in a rural community – available services are limited

Primary Problems:

- 1. Lack of facility (i.e. residential, independent living)*
- 2. May not qualify for additional support*
- 3. Limited funding – may lose ICG*

Easiest Things:

- 1. Therapy – counseling*
- 2. Transfer to adult CM services – if they live in Adams Co.*

Other comments:

No comments

Suggestions:

- Allow funding for time needed to review records.
- No time to bill for time needed to prepare for direct services
- Better response time from CARES i.e. some SASS have been on hold up to 30 min.
- Extend time allocated for SASS – as it takes time to build relationships w/families and gain their trust.
- Extend time for re-screened clients – as some do not want services until the 2nd or 3rd screening

COOK

PD#5

Barriers:

No comments

Primary Problems:

1. Most clients 18-21 yrs old don't fit into milieu with adults because the adults are much older and have chronic illnesses (Developmentally Disabled).
2. A great deal of the ct's are DD as well as MI and a PAS agency needs to be involved. This can take time to coordinate.
3. Most DCFS wards that turn 18-21 – are not considered for placement until they are 20 yrs., then the process is late in finding placements because it takes so long. DCFS is often reactive as opposed to proactive. Preparation for clients is poor.

Easiest Things:

1. Finding clients – psychiatrists to monitor medication.

Other comments:

No comments

Suggestions:

No suggestions

PD#8

Barriers:

No comments

Primary Problems:

1. Knowledge of service availability
2. Difficulties w/ placement
3. Day programming

Easiest Things:

1. Everyone's willing to help.

Other comments:

No comments

Suggestions:

- SASS website
 - need much quicker problem resolution.
 - for transfers, receiving agency should be allowed to fix issues, b/c the transferring agency doesn't care.
 - eligibility isn't on website quickly enough.
- All agencies don't seem clear on website processes.
- Need for more frequent CSPI trainings, since someone has to cover on call during trainings.
- Cares seems unsure pf process for hospital to hospital transfer – (new SASS assessment needed).
- Cares could be more consistent in the calls it accepts.

PD#13

Barriers:

No comments

Primary Problems:

1. Lack of services
2. Lack of accessibility to the clients
3. Training in order to better meet the needs of this age group

Easiest Things:

1. *Planning*
2. *Determining client needs*
3. *SASS involvement*

Other comments:

No comments

Suggestions:

No suggestions

PD#14

Barriers:

Currently we are a child focused agencies

Primary Problems:

No comments

Easiest Things:

No comments

Other comments

1. *All 18-20 should be SASS eligible not just HFS youth.*

Suggestions:

-The model of compensation for ICG case management is inadequate & does not make logical sense.

-I would like to see more of a push for screens to be completed if homes or schools & not hospital ERs.

-The web based reporting roll out was chaotic & difficult to train staff on because it was always changing.

-The flexibility in the amount of services we offer clients during the eligibility period is very helpful & beneficial to clients.

-Voice to voice immediate transfer/notification rule has helped in making us much more aware of incoming cases & able to begin serving them much more quickly & planfully.

PD#23

Barriers:

No comments

Primary Problems:

1. *Finding the resources to look and work with this population in a wraparound model*
2. *Not always know who should do what – C&A v's adult line services.*
3. *The self determination of the young adult and the crisis plan.*

Easiest Things:

1. *On going conversation w/ C&A & adult provider*
2. *Identify folks in both line of services to address issues in this population*
3. *Use research and evidence based information to help structure treatment to address this population*

Other comments:

The transition information is wonderful yet we have to see how it will play out in each community.

The challenges of how to intervene at the early ages such as 14-15 and see them through.

Suggestions:

No suggestions

PD#26

Barriers:

No comments

Primary Problems:

1. *The disconnect between the philosophy of serves: systems based tx versus individualistic.*
2. *C&A appear to be strength based versus their YA counterparts.*
3. *Lack of continuity of care between C&A & YA services.*

Easiest Things:

1. *Easy for organizations to have both*

Other comments:

1. *Many of the services (i.e. vocational) are not covered by Medicaid. Services for YA who are not wards are not Medicaid billable, as they may not be considered a “medical necessity”.*

Suggestions:

Problematic:

- Rigid 90 day eligibility.
- Unfunded mandates (i.e. clinical staff performing clerical duties that are unfunded).
- Temporary Medicaid does not cover outpatient MD time. The state appears unresponsive to provider concerns.
- Lack of timeliness & completeness of referrals from CARES.
- SASS website is NOT user friendly. There continues to be no manual or guide, was implemented before testing (i.e. no pilot) feedback was not requested from providers. Useless & time consuming.

Excellent:

- Medicaid clients now have access to SASS Services
- Aftercare services affect client's outcome

PD#29

Barriers:

No comments

Primary Problems:

1. *Parental involvement – client must now seek their own services.*
2. *Coordinating a smooth transition to adult program without lapse in services.*
3. *Adult programs seem to be more focused on case management and med monitoring where SASS was individual, group and family.*

Easiest Things:

1. *Our AMH is within our agency so referrals are simpler.*

Other comments:

Sometimes difficult to involve this age group into our group programs due to their age too old for teen program, not appropriate for parent group.

Suggestions:

When transferring it would be helpful if all SASS program provided similar services. Many families do not want to transfer because they like our range of services.

PD#30

Barriers:

1. *Not enough staff or resources*

Primary Problems:

1. *Lack of Spanish speaking psychiatrists*
2. *Lack of Spanish speaking therapists*
3. *Lack of Spanish speaking resources*

Easiest Things:

1. *Hospitalizations into psych hosp.*

Other comments:

No comments

Suggestions:

No suggestions

PD#34

Barriers:

No comments

Primary Problems:

1. *Lack of appropriate services to link these clients to*
2. *The adult system's unwillingness to work with child/adolescent provider*

Easiest Things:

No comments
Other comments:
No comments
Suggestions:
No suggestions

PD#35

Barriers:

No comments

Primary Problems:

1. *People not following up with counseling/therapy, medication management.*

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

1. *The major problem we have is the lack of follow-up by the parent/guardian after the child is discharged from the hospital.*
2. *Our staff has been able to respond to pages in a timely manner, and transfer the case to the appropriate SASS agency.*
3. *The NU website has been a good addition to the SASS program.*
4. *CARES line criteria for paging SASS workers needs to be refined because some calls that come through the CARES line are for children/adol. With behavioral problems that don't need a SASS assessment.*

NORTHERN REGION

PD#4

Barriers:

The Lake County Health Department has numerous adult services, so we refer clients in this age range to the appropriate program.

Primary Problems:

1. *The level (intensity) of services is different between adult services and SASS (SASS being more intense and assessable).*
2. *It is difficult to link to case management services*
3. *Transportation for parents is a hardship when attempting to access services*

Easiest Things:

1. *Psychiatric appointments*
2. *In Lake County we tend to coordinate well between adult and youth services*

Other comments:

No comments

Suggestions:

Overall SASS has become much more time consuming to manage. For the families that connect immediately (are invested) 90 days of service appears adequate. However, for the vast majority of clients, it takes approximately 30 days to build a trusting therapeutic relationship, and 90 days doesn't see, adequate. It would be easier if cases could be extended 60, rather than 30 days.

PD#16

Barriers:

Duplication of services in this area.

Primary Problems:

1. *Long waitlist for the chronically mentally ill adults community mental health provider*
2. *Adult CMH Provider does not do family therapy.*
3. *Waitlist for psychiatrist over 6 months*
4. *Often times waitlist is closed, Will not take new clients.*

Easiest Things:

No comments

Other comments:

Difficult to engage service providers for this population.

Suggestions:

- Eliminate 90 day time frame*
- Eliminate redundant entry on SASS website*
- Administrative costs significantly high to manage all necessary entries into SASS website*
- Redundant information has to be written by SASS therapist to comply with state requirements for charting. Some info now requested in SASS website i.e. hosp. staffings, CSPI etc.*
- Difficulty linking clients for continued mental health services*
- Many services provided that is not billable i.e. FRD contact prior to ITP development.*
- Extension requests are time consuming and not billable, thus clients then cycle in and out of SASS.*

PD#17

Barriers:

No comments

Primary Problems:

- 1. Differing levels of outreach*
- 2. Waiting list for adult services.*
- 3. Change in rights of client at age 18.*

Easiest Things:

- 1. Availability of linkage (adult) staff w/ hospital.*
- 2. Psychiatric care*
- 3. Interagency coordination*

Other comments:

Minimal residential resources as alternative to residential resources fir this population (i.e. ICG).

Suggestions:

No suggestions

PD#28

Barriers:

No comments

Primary Problems:

- 1. Generally poor motivation of the clients who have often worn out support. "I Don't have to do what you tell me" attitude.*
- 2. Adult services do not have programs geared specifically to this age range & needs.*
- 3. Often have problems with concrete needs: housing, transportation, food, no job skills.*

Easiest Things:

- 1. Ready access since we have adult services*
- 2. Good coordination & continuity of care possible between C/A & adult services*
- 3. Availability of MISA services if needed (& youth will cooperate)*

Other comments:

Generally poor motivation for services with frequent alcohol/drug overlay that they don't want to acknowledge.

Suggestions:

- 1. To improve the SASS program: Expand length of services and make the extensions easier to obtain and longer duration.*
- 2. To improve the SASS program: Develop a range of home based services for clients and families who can/won't make the linkage to in-office services at the end of SASS.*
- 3. To improve the SASS program: Improve the transportation to and from hospitals; the wait is tool long for ambulances to get to rural areas; it is often difficult or impossible for families to follow the ambulance to the hospital. We have to wait 6-8 hours for an ambulance and even occasionally until the next day. Ambulance services are not willing to transport or they don't want to mess with the DPA payment process. We have been able to help families with the cost of travel to the*

- hospitals using SASS flex funds but in the middle of the night the family may have child care needs or unreliable vehicles.*
4. *To improve the SASS program: We need a quality inpatient psychiatric unit for children and adolescents closer to home for these families.*
 5. *Particularly problematic: The coordination of CARES authorizations for SASS approvals when the child is in the ER and/or admitted to the hospital for medical care related to a psychiatric condition. Hospital emergency rooms and floor nurses are confused about why they have to call the CARES line and what they are asking for. Some ER nurses have refused to call because it is not their job (we try to call for them if we know this is an issue).*
 6. *Particularly problematic: It is difficult to program for clients and staff when SASS case loads can vary significantly from month to month; one month things are slow and the next month the demand is very high; this is a challenge for staffing patterns and providing cost effective services for this agency.*
 7. *Particularly excellent: We really like the website. Most of the “bugs” have been worked out and we find it helpful in identifying and tracking clients.*
 8. *Particularly excellent: The inclusive coverage of services for the children and families that receive services is very helpful. We think more children are now receiving services than were identified under the former program model. However, some children with insurance would benefit from SASS but comparable services are not offered or covered via insurance.*
 9. *Particularly problematic: ICG duties can be hard to manage at times when SASS case loads are high.*
 10. *Particularly problematic: Still can't find an FRD.*

PD#32

Barriers:

No comments

Primary Problems:

If child needs to be transferred to a new therapist, there is often a few weeks wait due to large case loads

Easiest Things:

1. *In same building*
2. *Same therapist can often continue with client*

Other comments:

1. *Our agency has an adult services program in the same facility which makes it easier to coordinate*

Suggestions:

The website does not allow you to write in the child's ethnicity & doesn't allow for a multi or biracial group, but prompts you to pick one.

Our biggest problem is our lack of psychiatrists in the area. We don't have a child psychiatrist or anyone that will see kids under 10 years old. Parents often have difficulty w/transportation, so it is very difficult to help connect them w/outside referrals because it's at least a 45 minute drive, if not 2 hours.

SOUTHERN REGION

PD#1

Barriers:

No comments

Primary Problems:

1. *lack of transitional housing.*
2. *lack of transportation options for client*

Easiest Things:

No comments

Other comments:

No comments

Suggestions:

No suggestions

PD#6

Barriers:

No comments

Primary Problems:

- 1. Some 18 year olds are developmentally not at an adult level of functioning in order to follow thru with services.*
- 2. Lack of younger adult groups for anger mgmt or DBT.*
- 3. Lack of young adult resources/programs.*

Easiest Things:

- 1. We have adult out patient services at our agency – so transition is smooth*
- 2. No longer need parental consent.*
- 3. No waiting list for adult services.*

Other comments:

Involuntary admission is/was new to SASS as only children under 18 were served previously.

Suggestions:

*Continued complaints from parents on short amount of time services are approved for (90 days).
Program is beneficial to children with no prior medical card.*

PD#7

Barriers:

SASS is the only program that KHU provides services for to over 18 years old – therefore it hasn't been a priority for us to develop services.

Primary Problems:

- 1. It is difficult when the client has not only MH issues, but also DD issues*

Easiest Things:

No comments

Other comments:

- 1. We have more problems with DD kids, then we do w/the transition from adolescent to adult services*

Suggestions:

The paper work requirements are too much when you consider that SASS is only a 90 day program. It is very difficult to get a comprehensive mental Health Assessment completed in order to provide the family with the services they need – once we get the MHA done we are lucky to have 45-60 days of service left. It just isn't enough time to deal with the serious problems that these kids and families need. We try to refer the families on to the local Mental Health Center, but they do not follow through. If we could bring on going services to the family, similar to SASS, then I think we would see a lot less recurrent clients. Clients who are on Medicaid need more options than just the local Mental Health Agency.

It would also be nice if we could bill FRD services prior to the MHA being completed – families need that contact at the time of the crisis, but without being able to get paid for it. We can't afford to have our FRD assessable.

I also think that agencies should be able to choose whether we have an FRD or not. It feels like a lot of the FRD requirements are mandated on the agencies, which it makes it very difficult on us. It is almost like the FRDs have their own little union that tries to control how they are treated at each agency.

SASS is an excellent program – but is only as good as the agency that has the contract.

State needs to develop more services for Developmentally Delayed youth. We get a lot of referrals to this population & generally have to hospitalize in Chicago. This is not good for the family. Transportation is a huge problem. Many times we have to call 15-20 ambulance companies in order to transport for a crisis.

PD#10

Barriers:

No comments

Primary Problems:

- 1. Staff issues – should a C/A therapist continue to see an 18-20 client*
- 2. We have clients who are 18-20 who qualify for services – But education of community resources to call the CARES line has been a challenge*
- 3. No other real problems*

Easiest Things:

- 1. Intensive services are available for both.*
- 2. Most transition & coordination of services are smooth*

Other comments:

No comments

Suggestions:

No suggestions

PD#12

Barriers:

Residential treatment and linkage to adult aftercare.

Primary Problems:

- 1. Available treatment*
- 2. Lack of residential or transitional care*
- 3. Cooperativeness of the consumer do to substance abuse issues*

Easiest Things:

- 1. Psychosocial rehab – for some consumers*
- 2. Case management*
- 3. Substance abuse treatment if the consumer is willing to accept it*

Other comments:

Youth in late adolescents do not wish to receive treatment from C&A providers. They are much less likely to engage with SASS. They perceive SASS as a children's service and very often substance abuse issues are present.

Suggestions:

- 1. Change the Illinois Outcome System to be less time consuming. Allow HIS information to be reported through the Illinois Outcomes System so information can be entered in one place.*
- 2. Evaluate the development of separate specialized services for youth who are late adolescents/young adults.*
- 3. Mandates on the size of caseloads would not work down state, but maintaining a staff to in county referral ... may be helpful.*
- 4. CARES must better screen youth and there needs to be a ... sequence when professionals make ... referrals.*
- 5. Many, many youth who do not need hospitalization are hospitalized.*

PD#15

Barriers:

Separate systems for adult clients (18 and over) – there already exists a system for serving at risk young adults (case management, day treatment, linkage).

Primary Problems:

- 1. A lack of understanding in both systems on how other system operates*
- 2. Lack of knowledge of external resources for this population*
- 3. Lack of formal policies and procedures to facilitate coordination.*

Easiest Things:

- 1. Talking with other staff*
- 2. Sharing WRAP services*

Other comments:

No comments

Suggestions:

1. SASS transfers from one provider to another are problematic due to web-based information lag time of 3 days
2. There should be a 90 day service eligibility upon hospitalization whenever a youth is hospitalized.

PD#18

Barriers:

No comments

Primary Problems:

1. *Communication between providers.*

Easiest Things:

1. *Follow-up*
2. *Psych Services*

Other comments:

Not enough housing between young adults come out of the hospital.

Suggestions:

-The biggest issue we have is maintaining staff.

**They would like to get paid better for the job. - The rate of pay does not allow for better pay.*

**As an agency travel is extensive and finding clients is frequently difficult (a lot of no shows)*

-The immediate response and intensity really helps stabilize families.

PD#20

Barriers:

No comments

Primary Problems:

1. *We do not have a child psychiatrists on site*

Easiest Things:

1. *We provide SASS C&A and adult services therefore we have coordination on site*

Other comments:

No comments

Suggestions:

1. *Increase funding to cover the cost of SASS services.*
2. *Eliminate the requirement for FRD in rural areas. We have case managers who currently do this. It is also difficult to employ FRD's that are not also clients (in our area).*
3. *Combine HIS & SASS websites to decrease duplicate entries.*

PD#27

Barriers:

Lack of commitment from adult outpatient population to ... services available to this age group

Primary Problems:

1. *Poor coordination of services because a client cannot bill when staff for 18-20 yrs*
2. *With transition to adult some services are not available to deal with this population*

Easiest Things:

1. *Get FRD involved in the client's life and family*
2. *Other comments: No comments*

Other Comments:

1. *Lack of adequate housing for this population*
2. *Services need to be extended to 6 mos*

Suggestions:

1. *Extend SASS services for at least 6 mos.*
2. *Allow FRD involvement at the initial assessment.*
3. *Time frame to see Dr. after discharge from hospital.*

FY06 SASS Community Mental Health Provider Survey Comments

Note: All comments are transcribed exactly as they appear in the original survey, including spelling and grammatical errors but with any identifying information removed.

CMHP #001

We have not utilized the services in the past 3 months.

CMHP #002

1. Coordination of care between a provide agency the client already works with and SASS is very tricky + complex. SASS must include current Therapist and Psychiatrist in all aspects of crisis care (assessment, hospitalization, staffings, aftercare, planning, etc) This is not always done.
2. Also, some clients go into crisis multiple times. Meetings/staffings should take place between provider agencies + SASS to plan for management of these clients.
3. Issues of “approval” of non-SASS agencies to provide SASS 90 day services is VERY difficult. Agencies should be able to work directly w/ CARES to get approval letters + notifications of eligibility without SASS serving as intermediary.

CMHP #003

We have 3 case managers in our Child and Adolescent “120” Case Management program. None of the case managers has made a SASS referral this fiscal year. One case manager has; however, take on a case where a SASS referral was made. As far as the case manager can tell from this case- no services were rendered by the SASS provider but they keep showing up as an open SASS negating our IPA billing each month. The case manager has worked with [Agency Name] to change this so we can get reimbursed. So far no change has occurred.

CMHP #004

No comments.

CMHP #005

It seems as though it is difficult to keep SASS workers. Often our staff have to help coach SASS workers through the steps.- We don’t mind it, though it could potentially be a problem if the SASS worker was unsure of the steps & we had a new therapist on site, who couldn’t coach.

CMHP #006

No comments.

CMHP #007

Educate community providers on how to make referrals
more willingness to work cooperatively with families and other providers
Showing more respect for parents that are in crisis.

CMHP #008

No comments.

CMHP #009

Need to have SASS paperwork for collaboration & billing. Also would like discharge information. I still have not received any paperwork about a client that started SASS services 2 months ago.

CMHP #010

We only use the CARES hotline services & are not familiar with SASS outcomes. We should be getting referrals for outpatient services in regard to the crisis calls, but this not seem to be happening. It would be nice if there were SASS services not related to crisis situations as well.

CMHP #011

No comments.

CMHP #012

CARES services needs improvement. We have had some problems in the past when we have had to call into CARES.

CMHP #013

1 suggestion would be to allow DMH funded and licensed agencies, who previously provided SASS services to be allowed to continue providing SASS services.

We do **everything** possible to **not** refer a child to SASS to prevent them having to work with the SASS agency for LAN XX, & when we have had to make the referrals, it is nothing but trouble for the family, the child & our agency.

Multiple attempts have been made to attempt to sub-contract for SASS that have all been turned down. These matters have also been brought to the attention of Network staff to no avail.

Basically, there are **no** SASS services for [Name] CO. We serve the children through our 120 program, (which is already over burdened.)

CMHP #014

1. CARES line referrals are inappropriate. All providers in the state agree. These are not community education problems. They are system problems that are allowing you who do not need SASS services to be eligible. Some youth barely meet criteria for an eligible diagnosis. Most are not target. After screening a SASS agency should be able to deflect from programming and simply make the appropriate referrals.
2. ILLINOIS OUTCOMES requires more documentation than was originally presented or figured into program costs. It is causing most providers large problems and the state has not been responsive to concerns.
3. Begin to review at random cases where there is a physician override of the SASS screening. This will allow data (qualitative) to be gathered about why that happens.
4. Examine the difference b/t screening diagnosis and medical diagnosis upon hospitalization and examine possible causes of very large discrepancies.
5. Provide more training on ICGS for those who are new to the process. There is high turnover in this program.

CMHP #015

No comments.

CMHP #016

We have not had referrals to/from SASS.

CMHP #017

No comments.

CMHP#018

- 1) More collaboration/communication w/agency staff
- 2) Develop aftercare plans and communicate /share these w/ agency staff

CMHP#019

-hire more staff-vacancies + inadequate staffing are an ongoing problem.

-lack of follow through w/ service post hospitalization discharge (not delivering 90 days of service in many cases)

- certain sections of the county get better and more timely services than other sections

(i.e. [Name] + less populated areas receive better services)

-timelines of services- screener can take referral hours to arrive for screening (90 minutes is supposed to be standard).

-Service providers through SASS are mostly **only** Bachelors level

-due to sensitivity + complexity of cares higher degree staff needed.

CMHP#020

There is a large discrepancy between those clients who have Medicaid and unfunded families. Medicaid pays for many more services than unfunded family get, for Intensive Outpatient programs for example.

CMHP#021

Communication between SASS workers & agency providers has improved but there continue to be instances of lack of continuity of care or difficulties of coordinating services.

CMHP#022

No comments.

CMHP#023

There are two major concerns I have w/ SASS services:

1. Not having Spanish speaking workers available to complete assessments.
2. The differences that exist amongst agencies when it comes to doing home visiting assessments. Some agencies will & others will not, this it's hard to tell families what to expect & the CARES operators don't have that info.

CMHP#024

Nights are particularly problematic- regular staff are on-call, not "SASS Workers". SASS provides not monitored on their ability/willingness to perform duties. We have experience problems with lack of response and the SASS agency attempting to "Steal" clients upon discharge.

CMHP#025

1. Follow-up with agency Therapist regarding client admission to hospital releases all Discharge plan, Summary, and recommendations for services Agency/Therapist.
2. Contact agency Therapist concerning all scheduled follow-up meeting and or appointments.
3. Issues related to 18-20 year old clients who have transferred to adult programs have been raised at DMH meeting in the past, still need clarification. (especially regarding inpatient psychiatric admission).

CMHP#026

More frequent communication between SASS and SCCS. When a guardian tells SASS that he/she wants to work with SCCS rather than SASS, it would be helpful if SASS acknowledged guardian's choice immediately, called SCCS to confirm that we are prepared to offer guardian/Clt. Services, & immediately called CARES to effect the transfer. We would then be able to offer services to guardian/Clt. immediately, w/out there being any gap in services.

CMHP#027

Would like the SASS agency to collaborate more with our agency staff in the child's SASS care planning. If our agency is not involved in the crisis we would like to be notified that a child in our area was referred to SASS.

CMHP#28

That SASS communicate with the initial providers of services. We have discovered kids in duplicate services and some who have not received followup due to the fact we thought they were SASS.

CMHP#29

It would be helpful if the SASS services were provided by the lead agency in our area or at least by an agency from our service area.

CMHP#30

The general response time has improved and the SASS workers I have encountered have been helpful in assisting with hospitalizations, however, I have never been contacted by SASS for follow-up or aftercare.

Also, the biggest problem we have encountered here has to do with the children and families in the community who are experiencing a psychiatric emergency and are privately insured. We recently received a call from a local police department who was holding a 15 year old boy who had made threats toward classmates and who also had a psych history. He was also privately insured. CARES was called, but told that police officer that they could not assist because the boy had insurance. The officer called this agency, and although we routinely screen adults, no one here knows anything about the rules/laws governing the hospitalization of children. The mother was afraid of the boy. There was literally no help & no support for this family, and this not an isolated case. I believe the police dropped the child off outside the nearest hospital.

It has been my perception that kids are not always followed up with consistently. Further, there is little effort made in coordinating services after discharge from a hospital. On a positive note, I have been in contact with a couple of excellent and caring SASS workers. However, I think there are several gaps in the system that make it difficult for them to do their jobs efficiently. There is also a gap in assisting children and families who have private insurance. Who do these people call if they are in crisis?

SASS worker did not contact client for several weeks after client's numerous phone calls. SASS was unable to meet client's needs for an eating disorder, trauma recovery group. According to client, SASS had no alternatives for client and did not assist her at all.

CMHP#31

For entire Appropriateness and Sensitivity of SASS section:

Little to no contact by SASS agency with counselors serving the child/family in the county they actually live – sometimes never know they are SASS – no coordination of services with our facility.

In Outcome of SASS section for Impact on agency's ability to serve the child and family question:

None – we rarely have contact with SASS provider to even know how child is doing no coordination of services.

Comment Section:

The agency who has the SASS contract does not coordinate with our agency. We rarely know what the outcome is after we make a referral, some clients come in and we never know they are SASS eligible until they are rejected in ROCS. The local school says coordination is poor and SASS providers don't always show up in this county to provide services. Our billing clerk has submitted some SASS claims and has not heard anything back. She has called and no one returns messages. Feel we are missing billing opportunities.

Hospital Survey Comments

Note: This survey was a phone survey and comments are not verbatim; comments are printed as they were transcribed by the surveyor but with any identifying information removed.

Psychiatric Hospitals (6 respondents)

1. Describe what you like about CARES?

CARES is responsive. Dispatches SASS very quickly. Not a lot of argument in terms of clinical presentation in about 98% of cases.

Most staff is friendly and helpful.

Generally very friendly and cheerful.

Easy to access.

Available 24 hours.

Very professional, detailed, responsive.

2. Describe what you dislike about CARES?

There are times when CARES workers are too overwhelmed. [Hospital name] usually calls CARES 5-6 times a day. Waiting for CARES or SASS adds an extra hour to every assessment.

It is a long process to get referral. Sometimes the hospital forgets to call SASS agency after hospital calls CARES.

Would be easier to call provider directly. The hospital has to make many phone calls. Too many hoops to jump through. When CARES is busy, the hold time can be long.

The fact that CARES is second guessing a clinician who is sitting right there with the client. The phone workers seem inexperienced or it seems that they are not clinicians.

Sometimes CARES won't send out a SASS worker when it is necessary.

Wait time.

Nothing.

3. Do you have any suggestions for improvement of CARES? (What should be done differently?)

Needs more staff. Eliminate it. The old method was more efficient for families. This is an extra step. Hospital has to call right away (instead of the next day). Too many hoops to jump through for the patients.

There should be three separate lines: one for crisis, one for SASS and one for hospital to call in for disposition.

More experienced or better trained clinical staff. Better computer system-a number of times, the computer was down.

Decrease the wait time.

No (2)

4. *Describe what you like about the SASS program?*

Exceptional discharge plan. 90 days of intensive service is a great help to children and families.

Good intentions, advocate for the families.

SASS is great. Upfront. Complete and full information. Hardworking.

At times SASS can be helpful to patients and families.

Professionalism of assessors. Bilingual SASS workers can always be provided. Works well as a team to help families.

Nothing.

5. *Describe what you dislike about the SASS program?*

The SASS process slows things down. [Hospital name] has clinicians there that should be able to admit by themselves.

SASS training is not consistent: 1) paperwork 2) clinical training (the difference between a BA and an MA affects clinical decisions). The hospital isn't given the correct information. There is a long waiting list of clients for one worker. Sometimes the SASS agency encourages families to just come to the hospital, which has the child leaving the catchment area (and then the family ends up dealing with a different SASS agency).

Overworked. [Agency name] doesn't give complete information (such as the kid is a sexual perpetrator) and this can cause major problems.

Sometimes there is a very long wait. This is a huge area of customer dissatisfaction. The hospital has no safe place for a violent patient. The hospital then has to admit the violent patient and the SASS worker gets upset about this. Additionally, the SASS worker and hospital are not always on the same page (e.g., disagreements on treatment recommendations).

Sometimes SASS interferes with medical treatment, trying to dictate treatment or disagreeing with the doctor and hospital. Sometimes SASS want the child hospitalized without regard to the time it takes to complete legally required procedures.

The 90 minute wait.

6. *Do you have any suggestions for improvement of the SASS program? (What should be done differently?)*

SASS needs more money and staff. They are stretched to the limit. There are not enough workers to give intensive care for the full 90 days and to help the kids truly avoid readmission to the hospital.

More consistency in paperwork. Increase the thoroughness of the assessment before calling the hospital-- better accuracy of information both demographic and clinical. Do not mislead the family about what hospitalization entails.

Pay SASS workers more. SASS needs more resources to work with.

Timeliness. This is not a problem with an individual person, it's the program.

More experienced clinicians. Better knowledge of hospitalization and transfer policies.

Decrease response time. The wait for the child can be up to 3 hours (including time with hospital staff).

7. *Have the changes to the CARES and the SASS program since July 1, 2004 impacted the children and families you serve? If so, in what way?*

Yes. The wait time for patients has been tripled. Families regularly complain.

Yes, 1) The families find it burdensome and are not given aftercare (from SASS worker) 2) Follow-up is not strong 3) SASS in staffings creates better continuity of care.

Yes. More wait time overall for a lot of clients. Even the ones with insurance.

Creates longer wait time for families. Greater burden and hardship for families.

Don't know.

No.

8. *Have the changes to CARES and the SASS program since July 1, 2004 impacted your hospital's clinical operations? If so, how?*

Yes. The kids are often quite agitated after so long and then present as more aggressive than they were when they came in.

Yes. It is a lengthier process for family, continuity of care is compromised by mismatch of qualifications, transfers not happening, kids fall through cracks, kids go into crisis, tremendous increase of hospitalizations.

Huge reimbursement issues. Public Aid says SASS did not do necessary documentation. This has cost hospital over \$100,000.

Longer wait in ER. This is especially a problem with violent or psychotic child.

Centralized number is efficient and easy.

Don't know.

9. *Which types of kids does your hospital best serve? (For example, kids with diagnoses of mental illness only, dual-disorder kids, kids with developmental disabilities, etc.) Do you have a specialization?*

Most kids are aggressive, oppositional defiant, violent and have troubles in school.

Severe MI ages 4-10, "to take the worse of the worst", severe behavior disorders.

Dual diagnosis, eating disorders, self injury recovery, clinical dependence, C&A.

Case-by-case basis: Stabilization, all mental illness, self injury, eating disorders, all mental illness, anyone who they can meet the needs of.

Mental illness, DD (2)

10. Are there types of kids that your hospital is less well-equipped to serve?

Medical issues. >7 months pregnant. Severe DD (sometimes [Hospital name] can take them, but it is on a case by case basis as to whether or not there are enough resources).

Pregnant teens, clients above age 17, severe DD (taken case by case), cutters, eating disorder.

DD.

Very violent child population. Long-term treatment.

Limited resources for pervasive developmental disorder.

Extreme sexual acting out.

General Hospitals with Child and Adolescent Inpatient Psychiatric Units (12 respondents)

1. Describe what you like about CARES?

Fairly responsive. Contacts SASS agency relatively quickly.

It is easy to get through to. CARES takes information and refers to SASS. Easy and friendly. CARES is less discriminatory than they used to be, less rigid, and almost always dispatches a SASS worker.

Kids are automatically assigned a SASS worker who stays all 90 days.

Quick response time. CARES are able to make decisions without always having to check with a supervisor. If anything is contentious, the hospital can always speak to a supervisor.

Good source of information. Clarifies issues and questions related to financial concerns and Medicaid.

Very helpful. Lots of improvement from the past year.

The central intake number makes things easier and streamlines care.

Pretty quick.

Have never had any problems. CARES is very responsive.

No problems so far.

Can't think of anything.

N/A

2. Describe what you dislike about CARES?

The time it takes to get in touch with SASS, lack of follow-up, continuity of who you speak with at CARES

Sometimes the hospital forgets to make the second call and then doesn't get paid until this call is made.

Hospital forgets to call and is not paid.

Last year the IHA proposed to limit CARES to data collection because CARES operators have very little training, experience and education. They never see the child. IHA proposed the previous DCFS model of directly contacting SASS worker. Maybe CARES could just do documentation, not make the decision. It should not be someone on the phone.

It is frustrating when you get a new worker. They are not well versed in policy and you are sent through many hoops.

Have to call for CARES entry number. This call is linked to payment and that is "insane." Overnight calls very problematic: if a child comes in at 11:30 PM and the call isn't made until 1AM, the hospital doesn't get paid for a day. Too much detail is needed for all of the phone calls.

Sometimes they ask silly/irrelevant or age-inappropriate questions. Sometimes CARES forgets to call SASS.

Nothing (3)

N/A

3. *Do you have any suggestions for improvement of CARES? (What should be done differently?)*

More continuity; don't pass off calls. Better follow-up on calls.

Hospitals should get paid even if the second call is not made.

Have it be the entry point not the decision maker.

Better training for new frontline staff.

CARES needs more people taking the calls. Be more forthright with temporary RIN cases.

"Not that I can think of." Age issues, e.g. age 20 (related to the fact that SASS sees clients up to age 20, and how they can be considered adults).

It should be eliminated for individuals presenting in a hospital ER when hospital has staff who can do the assessment of the child.

No (4)

N/A

4. *Describe what you like about the SASS program?*

SASS follows-up with kids on unit and aftercare.

SASS is very tuned into the needs of kids and really tries to provide services after discharge to make sure care is continuous.

In home program. Free assessment and linkage. Can help families access funding.

Good dialogue and teamwork. Continuity of care. Workers can talk openly with doctor about meds. Introduction of plans. SASS tries to keep kids out of hospital. Staffing 3x/wk. Daily hospital visits.

There are children and families that are suited to and better serviced by a community based theory and treatment approach.

Website is "awesome." All of the information is easily accessible.

90 days of service for all kids. After care services. SASS is involved, for the most part, in hospitalizations.

Great for Medicaid families. Great support. "They are THE advocate for the kid"

The idea of SASS, but how much help are people really getting?

Assures care for the patient. Otherwise it is not much different that it was before because most kids get transferred out.

Good outlet for kids who need intense, structured outpatient programming.

The idea that they guarantee post-discharge treatment.

5. *Describe what you dislike about the SASS program?*

How long it takes for SASS to respond to a call. Sometimes it takes hours. Some workers are irresponsible, dumping cases on the worker for the next shift.

Not enough SASS workers.

Major inconsistencies among the SASS agencies. Some are not as well organized and there is a lack of response and follow up.

Somebody else controls who is put in the SASS program. The hospital can't do this and has to go through the long screening process. It is labor intensive for administrators. The data entry is time consuming and non-billable. The hospital does not get paid if it only does the first screening.

Discharge box is linked to payment. When a patient is screened outside of home treatment center, the child has to be transferred. Workers are very overworked. The hospital is penalized if a SASS worker gets angry at the hospital for forgetting to call or if they have a lengthy intake process.

Depends on agency, but some are just not present: "They aren't doing their job." This is mostly with one agency in particular.

HSI--SASS will mark that they were not involved in discharge planning when they were, which means the hospital does not get paid for its services. SASS does not come to staffings as often as they should. Kids with temporary public aid--are they getting the same quality of follow-up as Medicaid clients?

Kids that are eligible are the only ones who can get these services.

Upfront screening is redundant. It should be eliminated for individuals presenting in a hospital ER when hospital has staff who can do the assessment of the child.

Nothing (3)

6. *Do you have any suggestions for improvement of the SASS program? (What should be done differently?)*

Decrease response time. Better responsibility with cases and better communication between CARES and SASS.

None. Not very familiar with the program.

Unsure know how helpful SASS is with helping families apply for aid. If they are not doing this, they should. SASS needs more workers.

Some outlying SASS entities subcontract w/ local hospitals, some don't. It should be more routine that local hospitals do daily assessments. Have local mental health center be involved when local hospital cannot.

The hospital's relationship with local SASS is great. Even when there are questions and problems, there are ways of communicating. Other SASS agencies, however, need improvement: 1) It is difficult to get a clear answer as to whether case has been transferred, who the worker is and who hospital should be in contact with. 2) Some agencies claim to be unable to attend staffings or visit children and families for up to 2 weeks. 3) Because of this (#2), the hospital is left with a vague discharge plan. There is no record of phone calls or visits. Hospital can't tell family what to expect in follow up. 4) The discharge planning box and how it is tied to payment. This is unnecessarily difficult and complicated, especially when there are two SASS agencies involved. The hospital gets stuck in between. When there is a problem here, it should not be the hospital's job to fix it. 5) When hospital tries to discuss problems with agencies, the agencies become defensive and problematic with treatments -- not returning calls, etc.

All agencies should use the same forms. There should be a note on the form specifying who is the treating agency and the supervisor to contact. Need to streamline the process of transfers. Discharge box and phone call timing should not be linked to payment. Statistics and feedback on follow-up should be provided.

Accountability for agencies that are not doing their job. Better system of dissemination of information; some agencies are better than others. At first it was difficult for families who had Medicaid to get used to CARES and SASS, but most are happy. Some families are dissatisfied with the lack of follow-up and wait time.

HSI issues with discharge planning. Wonders if the hospital can be able to change a no from a yes on HSI re: SASS discharge planning involvement (through one higher-up person).

Need more SASS workers (in other counties). [Name of SASS agency] does not have the workers come see clients while in the hospital. This might be due to a lack of workers.

Reduce required time it takes to respond.

Nothing (2)

7. *Have the changes to the CARES and the SASS program since July 1, 2004 impacted the children and families you serve? If so, in what way?*

Continuity of care in hospital, post hospital care and linkage.

Yes. Before it was hard to get unfunded families services. Now children and families are guaranteed SASS for at least 90 days.

Yes. There are fewer psych hospitalizations. Fewer readmissions. Only sick kids are being hospitalized.

Other ones get deflected.

Yes. At first, families struggled with the new program. There was no public education as to how the program would work. On the plus side, some families need this community based crisis intervention without hospitalization.

Yes. Negative: The agency cannot help a kid with SASS resources until a crisis. Positive: The extra money, resources and workers for recreation, community work and psychological testing.

Absolutely. After care is extremely helpful for families. Overall it has been good. However, many families don't know that if their child is uninsured they have to go through this process. It is good that parents can call CARES.

At first difficult for families who had Medicaid to get used to CARES & SASS, but most are happy. Some are dissatisfied with the lack of follow-up and wait time.

Yes. Now there is a guarantee of treatment.

Yes. Positive: Guarantee of services after discharge. Provides useful emergency services in the field. Negative: Angers families that they have to repeat their story to another person and they don't understand why.

Hasn't changed much.

N/A.

Don't know.

8. *Have the changes to CARES and the SASS program since July 1, 2004 impacted your hospital's clinical operations? If so, how?*

Yes. It has created a huge lag time between dispensation from ER to psych unit. It adds on a minimum of 2 hours. Parents are very unhappy with the lag time and the quality of care.

It has definitely impacted discharge planning. It is good that SASS is right there and part of the team during planning.

Yes. One concern: Some state facilities have closed their units since SASS started. How many beds have closed? This hospital has two child psychiatrists and it not covering costs. If too many units are closed and state hospitals have to be opened again, we are "back to square one." In July this hospital will start offering space to outlying hospitals.

Yes. 1) ER had to overhaul practice and policies and learn to understand how to work with child and family when it is a psychiatric presentation. ER has to get the family to wait for SASS worker to arrive and do assessment. This uses hospital's financial and physical resources. 2) Utilization and review of discharge and planning financial work has added lots more work. This hospital has added a part time job to do this. There is added cost.

Yes. It can be time consuming to track down information (especially with transfers) if other hospitals are not good about entering things into the website.

Lots more work and time goes into phone calls. This takes time away from clinical work.

Operations have improved. SASS is an integral part of the treatment team and helps with transition from inpatient to outpatient.

From insurance point of view, Medicaid and HSI are getting called on a more timely manner.

N/A.

No.

9. *Which types of kids does your hospital best serve? (For example, kids with diagnoses of mental illness only, dual-disorder kids, kids with developmental disabilities, etc.) Do you have a specialization?*

Mental illness only; no specialization.

Kids with diagnoses of mental illness only.

Mental illness, assessment.

Outpatient, meds non-compliant, uncontrolled ADHD, depression and suicidal kids. Mostly oppositional defiant kids who are brought by law enforcement.

Mental illness. Developmental. Retardation.

Mental illness.

Basically all Axis I diagnosis, specifically psychosis, neurological impairment, depression, early onset bi-polar, organicity, tourettes. Medical issues.

MI mostly, some substance abuse, some DD, can take pregnant teens, autistic, medically complex.

Primarily MI diagnoses, no specialization.

No specialization. Pediatrics are treated in the ER.

MI, behavioral problems: more ADD than ODD. Anger management. Very generalized programs. Program is flexible and age appropriate.

Mental illness.

10. *Are there types of kids that your hospital is less well-equipped to serve?*

Severe MR, DD & physical handicapped.

Mentally retarded population. No focus on dual diagnosis.

Severe DD. There is a need for an acute stabilization hospital for DD in Illinois. This hospital does not take <5-they are sent to [Hospital name] or [Hospital name].

Dual disorder.

Under 10. DD.

Severe MR.

Psychiatric children.

MR/autism.

DD (2)

No.

General Hospitals with Adolescent and Adult Inpatient Psychiatric Units Only (6 responses)

1. Describe what you like about CARES?

Receptive. Quick response.

No opinion. It's just part of the job.

Builds in services. Gives help through the community.

CARES has become more efficient.

Takes charge of figuring out which SASS agency to call.

N/A.

2. Describe what you dislike about CARES?

One has to repeat things (poor listening skills)

Nothing (3)

N/A.

3. Do you have any suggestions for improvement of CARES? (What should be done differently?)

Would appreciate a fax or letter for families to explain what to expect.

CARES line is useless, should be able to call SASS directly.

Answer the phone quicker.

No (2)

N/A.

4. Describe what you like about the SASS program?

Workers are very considerate, professional, courteous, willing to help, talk to clients.
Very accessible.

Follow up for consumer and initial contact during inpatient treatment.

Very helpful.

Follows student through age. Monitors and tracks services.

Responsive, do what they are supposed to.

Works as a team, open to input, true advocates of clients, responsive.

SASS comes out and see the patient and help with transfer.

5. *Describe what you dislike about the SASS program?*

Not enough workers.

That they have to come out, which in turn becomes double work, and the duration of the evaluation process.

Lack of communication with ER personnel.

Nothing (2)

No answer given.

6. *Do you have any suggestions for improvement of the SASS program? (What should be done differently?)*

No. Very quick to respond. Will sit in on family sessions.

More funding for mental health for children in IL! Better training and more staff and better pay for staff.

Improve communication with ER doctor.

No (3)

7. *Have the changes to the CARES and the SASS program since July 1, 2004 impacted the children and families you serve? If so, in what way?*

Yes. Now it takes longer to get patients admitted, however there are more appropriate admissions.

Yes. It is very helpful having someone available for first 90 days.

No (3)

N/A.

8. *Have the changes to CARES and the SASS program since July 1, 2004 impacted your hospital's clinical operations? If so, how?*

The process is quicker, but the hospital has to do it more often because of the kids on Medicaid.

Made it easier because the hospital can always call CARES.

No (3)

N/A.

9. *Which types of kids does your hospital best serve? (For example, kids with diagnoses of mental illness only, dual-disorder kids, kids with developmental disabilities, etc.) Do you have a specialization?*

Primarily psychiatric issues, mental health issues. Some DD and MR. Kids in special ED.

Primarily mental illness, secondarily dual disorder.

No specialization.

Mental illness, dual-disorder kids.

School social anxiety, dual diagnosis.

Mental illness and dual disorder.

10. *Are there types of kids that your hospital is less well-equipped to serve?*

MR. The programming at this hospital is too difficult for lower functioning kids.

There are no pediatric services.

There is no psych unit for kids; they are sent to a different facility. This hospital does not have enough connection to kids in the community.

Eating disorder clients.

DD, autistic.

Very disruptive disorder kids.

General Hospitals with Adult Inpatient Psychiatric Unit Only (20 responses)

1. *Describe what you like about CARES?*

CARES does its job.

Individualized to the child.

CARES checks funding for a client if the hospital is not 100% sure.

Screens calls quickly and efficiently. Contacts appropriate SASS staff.

Majority of people are friendly and ask pertinent questions. Quick to respond. Answer questions well.

Always finds placements.

Has gotten better. More responsive, easier to reach, more accommodating. Helpful with discharge planning.

Coordination of care with the community mental health agency.

Someone always answers. Easy, fairly stress-free.

There is no wait to talk to someone.

Once you call them, they are right on top of the cases.

Helps to get children and adolescents to proper facilities.

Someone will be coming out in 90 minutes to assess a child.

Not much besides receiving HSI #.

Service provided with SASS, easy to use.

Courteous and quick to respond, get all the info

No recent contact.

No opinion.

Nothing (2)

2. Describe what you dislike about CARES?

Get rid of it.

Authorization on wrong Public Aid numbers, comments not put into HSI in a timely manner.

No clear guidelines; should have worked out the details for CARES beforehand. Sometimes pre-screening for SASS and sometimes pre-screening for Medicaid; confusion, time-consuming, frustrating. SASS comes before CARES call; "too many people in the soup"; process takes too long, kids end up leaving the ER without services; kid comes from a different county; two SASSes in the same county.

More clarification is needed in regards to 18-21 year olds and hospital to hospital transfers. There is occasionally confusion in these areas.

Sometimes robotic in questioning; they just want to get the facts.

Inconvenient.

Creates additional layers and slows down service provision. It is not necessary. The previous SASS system was very functional. This adds additional steps and complicates things.

The hospital needs more time to call them (e.g. after midnight, or Fri-Sun admissions. More time is needed to call during those situations).

The time that it takes to make CARES call and wait for SASS worker.

Put on hold for forever.

Negate days of stay until we call them.

No recent contact.

No opinion.

No answer.

Nothing (6)

3. *Do you have any suggestions for improvement of CARES? (What should be done differently?)*

Get rid of it.

Improve set up of CARES; redundant for assessor to come out and assess a child. The hospital's assessment should be sufficient. Payment system is a detriment to hospitals (missed steps means no payment for hospital). Put responsibility on another agency for hospital payment. Disincentive for psych units. Allow hospital to refer SASS agency to aftercare. CARES is another layer of bureaucracy.

More consistency in how calls are handled (by the different people who answer the phone).

Would be easier if there was a list, broken down by geo codes, for the offices.
Sometimes have to search a bit.

Quicker call and response time.

CARES should be gone.

Give the hospital more time, such as within 24 hours, for those cases of admissions that come in during the night or the weekends, due to staff not being there. CARES should come and do an in-service for the hospital.

Quicker response time.

More SASS workers because they must be swamped.

No recent contact.

Nothing (10)

4. *Describe what you like about the SASS program?*

SASS is high quality, professional, and expeditious.

SASS will do the pre-screening; this saves the hospital time.

SASS emphasizes focusing on the kids lost in the system.

Usually friendly and thorough.

[SASS agency name] is excellent. Responses time is good. Thorough. They really try to understand what is going on with the child. They seem to really care. Easy to talk to.

Responsive.

The SASS workers find placements.

Easier to find. Attitudes much better lately. It hasn't always been this way.

Continuation of care.

Support and community help.

Individual SASS workers and agencies--they are very nice and are eager to assist.

They do a good job sorting out who needs hospitalization and who doesn't.

Now that [SASS worker] is there, hopefully it will be more efficient.

All are very caring individuals.

A group of workers that comes in and assesses clients.

Keeps track of these kids, calls back and visits frequently.

Services provided (90-day intensive services for at risk population). It's mobile; workers can go to client's home.

Good communication.

Helpful. Provides some resources for the patient.

No opinion.

No answer.

5. *Describe what you dislike about the SASS program?*

Nothing. Bureaucracy becomes an impediment to treatment. SASS kids get treated first, and then there is not enough care for kids in the community who need treatment. About 90% of kids seen are SASS. 18-20 year olds should be treated as adults.

No answer.

It takes a decent amount of time for them to come out.

It takes too long. Hospital's psychiatric team can do the evaluation. No need for anyone else. Waiting for assessment increases patient's length of time in the ER.

Extra assessment/slows down process of admission.

Doesn't seem like the appropriate follow-through and documentation is being done for 18-21 population.

Sometimes it would be easier to go right to the SASS program.

Sometimes the wait is a little bit long.

Inconvenient. It is difficult when there are disagreements between hospitals. Response time. Lack of funding.

SASS workers screw up the paper-work all the time. They forget to check the discharge box and then the hospital doesn't get paid.

Sometimes the follow-up has a lag of 1-2 days.

Hard to get in touch with case managers who are assigned to a specific client that has been admitted. Bad/faulty communication has caused four denials of clients to be admitted into the SASS program and then the hospital does not get paid.

The time it takes.

Amount of time it takes for placements/assessments (not necessarily their fault).

Exclusive criteria for clients that don't have Medicaid or are self-pay. Complicated expectations of hospital responsibility and SASS agent. Billing issues: who to contact at what time?

Confusing as to time frame of services provided. Inconsistent. SASS worker can be difficult to get in touch with. There is a lack of follow-up and treatment plan.

Nothing (4)

6. *Do you have any suggestions for improvement of the SASS program? (What should be done differently?)*

Need more resources for kids who are not SASS. 18-20 year olds should be treated as adults.

Need more facilities to care for clients.

Add more workers.

Outside assessment feels unnecessary because of hospital's own 24-hour psychiatric crisis team. For hospitals with a C&A unit this might be a conflict of interest, but they do not have a C&A unit.

Eliminate extra screening.

Clarification of documentation and procedures for 18-21 year olds.

Need a list of telephone numbers for better access.

Do the paper work right!

Better communication of discharge planning.

Hopefully, with [SASS worker] in charge (vs. [SASS worker]) things will improve.

SASS needs more workers.

Eliminate the CARES line. It is a waste of time and it is much easier to page SASS directly.

Need yearly training. More culturally competent. Need more Spanish speaking personnel.

Nothing (7)

7. *Have the changes to the CARES and the SASS program since July 1, 2004 impacted the children and families you serve? If so, in what way?*

It has limited access to services for the community's kids and families. SASS services are now limited to IDPA kids only.

Yes. More follow-through with treatment and continuity of care are very beneficial. However, there is a much longer wait time for the clients.

Helps kids under 18 who are uninsured -- this is really a benefit. Uninsured kids between 18 and 21 can

be treated as adults and that is good.

Yes. Discharge planning is more comprehensive. Puts families at ease by meeting at the hospital.

Yes. It helps by decreasing services hospital has with the clients.

Yes. Since CARES system was created, access to services is delayed.

Very disorganized and confusing, things have been changed around so many times, about who to call when, etc.

Yes. Adolescents used to have to sometimes wait a few days in the hospital before placement could be found.

Increased amount of time spent in ER.

Yes, SASS was more flexible, used own discretion. Getting extensions are more difficult for SASS to get. Another hospitalization does not trigger a new 90-day service period.

Don't know (3)

No (3)

N/A (3)

8. Have the changes to CARES and the SASS program since July 1, 2004 impacted your hospital's clinical operations? If so, how?

It has made evaluation process more drawn out.

Yes. Now with minors, the hospital often has to involve SASS and they have had to rewrite procedure.

Yes. Inpatient staff has to coordinate with SASS worker. More accountability for everyone.

Helps find resources at family's home area. Discharge planning at least 60% easier.

Emergency staff sees it an inconvenience to call SASS for screening.

Not really. A minor inconvenience is that there are extra phone calls now.

Yes, we have a lot of denials due to having to call CARES ASAP when we don't have the capability to do so.

Turnover for more critical care clients is delayed because of paperwork needed for SASS.

Yes. Hospital has challenged screeners about how the process works. Age limitations.

No (6)

Don't know (3)

N/A.

Blank (2)

9. *Which types of kids does your hospital best serve? (For example, kids with diagnoses of mental illness only, dual-disorder kids, kids with developmental disabilities, etc.) Do you have a specialization?*

Dual disorder.

Dual disorder (DDMI).

Out-patient only: Mental illness, dual disorder, developmental disabilities, substance abuse.

MI diagnosis.

[Hospital name] gets good response from local adolescent treatment centers.

Depression.

18-21 year olds. Mental illness.

Medical problems.

Mental illness only.

Young adults, 17-21. Mental illness.

MI, ages 17-21.

No kids.

MI only, no specialization.

Mental illness, dual disorder kids.

No specialization, MISA and MI.

Hospital treats 18-20 year olds as adults.

Mental illness.

N/A.

No.

No answer.

10. *Are there types of kids that your hospital is less well-equipped to serve?*

Kids who are under 5 years old.

The very young, anyone under 16, those who are extremely violent.

In-patient care.

Kids who are really violent.

Children and adolescents.

Autistic kids during an aggressive outburst. [Hospital] has trouble placing them anywhere in the area.

Under 18, Developmentally delayed.

MR or MI requiring hospitalization.

Kids.

Under 17; profoundly developmentally delayed.

DD (for placement issues), kids under 17.

Children and adolescents.

No psych beds for children and adolescents. Dual disorder: e.g. Down's syndrome and MI: Public Aid not paying as much as they used to.

Not equipped to deal with anyone under 18.

MR population.

Severely delayed. Autistic spectrum.

DD (2)

Blank .

N/A.

No.

General Hospitals with No Inpatient Psychiatric Unit (36 responses)

1. Describe what you like about CARES?

Answered promptly. Only had to make one call.

CARES just focuses on children and follow-up. Gets them into a system.

Quick to respond. Helpful.

Takes the load off nursing with clients who have social problems.

It is nice that CARES can take over. It frees up time for the social workers.

Quick to respond.

Responsive, gets things moving (dispatches SASS worker).

Additional support. This hospital has limited psychological resources.

She had very little experience with them, but said the experience was pleasant.

Quick response. The CARES system has been a really good addition.

Respond to the hospital's needs. Timely.

Staff is wonderful and knowledgeable.

Have not had any bad experiences.

CARES tracks services for children. Universal information.

They do all the work. Very responsive.

Has not heard anything bad about CARES.

Initially, nothing. Wait used to be long, but it has sped up.

Answers the phone quickly.

The concept behind it.

"It is of great comfort to us" that the hospital can refer kids to CARES.

Assistance in placements.

Quick to come out, gives the hospital lots of placement help.

Quick response, ease of referral, very clear about information, easy to access.

The idea of it. Good intentions.

Until one recent incident, CARES was quick and there was no wait.

Usually helps expedite process of finding psychological hospitalization for kids who need it.

Not enough experience with CARES to answer the question.

Nothing (2)

N/A (3)

No answer (4)

2. Describe what you dislike about CARES?

The time up front to call and the number and variety of questions to answer. The hospital's initial interview does not include these questions.

Often have to leave a message, but CARES calls back quickly.

Needs to be more efficient.

Have had past problems when a child has both insurance and Medicaid. The policy is to have a SASS

worker screen them, but CARES doesn't always agree.

In the past there have been inconsistencies (e.g., types of cases being accepted).

Can take a long time to get through to a person and answer all the questions. Lots of repetition during the many necessary phone calls. Would be easier to call SASS directly.

Ask for too much information. Too long of a phone call. Too long of a wait for SASS to come. Rude staff at times. Need follow up after SASS worker as been dispatched, i.e. a phone call to the hospital staff of an ETA for SASS worker.

A little confusing at times. Insurance issues i.e., kids without insurance are seen within 90 minutes, and kids with insurance are seen within 24 hours.

Have not had a bad experience yet.

Difficult for parent or layperson to articulate what is going on with their child. This can cause a dangerous judgment error because CARES cannot visibly see the child.

Sometimes workers are impatient regarding the patient evaluation.

It's just another step in the process, another phone call to make. Problems with staff: not helpful, become annoyed when the hospital does not call CARES first, impatient, and rude.

Extra work, things to get taken care of. Would be easier to call SASS directly.

Sometimes the hospital calls, and if the child is not in the system, no evaluation will be done. NO HSI is ever given from CARES to hospital staff (re: billing issues).

There are so many loopholes where clients cannot receive services (re: insurance and funding). People are falling through the cracks, like those with extreme poverty but not eligible for services.

The delay in response.

You get the runaround and it takes 90 minutes for SASS to get there.

Utilization. Very difficult. People are rude. Red tape.

CARES asks so many questions that hospital doesn't even ask the child. Inconsistent. Usually CARES just asks for Public Aid number. One time they asked 20 minutes of questions.

Sometimes hard to get through to the right person. Long wait for a call back.

Not enough experience with CARES to answer the question. .

N/A (3)

Nothing (10)

Don't know.

No answer.

3. *Do you have any suggestions for improvement of CARES? (What should be done differently?)*

Streamline the initial questions.

Needs to be more efficient.

Better consistency of responses.

Make CARES lines easier to use.

Streamline the process.

In a perfect world, respond quicker.

For emergency situations there should be another expedited process.

The letter about who fits the criteria for CARES is difficult to understand.

No comment--"Mental health is poor across the board, no matter what state you're in."

There are too many questions that the hospital doesn't usually go into in intake (such as sexual orientation). Complicated. It is very confusing that for different IL programs clients are considered adults at different ages.

Better communication with SASS workers re: HSI numbers. Kids ages 18-20 that have no insurance are refused by CARES.

When CARES was first presented, there was no education for the hospitals. [Hospital name] started late; so they need better and sooner educational opportunities about CARES.

Respond faster.

Faster referrals.

Need clarification of the age ranges for services.

People should be nicer and more helpful.

Consistency. "We need to know up front what questions to ask" the patient.

No (16)

N/A (3)

4. Describe what you like about the SASS program?

SASS does the assessment interview, finds placement, saves the ER time.

SASS came out and took care of it (the screening and placement process).

Focuses on that particular age group. This is a huge benefit.

Knowledgeable, open to suggestions.

The website system makes it easier to import information. Overall the idea of more intensive services when needed. SASS pays for the treatment. Ease in hospitalizations. Staffings encourage collaboration.

Helpful in finding placements for those who need it.

If SASS has already seen the child, past services can be continued.

Care is excellent.

Great with follow-up services, especially for uninsured kids.

Follow-up. Acts as a resource and advocate for child and family. Helps determine need for inpatient and outpatient and helps set that up.

Very interested in the patient, and explains things to the patient.

Very helpful with networking, placement, "they do everything we need them to do."

Very thorough and comprehensive.

Evaluate appropriately. Good follow-up. The hospital doesn't have to make calls or do evaluations.

Knowledgeable staff, readiness of staff.

Very thorough.

Uniformity. Correctively take care of kids. Continuity of care. Clients don't fall into a black hole.

In home care.

Responsiveness. The quality of people that come out.

Nothing specific.

Pretty helpful, find placements for clients.

Nothing.

The worker comes out when SASS says they will to see the child in the hospital. Usually in agreement with hospital staff. Works well.

The concept behind it.

SASS workers are available, assess the patient, find placement in psychiatric hospital.

Great working relationship.

SASS handles it. Pretty responsive and quick.

The program is ok. SASS checks for insurance coverage for client.

Immediate response. Takes full responsibility for transfer of client.

Good idea. Good intentions.

Having someone who is knowledgeable and familiar to work with the family and help with the paperwork.

Helpful with placement in psych hospitals.

No experience.

N/A.

Blank (2)

5. Describe what you dislike about the SASS program?

Response time is slow.

Requirements are helpful, but redundant and cumbersome. Hard to find the time for this. Voice to voice transfers are very difficult. A lot of time is spent calling back and forth. The caseload is so large.

Doctor wants child hospitalized and SASS worker doesn't agree. There is kind of an attitude problem. Sometimes the kid will come back.

SASS takes too long to get there.

There were two times the hospital had difficulty in contacting SASS.

Should evaluate kids who are not Medicaid. These kids get poor service from SASS workers.

The program availability is delayed (in getting them admittance into placements for clients).

Long response time. SASS declining to hospitalize a child who is obviously in need of hospitalization/SASS worker disagrees with psychiatrist and pediatrician.

Nothing specific.

She "just can't see it working." Complicated. It is very confusing that for different IL programs clients are considered adults at different ages.

Lack of communication between SASS worker and the attending doctor.

So many loopholes where clients cannot receive services (re: insurance and funding) People are falling through the cracks, like those with extreme poverty but are not eligible for services.

Takes too long for evaluation.

The hospital sees the same patients over and over. Not sure why. Wonders about follow-up for these clients, if it's happening.

Long wait for assessment and the transfer out.

Red tape. A little rude.

No experience.

Nothing (14)

No answer (2)

Blank (2)

N/A.

6. *Do you have any suggestions for improvement of the SASS program? (What should be done differently?)*

Better timeliness of response.

SASS need more counselors/staff, and better timeliness.

Need to educate SASS supervisors as to how much work and time is needed. More education for agencies in general besides the provided SASS packet. Eliminate voice to voice transfer.

More staff that can respond more quickly.

Make sure to leave paperwork for the chart.

It would be great if services could be offered for longer than 90 days.

Respond more quickly.

More funding for more crisis counselors. A 24-hour crisis hotline that anyone can call.

SASS services should be expanded to insured kids; SASS can charge insurance companies for their referral services, maybe have a master list of clients.

Better training. More timely response.

There are too many questions that the hospital doesn't usually go into in intake (such as sexual orientation). Complicated. It is very confusing that for different IL programs clients are considered adults at different ages.

Better communication and knowledge of operations.

Respond faster.

Need more follow-up. Updating on recurring patients, but wonders if that has to do with HIPAA.

If SASS is going to be delayed, the hospital needs to be notified. Communication needs improvement.

Faster response.

No experience.

Nothing (14)

Don't know (2)

N/A.

Blank (2)

7. *Have the changes to the CARES and the SASS program since July 1, 2004 impacted the children and families you serve? If so, in what way?*

SASS's resistance to admit children can make it hard because the child will often return.

Better care.

It has improved services children and families can receive. It would be helpful if services could last longer.

There isn't the 24-hour crisis hotline, which, in turn, has more patients being seen in the ER who just need someone to talk to or for reassurance.

It is hard to tell, as hospital has no further contact with child or family.

Increased uniformity. SASS correctively takes care of kids. Increased continuity of care; clients don't fall into a black hole. Discharge planning. Makes programs more accessible. Develops programs that clients and families want; try to see what is possible.

Yes, long delay. Longer time in ER (at least 1-2 hours) while waiting for SASS.

Linkage to services is quicker. Medical clearance--hospital has one definition, and SASS worker has another, so definitions and connotations need to become more refined.

Children and families (that qualify for services) are finally getting help.

The hospital is assured follow up and a payment source. There is some confusion with who to call regarding the client's age (if they are under 18, 18-20, and 21 and over).

It is no better than before, still a long wait.

Yes, positive changes. On-site evaluations benefit clients and families.

I hope so, but the hospital doesn't know after setting up the follow-up.

Yes. More positive experience for children and families.

No (6)

Don't know (2)

Unable to answer.

No experience.

N/A (11)

Blank.

8. *Have the changes to CARES and the SASS program since July 1, 2004 impacted your hospital's clinical operations? If so, how?*

Saves time.

Website creates more work. It all can be overwhelming. On the SASS website, there needs to be a multiracial option or the ability to check more than one box under race.

Social workers don't have to be as involved.

Helps determine where child should go, helps get the appointment and helps the family follow up.

It is a positive impact that the hospital now has a way to quickly transfer children to a psych unit.

Continuity of care is improved.

Hospital has to make another call.

Hospital can't move clients out of ER fast enough.

Delays within the ER and transfers out.

No difference. If the client has insurance, they are seen by the hospital. If they do not have insurance, they are seen by SASS.

Ties up ER rooms.

Yes. It has made things smoother and easier.

Yes. Hospital had to change procedure. Even though it is easy, the staff has been overwhelmed by the changes.

No, hospital usually just calls [SASS agency].

No (12)

N/A (8)

Blank.

No answer.

9. *Which types of kids does your hospital best serve? (For example, kids with diagnoses of mental illness only, dual-disorder kids, kids with developmental disabilities, etc.) Do you have a specialization?*

Medical only. Kids with mental health issues are transferred out.

Whatever walks into the ER.

ADHD.

Dual disorder.

All kids. They see lots of behavioral disorders.

MI, MIDD, DD.

Drug, alcohol, suicidal tendencies are what this hospital sees most.

Only do assessments--transfer kids out.

Dual diagnosis.

Dual disorder.

Suicidal.

Chronic illness and specialty care.

MI only.

All medical/no psych.

All kids.

Chronic medical conditions.

Suicidal clients.

No pediatric unit, admit kids approx from ages 6-8 and above, mainly MI.

Dual diagnoses, no specialization.

All kids.

All types of kids. This hospital has a Trauma 1 center. Suicidal, homicidal, and psychotic (more SASS because of CARES and SASS).

Anything that walks into the ER.

Non-psychiatric patients.

Anyone that walks in the door. No specialization.

No specialization, no psych clients.

No specialization, ADHD/behavioral disorders.

MI only, no specialization.

Good variety.

Cardiac.

Kids without insurance. Medical problems with psych problems.

ADHD.

N/A (2)

No (3)

10. Are there types of kids that your hospital is less well-equipped to serve?

Mental health.

Transfers out for services.

Kids in need of psychiatric treatment in general.

Kids who need psychiatric hospitalization.

No inpatient psych; substance abuse: the kids have to be sedated before they are transferred.

No inpatient care.

Children with violent tendencies.

Inpatient.

Psychological issues.

Kids with mental health disorders.

Youth. Transportation is an issue. It is hard for clients to get to resources.

Only seen in the ER, and then transferred out.

Hospital is primarily geriatric.

Inpatient psych.

Psych kids in general.

No inpatient ward for pediatric psych, so patients are transferred out.

No psych, no PICU.

Psychiatric patients, acute medical problems.

Psychiatric.

Kids below age 5

Can only take care of the immediate psychiatric needs of patients.

Inpatient psych needs.

Anyone in inpatient psych.

Kids with psych issues.

No psych clients.

No pediatric or pediatric psych.

Hospital can evaluate any pediatric case.

Psych and pediatric. Hospital treats and transfers out.

Inpatient psych.

Not really, do not see much DD.

N/A.

No (5)

FY06 SASS Parent Survey Comments
May, 2006

Note: All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Any Spanish comments were translated into English.

These comments related to the following question: **What specific suggestions would you make to improve SASS services and/or what aspects of services are particularly good?**

NORTHERN REGION

Spanish Parent #1: The services and the worker are very good. I like how (the worker) explains things and conducts the sessions.

Parent #2: This questionnaire should be completed, after the completion of the counseling services to make an accurate evaluation of the services rendered. Too early.

Parent #4: [Caseworker's name]-West Chicago is fantastic w/ my son!

Parent #7: The time some families will need your services longer than others! I have learned a lot from watching how the SASS worker helps my kids with the smallest to biggest of problems. I learn more from hands on and watching how things are done! Thank you very much!

Spanish Parent #13: My opinion is that (SASS) is very good and I celebrate them. I give them many thanks for helping me with my son. May God bless them and give them strength to move forward. Thank you.

Parent #42: We have had an outstanding WORKER For [child's name], our son. The worker's name is [caseworker's name]. The only reason that I showed "good" instead of "Excellent" is that [child's name] has made many strides, No person can get better results as [child's name] is a tough nut to crack. "She has one wonders!"—[Father's name], Father.

Parent #53: SASS worker is struggling with behaviors related to fetal alcohol spectrum disorder. While his intentions and efforts are good, he does not have resources to turn to for support. We are spinning our wheels after 8 weeks without a plan, not because we all don't want one, but there doesn't seem to be secondary support to refer us to. With FARD as prevalent in the system as it is, there should be more training available to workers than mothers who sought knowledge when they had no other options.

Parent #68: To have made more worker like this SASS worker.

Parent #94: The service that my child received was overall excellent. from [parent's name].

Parent #100: NONE AT ALL I AM VERY PLEASED

Parent #102: I would like to have a chance to talk with the head of SASS.

Parent #103: Knowledgeable staff who are professional and caring`

Parent #137: Outcome of SASS services & global satisfaction of SASS services not completed. Client states "Too early to tell".

Parent #140: I think it would be difficult to improve on such a well run program. I would like to thank our SASS counselor, [Caseworker's name]. She saved our family. We owe here a debt of gratitude that I'm not sure we can repay. Thank you [Caseworker's name], From the bottom of our hearts. The [Family.

Parent #142: I believe the group therapy is a very good thing. My granddaughter says she doesn't like to come but she actually enjoys coming.

Parent #144: It's an Excellent program. My Daughter just started. I don't see any room for improvement at this time.

Parent #160: I love the idea of the SASS worker coming to the house because when my child get to a office her attitude changes. I love the group session.

Parent #167: Classes on handling mentally ill people in the home to keep them out of the hospital - Technical devices available in the home and how to use them or modify them. (keep the person in the home and safe at night when everyone is trying to sleep.) Calming down methods and restraining methods. 2) When I called CARES, they wouldn't help me due to their procedure confusion. They had me call SASS for help and SASS had me call CARES back to get help. I was in the middle of a crisis and stuck in the middle of red tape regarding who should handle the call to send a SASS worker over.

Parent #187: SASS really helped especially overall with the crisis prevention especially in the beginning when we were at our lowest point in our lives with our daughter. They guided us and helped us at a really tough time. Thank you.

Parent #193: I feel the program helped very much for my daughter.

Parent #195: I think SASS offers a broad range of service... I don't know that I could suggest any improvements. I think the SASS case workers (we've worked with two) are excellent and definitely do all they can to help their clients and client families. Sadly our daughter has chosen not to take advantage of what SASS has to offer and has not taken the opportunity to improve things for herself. Hence the poor ratings in the "outcomes" section above reflect our daughter's lack of commitment and not a shortcoming on the part of SASS.

Parent #207: considering we are dealing with a teenager and they are very hard to deal with my sass worker was very supportive and very willing to be their and helpful

Parent #211: none

SOUTHERN REGION

Parent #3: [Caseworker's name] is very helpful with my child. She is always kind and full of smiles. My child really enjoys her time with [caseworker's name].

Parent #13: It is a good program because they work with you that talk to you and help you understand about how to program work and how to set up different things and work with you very good an make you understand and compremis with you.

Parent #19: There's no improvement needed.

Parent #20: Long time to see a psychiatrist.

Parent #34: The people working for them.

Parent #35: I like all the programs that SASS has to offer.

Parents #65: My child need residential he is not going to improve until he is in residential and I am glad U get [caseworker's name] some help She was overloaded yet she performs her job well and she never complains about the amount of work the agency gives her and thank for her assistance and [caseworker's name] they are both outstanding people who get the job done people who get the job done when no one else can!

Parent #69: Every effort is made to make youth comfortable in receiving services.

Parent #80: If the workers wouldn't lie, did there job, and actually tried to help.

Parent #83: Have [Caseworker's name] train everyone. [Caseworker's name] has been a god sent to us. She is very helpful, understanding person. I have had [Caseworker's name] for several children. She always is there night or day. I am really glad we have her I will be sad & a little nervis when our time is up. But she will make sure we have someone to take her place. Even though that will be very hard, because she is the best! Thank you for [Caseworker's name]! [Parent's name]

Parent #133: I was so impressed with the workers ability to listen to both the parties (my child & myself). She was great at her job and has improved my childs well being which in turn has improved mine. Thanks so much.

Parent #134: [Caseworker's name] says that same things that I have said to [child's name] for 5 years now and it is good for [child's name] to hear the same thing said to her, but not from someone in the family. I like the way [Caseworker's name] deals with [child's name] and is able to pick up on her behaviors and deal the problem to resolve it. [Caseworker's name] is just wonderful and you can tell she really cares and it not just a job to her.

Parent #147: N/A

Parent #164: The SASS worker for my foster daughter, I felt was unprofessional, I never met [Caseworker's name], only spoke to her a couple of time and she then asked to speak to [child's name]. She conversated with [child's name]. through the schools which i felt was unsatisfactory. I felt that I should have met [caseworker's name] first, then perhaps it would have been okay to visit her at school. I felt she shouldn't have came into my home without meeting me first (you teach your kids not to let anyone in with a parent present) which was overlook.[Caseworker's name] could have met me at my job if our schedules didn't coincide. I was very displeased.

Parent #171: In appropriateness and sensitivity of SASS services section - the opportunity for you and your child to be involved in his/her SASS care planning - opportunity is a poor choice of words.

Parent #175: The Sass worker should be fiar sometimes.

Parent #179: I wish they could last longer.

Parent #185: To be more responsive at getting back to clients. To have family involvement, and to have appts. with family, not child only. also

Parent #186: Have more educated workers on the evening and weekends. They should have a social work degree- not just a school teacher with minimal training. [Name] has been great.

Parent #191: Our SASS worker is always there when we need her. She is very helpful in all ways. In our area we need more behavioral doctors and clinic for those in need. People more helpful and understanding than whom we do have.

Parent #197: I believe the SASS work was done very well with my son.

Parent #198: Please Keep up The Work!

Parent #199: We have been satisfied and very pleased by SASS services.

Parent #200: No comments at this time.

CENTRAL REGION

Parent #6: I would suggest more personable counselors.

Parent #27: Them girls need more help.

Parent #37: More workers are needed.

Parent #41 Still on going. Child refuses to talk w/counselor

Parent #45: The main aspect of the service is that it helps bring issues out in the open to where parent and child work through the problems.

Parent #46: Make the program for a longer period of time. Some of these kids need the longer time and help.

Parent #47: I feel the SASS workers who work the case should follow with the clients when told they will return. Should notify family when child has escaped their care!

Parent #49: You have a well organized & helpful., also polite.

Parent #50: Don't need improving Everything is just fine.

Parent #51: Keep up the good work!

Parent #52: [Caseworker's name] is a very delightful, friendly person. She is easy to talk to by both parent and child. She seems genuinely concerned about the welfare of her client and the family. She explains things on a level we can understand without belittling us. She always has time to talk to us even when we called at her office between appointments. I hope our next mental health worker will be as helpful. On the otherhand, if you sent me a questionnaire asking about the services i received from the worker who responded to the emergency call, my remarks would be very!! poor!! She didn't listen nor respond to me. She was short and rude. She wouldn't cooperate. She drew her conclusions only from what the child said. She refused to call [Caseworker's name] when I asked her too. I hope I never see her again!!!!

Parent #61: Need program for kids who are child or adult that don't want to be in your program rather 18 yrs or older. they still need a program whether they want them or not and they are not in there right mind most of the time parent or gaurdenship should have the say so! to help them rather they want help or not!!!

Parent #62: This program is really great, but i feel the person who was helping my daughter had to many other things going on also. Other clients & foster kids. She seemed always to be hurried or had to take personal calls. Like I said though, the program is great and very helpful. It has given me my daughter back.

Parent #67: Services could be longer. 3 months is too short.

Parent #75: You need some people that are able to deal with more intense & difficult problems. Our case manager and counselor are very caring, nice & concerned people- but our particular needs are more "Down & Dirty".

Parent #76: My child was SASS'ed while in juvinile detention center so I cannot really answer these questions.

Parent #78: To Be informed more about what is really going on. (Kind of in the dark with the whole SASS Services.

Parent #79: They jumped to be involved and been there in any situation work extremely well with me and my family. Curteous & respectful! I was able to heal also by having there support so that I don't feel I'm alone anymore. Thank you so much for helping my family heal!

Parent #87: My family was in the SASS program Feb to June 2005 & it was a less than desirable experience. We joined the program again in nov-ongoing & the program was reorganized with new staff & couns & was excellent! I am very happy and respectful of the current program.

Parent #97: She was very knowledgeable about resources to help me.

Parent #119: To open a Diaplen Office

Parent #121: to be more informed of services availability- where, what criteria there may be; thought SASS would have more knowledge about how to get services; quickness of response-

Parent #122: I have really appreciated how the workers have been available to listen and assist us as parents, especially during a crisis. the help has been invaluable.

Parent #126: The counselor is very good. He does not judge. He gives insight on what my son thinks. He helps by giving us suggestions on how to deal with anger. The only problem is sometimes it is hard to schedule due to sports. However, getting my son the help he needs is more important. His school is always commenting on how much he has improved. We just need to work more at home.

Parent #127: Just what they do now.

Parent #130: I have 2 children that have received SASS services. Our counselor has been a great "moderator" between myself and my daughter. After every session we continue to learn new ways of dealing with issues.

Parent #145: I like the UNGAMES that you have and I think they should be used more often to bring people closer together.

Parent #156: Make it shorter.

Parent #163: I would like more planned activities.

Parent #169: [Child's name] has been receiving services off and on for 7 months or so. We are seeking new alternatives for my daughter and myself to cope with life and future needs. My reply to these questions could be better if we accomplished more than we have. So far, my daughter and I feel this program is very helpful. the case workers are wonderful!

Parent #182: I really need help on how to help my daughter with managing her anger. She gets really worked up on the littlest things. She doesn't know how to manage her anger with others either. Relationship with everyone in the house is really, really good until something sets her off (usually something little & stupid).

Parent #188: People Lesson are willing to help and understand.

Parent #192: When "crisis" occurred I wish you go directly to SASS services instead of the emergency at the hospital.

Parent #194: Loved that the worker could come to the home at convenient times

Parent #196: [Name] - excellent!

COOK COUNTY

Spanish Parent #2: For this being my first time with SASS, everything was excellent and I don't have a negative opinion about the program. May God bless them for helping us on time. I am grateful with all my heart.

Spanish Parent #3: SASS has 2 ideas that I like. It's to help children have confidence in their families and to be there every time there is a fight (argument). I like these two parts.

Spanish Parent #7: All the services were good. I am happy with them (services) and the staff.

Spanish Parent #8: I want to say thank you because my son has changed a lot. His behavior towards me, his sister, and school has significantly changed. I am quite grateful for your help and god bless them always. Thank you...

Spanish Parent #9: The services offered to patients for help and fun (services that keep patients entertained).

Parent #9: Worker should come out immediately after initial evaluation was done, not one month later. Once she started, she has done a good job.

Parent #10: Need service for long time period. It was only for 6 mos. I think we behavioral problems the program should last for at least 1 yr.

Spanish Parent #11: I think that SASS services are fine and do not need to change.

Spanish Parent #12: The only suggestion I would make is that I would like to see services extended. Three months is just too short. Both the child and families need more therapy and counseling sessions. SASS thank you for existing. When my daughter had her crisis, my husband and I were really sad, desperate, and felt lost. We didn't know what to do to help her. Thank you to the SASS workers who arrived and helped us. They were like "angels" from heaven that helped and guided us with the problem, they surely helped my daughter. May God Bless.

Spanish Parent #14: I don't have to say everything about the services because for me, they were excellent. I just want to say thank you for the services received.

Parent #14: Why is the service so slow. And when you are at the hospital they don't tell you that a SASS worker is coming.

Parent #31: The above selections I chose refer to [caseworker's name] (the initial contact) and [caseworker's name] (the weekly counsel) only not [Doctor's name] in the {SOC agency} office. He was late for each appt. by at least 15 mins and treated my son very cold and harsh. We left feeling he could care less about the situation. After glancing at my son's file for about 30 seconds he barked at my son while incorrectly stating what he thought he read, and had no apologies for it. I would only recommend him to an enemy.

Parent #57: I'm very happy with the results.

Parent #64: The only thing we received from SASS was a social worker for 2 months and the services ran out she was gone! (We were promised a lot of help but never received it.) I really wish SASS was never involved with my child. I have, by myself, with help of other Dr's found a suitable school for my child and she is doing very well. Sorry, but you people have to learn you just can't jump into the lives of people and disrupt them and then just go away! Is your moto, "out of site, out of mind?"

Parent #84: None our SASS worker was excellent, a true blessing to our family. I know we are to remain anonymous but [Caseworker's name] has been a god send to our child as well as to helping us rebuild our family.

Parent #85: I appreciate all the help my son and I received from SASS. I did not know this program existed. I am glad to hear and know that there is such a program for the children and their families, to help us in these situations. Thank you [Caseworker's name] for you help and time with my son [child's name]. [Mother's name].

Parent #89: I think the SASS program was a great help for my family. I think the program should be extended to at least 6 months to 9 months. (consecutive) The personal attention & follow-ups to any appointments or phone calls were excellent.

Parent #110: To expand the program to work also as a long term team as a outside program to the community for long term treatment as needed. I feel that SASS is more sensitive to you and your child's needs.

Parent #114: The individual SASS worker was outstanding and made a life changing impact on my son's life- he is a new wonderful person to be with.

Parent #117: I would like to see a long term program to continue to work with me and my child. They work with you and your child to help resolve the problems and to stabilize the home.

Parent #118: Communication to the parents better or some at all. More follow through and follow up. My child is a nervous breakdown and about to explode and i have no where to turn. [SOC agency name] SASS program is the worst around. Thank you.

Parent #131: There needs to be more than 3 months thing were just starting to make a difference and then we lost our SASS person. You need to give us the option of more time, Mr. [Name] was just starting to be able to help- I think our SASS worker had a much better understanding of the situation than our therapy in the hospital.

Parent #132: SASS has been great, in the end its all the childs responsibility to change things for the best.

Parent #151: Nada

Parent #155: None

Parent #168: More time.

Parent #183: SASS has been a great help.

Parent #210: The personal approach.

Parent #213: All were very good and professional

Parent #218: No, they are pretty good.

FY06 SASS Youth Survey Comments
May, 2006

Note: All comments are printed exactly as they appear on the survey (e.g., with spelling and grammatical errors) but with any identifying information removed. Comments in *italics* were dropped due to the age of the respondent. All Spanish comments, except #2 (Spanish), were translated into English from Spanish. #2 was written in English. Responses from the Youth 12 and over surveys are listed first, followed by Youth under 12.

Youth 12 and over

Key to comments

Respectful refers to the statement: If you didn't think the SASS worker was respectful, please tell us what happened.

Doing now refers to the question: How are you doing now compared to before you met with SASS?

Like refers to the question: What did you like most about your experience in SASS?

Dislike refers to the question: What did you like least about your experience in SASS?

Anything else refers to the statement: Please use the space below to tell us anything else you would like us to know about your SASS experience.

CENTRAL

Youth #16

Respectful: [Name] and I met once a week every week. She was nothing but respectful which kept me on my toes to keep me being respectful to her.

Doing now: [Name] makes me feel that I am a person and everyone has flaws that doesn't make them ugly just unique.

Like: Every week we played a game and talked. I liked that because I don't like people to talk at me for an hour.

Dislike: I didn't get more time with my worker. The time goes by so fast and I don't get to talk to [Name] anymore.

Anything else: Keep up the good work. You Hire all the best people.

Youth #20

Respectful: No comment

Doing now: No comment

Like: My counselor

Dislike: I like everything

Anything else: No comment

Youth #22

Respectful: No comment

Doing now: I have my ups and downs

Like: I could share my feelings

Dislike: When she left the first time

Anything else: No comment

Youth #26

Respectful: No comment

Doing now: No comment

Like: I don't know

Dislike: Nothing

Anything else: She is the best SASS worker I ever had. So I had nothing wrong with her.

Youth #28

Respectful: No comment

Doing now: No comment

Like: Meeting with my worker.

Dislike: Going to the hospital
Anything else: No comment

Youth #31

Respectful: Yes, I clicked with her immediately and she helped me out. I felt that I could instantly talk to her.

Doing now: The process to success is a long and hard struggle. Its taking time but is gradually getting better.

Like: Being able to talk to someone when I needed to most.

Dislike: That I felt uncomfortable sometimes.

Anything else: I think the sass program has helped me to put my priorities back in order, and realize whats truly important in life.

Youth #35

Respectful: No comment

Doing now: No comment

Like: A different perspective

Dislike: No comment

Anything else: No comment

Youth #36

Respectful: No comment

Doing now: No comment

Like: The help and how kind my case worker is to me

Dislike: nothing.

Anything else: Im have a really good caseworker he is the kindest and most genouris case worker ive ever met. he helps me the best he can. and we have alot of fun! I like SASS.

Youth #37

Respectful: *No comment*

Doing now: *We would like to speak to [Name]*

Like: *They are very polite & they listen to a person's situation and solve the problem in a professional manner..*

Dislike: *No comment*

Anything else: *We are very grateful of all the assistance available in helping with a loved one who has a disorder we want [name] to acheive is goals in life. Thank you very much. [Family name].*

Youth #38

Respectful: No comment

Doing now: No comment

Like: It helped me know more about me and helped me to learn how to make right choice

Dislike: Nothing

Anything else: 1. Do you like helping people and their faimly.

Youth #39

Respectful: No comment

Doing now: No comment

Like: They talked to me about problems and hot to deal with my problems and choices

Dislike: I don't get to talk to talk to the people I talked to

Anything else: I experienced in SASS that if you kill yourself it doesn't do anything or help anything.

Youth #40

Respectful: nothing

Doing now: No comment

Like: When [Name] was talking about my problems with me.

Dislike: nothing I liked everything

Anything else: No comment

Youth #45

Respectful: No comment

Doing now: I am doing much better because [Name] taught me that I can do so much more with my life.

Like: Getting my feelings out.

Dislike: Everything was great. I didn't have a least favorite experience.

Anything else: I just really enjoyed it. I am glad I got help from SASS. [Name] was great, and funny, and very smart! Thank you!

Youth #46

Respectful: No comment

Doing now: No comment

Like: Nothin

Dislike: 12- Sping Break Ruined

Anything else: No comment

Youth #47

Respectful: No comment

Doing now: No comment

Like: People to talk to

Dislike: nothing

Anything else: No comment

Youth #48

Respectful: *No comment*

Doing now: *No comment*

Like: *No comment*

Dislike: *No comment*

Anything else: *Child refuses to talk w/ counselor or fill this out*

Youth #49

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: She helped me at school

Youth #50

Respectful: *No comment*

Doing now: *No comment*

Like: *Spent time with me*

Dislike: *came to my school*

Anything else: *[Name] was fun.*

Youth #51

Respectful: No comment

Doing now: I am passing my classes. I have a job. =)
Like: Told me I could do better. Helped me with my problems
Dislike: Nothing. =)
Anything else: Awesome

Youth #54

Respectful: No comment
Doing now: No comment
Like: The respect from each person to come to help
Dislike: No comment
Anything else: No comment

Youth #55

Respectful: No comment
Doing now: No comment
Like: playing games
Dislike: do not know
Anything else: No comment

Youth #59

Respectful: The lady I met from SASS tried to put word in my mouth. It's not the one helping me out. The SASS worker [name] is the one helping me.
Doing now: No comment
Like: The fact that [name] helped me
Dislike: The fact that the lady the i met from SASS, that came to school, gave me and my family no choice as to if I went to the [hospital name].
Anything else: The first SASS person was a lady, I don't remember the name. Said i had to go to the [hospital name]. She also tried to put words in to my mouth. [Name] the I'm with now I like him, and so does my parents. I think [name] is trying to help me.

Youth #60

Respectful: No comment
Doing now: No comment
Like: She listened to me
Dislike: none
Anything else: I'm really glad she helped me with problems

Youth #63

Respectful: She gave me consequences
Doing now: No comment
Like: Helping my family
Dislike: Working with the police
Anything else: No comment

Youth #67

Respectful: N/A
Doing now: N/A
Like: It gave me more help with what I needed
Dislike: N/A
Anything else: Everything

Youth #69

Respectful: No comment
Doing now: I've stopped fighting with my sister as much. Me and my family are kinda getting along more
Like: No comment
Dislike: No comment. Just helps me.
Anything else: no comment

Youth #73

Respectful: No comment
Doing now: No comment
Like: i was always talking to someone. [Hospital name] is the best facility around, when i was in [Second hospital name] I never talked to anyone it was crap.
Dislike: No comment
Anything else: The food was good, it is way better than [second hospital name]!!!

Youth #74

Respectful: No comment
Doing now: I really like the program
Like: How the SASS worker let me know what was going to happen and why I was how I was
Dislike: nothing much
Anything else: Don't really have anything to say

Youth #75

Respectful: No comment
Doing now: [Name] is a great SASS worker
Like: the kindness was great.
Dislike: She talked to me about really personal things
Anything else: It has been very helpful =)

Youth #76

Respectful: No comment
Doing now: Well I think I need to be put on new depression medication. Plus i am always comparing everything to "it would be better if i wasn't alive right now!"
Like: I'm really not sure
Dislike: I guess the 6th floor! And all the therapist I had to see until I found the right one!
Anything else: nothing

Youth #77

Respectful: No comment
Doing now: Life is still tough! My caseworker will not always be there for me to talk to.
Like: Its with my caseworker
Dislike: nothing went wrong!
Anything else: It went very well!

Youth #78

Respectful: No comment
Doing now: No comment
Like: going places
Dislike: nothing...
Anything else: No comment

Youth #79

Respectful: No comment
Doing now: None
Like: Getting to do different things
Dislike: Having to leave the Y's computer
Anything else: No comment

Youth #80

Respectful: No comment

Doing now: She was really nice to me

Like: Just don't like counseling

Dislike: No comment

Anything else: No comment

Youth #88

Respectful: No comment

Doing now: No comment

Like: I got to talk to someone different about my problems

Dislike: Nothing but at first it was having to talk to a complete stranger

Anything else: It was fun.

Youth #89

Respectful: No comment

Doing now: No comment

Like: I don't know

Dislike: I don't know

Anything else: No comment

Youth #90

***Respectful:** No comment*

***Doing now:** No comment*

***Like:** No comment*

***Dislike:** No comment*

***Anything else:** No comment*

Youth #92

***Respectful:** No comment*

***Doing now:** No comment*

***Like:** There helpfulness in helping with my daughter*

***Dislike:** N/A*

***Anything else:** [Name] was awesome in helping me deal with issues with my daughter*

Youth #94

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: Meet [name]

Youth #95

Respectful: No comment

Doing now: No comment

Like: There trying to help me deal with my problem.

Dislike: No comment

Anything else: No comment

Youth #96

Respectful: No comment

Doing now: No comment
Like: [Name]
Dislike: No comment
Anything else: No comment

Youth #97

Respectful: No comment
Doing now: No comment
Like: meeting her 2nd being able to talk
Dislike: nothing
Anything else: it was great

Youth #99

Respectful: No comment
Doing now: No comment
Like: I'm respected as a kid
Dislike: doing packets
Anything else: No comment

Youth #103

Respectful: No comment
Doing now: No comment
Like: Going places, having fun & talk to the same time.
Dislike: Nothing really
Anything else: Not much really.

Youth #117

Respectful: No comment
Doing now: No comment
Like: No comment
Dislike: I liked pretty much everything
Anything else: No comment

Youth #121

Respectful: No comment
Doing now: No comment
Like: They were very nice and understanding
Dislike: No comment
Anything else: No comment

Youth #128

Respectful: No comment
Doing now: No comment
Like: Someone listening to me for once.
Dislike: I had someone to talk to.
Anything else: No comment

Youth #130

Respectful: No comment
Doing now: No comment
Like: Having someone to talk to that is not in my family.

Dislike: being in the hospital.
Anything else: No comment

Youth #131

Respectful: No comment
Doing now: No comment
Like: It was helping me alot.
Dislike: No comment
Anything else: No comment

Youth #132

Respectful: Yes, she didn't treat me like I was crazy when I told her what happened
Doing now: No comment
Like: That they helped me get help when I needed it
Dislike: Having to talk to someone.
Anything else: No comment

Youth #133

Respectful: She said she needed to do whats best for me. She talked in a good manner and was polite respectful and told us who she was and why she is here.
Doing now: [Name] is AWESOME! She even gave me her number to call when I really need some help!
Like: I liked how the staff is so nice. They really put there full effort into it.
Dislike: That I had to go to the hospital because [name] thought it would be the best.
Anything else: I've overcome a lot of obsticales and I am on my way to healing and getting better. I couldn't have done that on my own or without the help of [Name].

Youth #146

Respectful: No comment
Doing now: I think that it would help a little but I've only seen my SASS worker twice.
Like: (My SASS worker)she is really funny.
Dislike: My other worker in a different country was mean.
Anything else: No comment

Youth #149

Respectful: No comment
Doing now: I loved how they helped me. I still talk about suicide but nothing near me doing it.
Like: They cared
Dislike: That the problems can't all go away.
Anything else: I had a lot of problems with the world now just my friends and family but everyone had that LOL (laugh out loud). Just because someone is gothic doesn't mean there depressed.

Youth #157

Respectful: No comment
Doing now: No comment
Like: Talking
Dislike: the worksheets
Anything else: No comment

Youth #158

Respectful: No comment

Doing now: No comment

Like: Nice Counselor

Dislike: No comment

Anything else: No comment

Youth #167

Respectful: No comment

Doing now: No comment

Like: Having someone other than my mom to talk to.

Dislike: I don't know.

Anything else: No comment

COOK COUNTY

Youth #18

Respectful: No comment

Doing now: I now feel more confident about my self but I wish it was a longer treatment.

Like: I realized how my problems can get resolved and how this (treatment) helps me alot.

Dislike: There is not much to say because I so happen to like everything about SASS

Anything else: My SASS worker is a very good listner and remembers everything I said in the last app. She pays very good attention to what I said. And I appreciate that. It's seems I'm getting all the help I need. And I thank you for that.

Youth #19

Respectful: No comment

Doing now: [name?] cool with me

Like: playing Basketball

Dislike: He did not like some of the thing I said

Anything else: No comment

Youth #23

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: Doctor [name] is cold, mean, disrespectful, reads to fast when we left we felt bad, And treated unfairly.

Anything else: No comment

Youth #27

Respectful: No comment

Doing now: No comment

Like: I liked that I could talk to the SASS worker without no problem

Dislike: No comment

Anything else: No comment

Youth #32

Respectful: Made me go back to my old school, said if i didn't go back i was just running away from my problems. wasred 3 months at my school in BD classes and now am transfered to another school.

Doing now: I like the new school I wanted to go to in the first place, thanks for letting me waste 3 months.

Like: the social worker

Dislike: Everything but social worker!!

Anything else: No comment

Youth #33

Respectful: No comment
Doing now: Visitation
Like: No comment
Dislike: Nothing
Anything else: No comment

Youth #52

Respectful: No comment
Doing now: No comment
Like: That we can talk about anything and it's confidential
Dislike: There's nothing that I don't like about SASS.
Anything else: My SASS experience went well, I loved it. And I feel much better after i got it

Youth #58

Respectful: Then I will give him a bade atenchen and i will not lisen to him
Doing now: The best. The coolest of all. The nicest of aney one.
Like: I don't know? Everything.
Dislike: Nothingh. It all cool
Anything else: No comment

Youth #61

Respectful: No comment
Doing now: No comment
Like: He really helped me with my problems
Dislike: nothing
Anything else: No comment

Youth #62

Respectful: No comment
Doing now: No comment
Like: The way SASS also help people (like paying our gas bill) and helping me to learn more other things that I was ignoring since i come from different culture
Dislike: Sometime, instead of doing my homework I have to be with SASS worker
Anything else: No comment

Youth #65

Respectful: No comment
Doing now: I love SASS and [Name]
Like: It is very helpful
Dislike: nothing
Anything else: I love SASS. It helped me with my family issues. [Name] helped me the most anyone ever did. Thanks [Name]

Youth #66

Respectful: No comment
Doing now: No comment
Like: She's nice and a girl and I can tell her stuff
Dislike: I don't have any.
Anything else: I like everything but I just don't like talking to guys, but I am willing to do that.

Youth #68

Respectful: No comment

Doing now: No comment

Like: She understands how growing up today is.

Dislike: Nothing really. I like my SASS worker

Anything else: No comment

Youth #81

Respectful: No comment

Doing now: thank you for your help!

Like: I like [Name]

Dislike: nothing

Anything else: it is fun it is helpful i love it alot

Youth #82

Respectful: No comment

Doing now: The social worker, [Name], is very nice and understanding.

Like: That my social worker talks to me about what's going on in my life and helps me by giving advice.

Dislike: Nothing because I have liked it so far.

Anything else: No comment

Youth #83

Respectful: No comment

Doing now: No comment

Like: That I had someone to talk to. And I learned how to deal with some situations.

Dislike: It helpme me alot. And learned to deal with problems better.

Anything else: No comment

Youth #84

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: No comment

Youth #85

Respectful: No comment

Doing now: No comment

Like: The therapy.

Dislike: Location

Anything else: It has really helped me change my life in a positive way.

Youth #91

Respectful: *No comment*

Doing now: *[Name] helped us a lot. She was very nice and respectful.*

Like: *Everytime I called [name], she called back right away. She guided me what to do when my son was sick.*

Dislike: *No comment*

Anything else: *My son got quality benefits and [Name] was careful to get the what my son needed. We are very happy with the services we got.*

Youth #98

Respectful: *No comment*

Doing now: *No comment*

Like: *[Name] was giving me changes and was getting me into karate and guitar. [Name] being very nice and helpful*

Dislike: No comment

Anything else: The program is only 90 days. I feel that more time is needed- It just isn't enough. We just get started with things and then it has to end.

Youth #102

Respectful: N/A

Doing now: Whenever I meet with him I feel like he understands me and know alot about me.

Like: That i got to stick with the same SASS worker all the times after the hospitalization.

Dislike: N/A

Anything else: My SASS consoluer was very polite and committed. He was there for me emotionally. He came weekley and showed that he really did care and really wanted to see me do well. So thanks.

Youth #111

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: He has ADHD, Also mentally retarded. Client was unable to answer any of these questions.

Youth #113

Respectful: No comment

Doing now: No comment

Like: Being able to have my thoughts understood and heard out

Dislike: The amount of time given.

Anything else: How come it is SASS is not for a longer period?

Youth #114

Respectful: No comment

Doing now: No comment

Like: All

Dislike: Nothing

Anything else: No comment

Youth #115

Respectful: No comment

Doing now: No comment

Like: Everything

Dislike: ?

Anything else: ?

Youth #119

Respectful: No comment

Doing now: I really looked forward to talking to her

Like: That I could talk about my feelings to someone who would listen.

Dislike: That sometimes I had to talk about cutting, something that I wasn't used to.

Anything else: No comment

Youth #122

Respectful: No comment

Doing now: No comment

Like: I pleasure [Name] come
Dislike: No comment
Anything else: No comment

Youth #123

Respectful: No comment
Doing now: No comment
Like: She listen.
Dislike: they repeat everything
Anything else: N/A

Youth #124

Respectful: No comment
Doing now: [Name] was a wonderful, caring, man. He helped feel a lot better about myself. He is definitely an awesome SASS worker.
Like: [Second Name] (my big sister) she knew were I was coming from and she understood me.
Dislike: Nothing really! It helped me a-lot. [Second name] and [Name] are very wonderful people. They understand you completely.
Anything else: I just wanted to say thank you for everything it was a very helping experience. And I would recoment [Name] and [Second name] they helped me in so mayne ways possible. A way other just could never understand or even help. Thank you guys for EVERYTHING! (You have two wonderful people working for SASS!)

Youth #127

Respectful: No comment
Doing now: no
Like: I don't now
Dislike: No comment
Anything else: No comment

Youth #147

Respectful: No comment
Doing now: No comment
Like: My other worker in a different country was mean.
Dislike: nothing
Anything else: No comment

Youth #148

Respectful: No comment
Doing now: I still get depressed sometimes.
Like: That I also had a sayin in what suggestions I had for my treatment.
Dislike: Everything was great
Anything else: SASS is a wonderful "committe"

Youth #152

Respectful: No comment
Doing now: No comment
Like: That can help me with my anger
Dislike: noting
Anything else: No comment

Youth #162

Respectful: No comment

Doing now: It just been a good experience all the way through. SASS has really been helpful

Like: What I like most about my experience in SASS is that it is not hard to talk to your social worker. they act like little kids [no offense]

Dislike: Nothing really. all my sass encounters have been good ones.

Anything else: There's not really anything I would like to know now nothing I could think of right now anyway big UPS to SASS keep doing what you're doing Keep your head up.

Youth #164

Respectful: No comment

Doing now: No comment

Like: nothing

Dislike: Everything

Anything else: Why can't I eat your food? Why!!! Why..... Why.....

Youth #165

Respectful: No comment

Doing now: No comment

Like: He nice fun and cring love to ask what i have been doing in the week and i want to keep seeing him

Dislike: nothing

Anything else: No comment

Youth #166

Respectful: No comment

Doing now: I can say for myself that before I started SASS I was terrible but with the help from [Name] I'm doing much better.

Like: I got to put most of my trust in these people with telling them about my life and the things that was going on in my life and the things that are still going on right now today.

Dislike: I liked everything because they told me everything that I needed to know about life and what to expect when things come my way

Anything else: None

Youth #168

Respectful: No comment

Doing now: None

Like: She listen

Dislike: The support

Anything else: No comment

Youth #3 (Spanish)

Respectful: No comment

Doing now: I feel that SASS is doing a very good job. But SASS also has to teach the youth (boys) to respect their family and to participate in the education of (other?) children.

Like: He doesn't feel like we are his family and SASS is trying to help him. My son feels supported by SASS for the bad things he has done.

Dislike: After spending the day talking (in session), my son does not show any respect. He has improved a bit, but there are things missing in his treatment.

Anything else: I am quite satisfied with my experience with sass. The staff helped me to understand many things that families should know. I am very grateful and good luck

Youth #4 (Spanish)

Respectful: No comment

Doing now: No comment

Like: When I was able to go to the YMCA, so that my body can be in shape. And when I was able to tell the worker my most intimate things.

Dislike: When I was told that I had to stop smoking and leave my house

Anything else: The only thing I want to say is that (for the program) to keep moving forward. Thank you for all that you've done for me. They have taught me many things about life that I still have to learn. And that in life, there aren't always answers for all questions asked.

Youth #5 (Spanish)

Respectful: No comment

Doing now: Thank you to [Name]. I learned a lot through his advice, so again, thank you. Like previous years, thanks to him my relationship with my parents improved. Thank you to the SASS program

Like: [Name] gave me advice for every problem that I had. Thanks to him I am enjoying my parents confidence (in me). I would prefer to have [Name] than any other therapist in session. I prefer [Name] and would not like to see anyone else in the agency.

Dislike: I can really say anything other than they fact that I really liked [Name] advice about how to work with my parents and in general. I felt like a friend was giving me advice.

Anything else: Thank you to the SASS program for connecting me with [Name]. I liked having his as a therapist He supported me through many things. I liked him so much that I wouldn't want to go to anyone else for therapy. Thank you to the SASS program and to [Caseworker name].

Youth #6 (Spanish)

Respectful: No comment

Doing now: The SASS worker is really good and helped me a lot. Especially in helping me to forget what I used to think about. I am very grateful for his serve (having helped me).

Like: That he was helping me and that he is a very good psychologist because he can help youth like me.

Dislike: No comment

Anything else: No comment

Youth #7 (Spanish)

Respectful: No comment

Doing now: I am much better, I think things through better

Like: The worker I had, [Name], he was really god to me.

Dislike: The time that I spent in the hospital.

else: My SASS experience was really good. They helped me a lot with my feelings.

Anything

NORTHERN

Youth #1

Respectful: No comment

Doing now: No comment

Like: Consideration of my wants, needs & thoughts

Dislike: Nothing

Anything else: No comment

Youth #7**Respectful:** No comment**Doing now:** Before I was very suicidal, no I'm not thinking about that at all. Thanks to the SASS worker.**Like:** Well I had people I could talk to, trust, and have confidence on them. And they also help me when I needed advice.**Dislike:** Honestly it was okay.**Anything else:** Keep up the good work. I really like the SASS program because it really change my life in a good way. I'm sure that the SASS program could help other people that needs help like I did.**Youth #8****Respectful:** No comment**Doing now:** No comment**Like:** No comment**Dislike:** No comment**Anything else:** No comment**Youth #11****Respectful:** No comment**Doing now:** I can control my anger a lot better than I could before.**Like:** Being able to talk to someone about my problems and actually having them listen.**Dislike:** Sitting at the computer for a long period of time taking the survey**Anything else:** No comment**Youth #14****Respectful:** No comment**Doing now:** Thank you**Like:** The ant lesson**Dislike:** Some of the family sessions**Anything else:** No comment**Youth #21****Respectful:** No comment**Doing now:** I have my ups and downs**Like:** I could share my feelings**Dislike:** When she left the first time**Anything else:** No comment**Youth #42****Respectful:** No comment**Doing now:** They helped me out during a hard period in my life**Like:** Nothing Really**Dislike:** I could ask her anything she wood help me out with my problems**Anything else:** No comment**Youth #43****Respectful:** I felt funny when she asked about my dreams.**Doing now:** No comment**Like:** That we get to talk. that we're very friendly**Dislike:** Having to talk about my dreams.**Anything else:** No.**Youth #44****Respectful:** No comment**Doing now:** No comment**Like:** Do not know

Dislike: Do not know
Anything else: No

Youth #56

Respectful: No comment
Doing now: No comment
Like: Helped me with my depression
Dislike: talking about depression
Anything else: No comment

Youth #57

Respectful: No comment
Doing now: No comment
Like: We went places and talked about my problems
Dislike: We talked more about outside stuff than my actual problem
Anything else: I liked working with my caseworker. She was a fun person to be with

Youth #64

Respectful: No comment
Doing now: No comment
Like: Not Sure
Dislike: Not Sure
Anything else: No comment

Youth #86

Respectful: No comment
Doing now: that I saw [Name] almost every week
Like: No comment
Dislike: the token system
Anything else: No comment

Youth #87

***Respectful:** No comment
Doing now: No comment
Like: No comment
Dislike: No comment
Anything else: No comment*

Youth #93

Respectful: No comment
Doing now: Its my fault that i'm not at "much better" instead.
Like: Meeting other people in IOP w/the same problems. and struggles that I can relate to.
Dislike: I had to talk about alot of things that I don't like to talk about.
Anything else: No comment

Youth #104

Respectful: No comment
Doing now: No comment
Like: I was able to express my thoughts and feeling when I felt like hurting myself
Dislike: Nothing. I like talking to her and my self harm and feelings.
Anything else: they do their jobs good and I think they help us alot and make us feel better about my self.

Youth #106

Respectful: No comment

Doing now: No comment

Like: My worker is very helpful and understanding and very respectful.

Dislike: No comment

Anything else: She was there when I needed her. Shes very helpful.

Youth #107

Respectful: No comment

Doing now: No comment

Like: She told me what we are going to work on

Dislike: no coping skills. no tools for change.

Anything else: No comment

Youth #109

Respectful: No comment

Doing now: I am more interested in school and willing to do activities and participate

Like: Gaining trust and feeling comfortable and open to talk about difficult subjects

Dislike: How we only got a certain amount of days to meet

Anything else: I really enjoyed this experience. It helped me open up and feel comfortable to talk to my family. It also taught me how to let my feelings out and comfort people in a positive way.

Youth #110

Respectful: No comment

Doing now: No comment

Like: Understand what I'm saying

Dislike: No comment

Anything else: No comment

Youth #116

Respectful: No comment

Doing now: No comment

Like: That the workers are very nice

Dislike: No comment

Anything else: No comment

Youth #118

Respectful: No comment

Doing now: No comment

Like: I got to make my own decisions

Dislike: I had to go to the 2nd Floor (hospitalization)

Anything else: No comment

Youth #120

Respectful: No comment

Doing now: Nothing

Like: I got to see doctor [Name]

Dislike: No comment

Anything else: NO

Youth #129

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: It helped me understand to help myself

Anything else: none

Youth #140**Respectful:** No comment**Doing now:** No comment**Like:** That I had a good SASS worker.**Dislike:** No comment**Anything else:** That he should have a paid raise.**Youth #153****Respectful:** No comment**Doing now:** doing excellent**Like:** it helped more than I thought it would help me.**Dislike:** telling them the bad things**Anything else:** [Name] was great!**Youth #154****Respectful:** No comment**Doing now:** No comment**Like:** Have someone to talk to.**Dislike:** No comment**Anything else:** No comment**Youth #155****Respectful:** No comment**Doing now:** I still have some problems but SASS has really help me.**Like:** How our home went from trashy to nice and clean**Dislike:** Doing alot of cleaning**Anything else:** The councler was really nice and helpful. and understanding.**Youth #156****Respectful:** No comment**Doing now:** I'm off alot of the meds and just her caring that much made me feel alot better**Like:** The ability to talk about my feelings**Dislike:** Nothing really I liked it all...Except for the mental hospital which I don't know if SASS had any part to do with that but I didn't like it**Anything else:** No comment**Youth #163****Respectful:** No comment**Doing now:** No comment**Like:** When I needed help they came when I called**Dislike:** talking about my past**Anything else:** No comment**Youth #1 (Spanish)****Respectful:** No comment**Doing now:** No comment**Like:** That they helped me when I needed help.**Dislike:** No comment**Anything else:** No comment

Youth #2 (Spanish)

Respectful: No comment

Doing now: the worin is very mode avediede and always had a smilale on her face.

Like: having fun with the woriin she made the seccion fun

Dislike: Nothing everything is grate they were always conncerend

Anything else: The Program was exalent the worin is very moadvadeate and I had lots of un and I think the Program helped a lot it change lot's of thing I would like a part of SASS wen I grow up some day would like to help kids.

SOUTHERN

Youth #2

Respectful: No comment

Doing now: No comment

Like: I can talk to her about anything and she won't tell my mom.

Dislike: Being in the hospital.

Anything else: No comment

Youth #3

Respectful: No comment

Doing now: Depressed feelings have gotten a little better, but other feelings like less energy, interest, motivation, etc. need to improve

Like: Counselor is easier to talk to than my last one

Dislike: Nothing

Anything else: No comment

Youth #4

Respectful: No comment

Doing now: No comment

Like: She really listened to me

Dislike: The rooms are blank and I can't keep my mind on what we are talking about.

Anything else: No comment

Youth #5

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: No comment

Youth #6

Respectful: No comment

Doing now: Can't rate I just started

Like: I don't know

Dislike: No comment

Anything else: No comment

Youth #9

Respectful: No comment

Doing now: No comment

Like: No comment

Dislike: No comment

Anything else: No comment

Youth #10

Respectful: No comment

Doing now: No comment
Like: No comment
Dislike: No comment
Anything else: No comment

Youth #12

Respectful: No comment
Doing now: Need different meds
Like: Very helpful
Dislike: N/A
Anything else: N/A

Youth #13

Respectful: No comment
Doing now: No comment
Like: Learning more about things myself and how comp
Dislike: I met alot of people and a little enjoyed myself
Anything else: No comment

Youth #15

Respectful: No comment
Doing now: No comment
Like: Much better
Dislike: They tell me what to do when I have a problem
Anything else: No comment

Youth #17

Respectful: No comment
Doing now: No comment
Like: I Got to get out of the house and talk about things
Dislike: Can't think of anything
Anything else: No comment

Youth #24

Respectful: No comment
Doing now: No comment
Like: Talking about my problems, and opening up to someone who understand.
Dislike: There wasn't anything I didn't
Anything else: No comment

Youth #25

Respectful: No comment
Doing now: She's alot of fun and easy to talk to
Like: Being able to talk to someone without being judged
Dislike: Not being able to do more out side of [name?]
Anything else: No comment

Youth #29

Respectful: No comment
Doing now: No comment
Like: No comment

Dislike: No comment
Anything else: No comment

Youth #30

Respectful: No comment
Doing now: No comment
Like: No comment
Dislike: No comment
Anything else: No comment

Youth #34

Respectful: No comment
Doing now: No comment
Like: You get to talk with your worker and go places with them and they listen to you
Dislike: No comment
Anything else: I like seeing the doctor and talking with my counselor

Youth #41

Respectful: No comment
Doing now: No comment
Like: That she was nice
Dislike: nothing
Anything else: No comment

Youth #53

Respectful: No comment
Doing now: I'm doing a lot better with school and stuff. Behavior is much better. This is the longest time I've maintained a foster home
Like: going to place like park and pet store.
Dislike: Nothing
Anything else: No comment

Youth #70

Respectful: No comment
Doing now: I have my ups and downs still.
Like: Some to be able to talk to.
Dislike: Talking about some of the past.
Anything else: i really appreciate [Name]. She has helped with a lot of things.

Youth #71

Respectful: No comment
Doing now: No comment
Like: Getting to talk about how I feel and the things that went on. Also no one judge me.
Dislike: Having to talk about the personal stuff, but I guess it was okay. Having to describe my feelings, they were very complicated feelings, but I did it.
Anything else: should do it more often.

Youth #72

Respectful: yes
Doing now: No comment
Like: No comment

Dislike: No comment
Anything else: No comment

Youth #100

Respectful: No comment
Doing now: No comment
Like: Being able to talk with Mrs. [Name] in general. She is nice.
Dislike: Nothing.
Anything else: Mrs. [Name] listened to me and we could talk about anything like things we both do and thing that bother me. She was very kind and patient with me.

Youth #101

Respectful: No comment
Doing now: No comment
Like: The game board
Dislike: Hospital, people looking at me funny
Anything else: No comment

Youth #105

Respectful: No comment
Doing now: No comment
Like: She made me feel like I mattered. She made me feel good about myself.
Dislike: I didn't like the fact that the first time I was here I felt very uncomfortable.
Anything else: No comment

Youth #108

Respectful: *No comment*
Doing now: *No comment*
Like: *They teache you on how to deal with your anger and probblesmes.*
Dislike: *I liked everything.*
Anything else: *No comment*

Youth #112

Respectful: *He is nice [Name] works very well with me.*
Doing now: *No comment*
Like: *He is funny. [Name] comes to my school, and see me and make sure that I'm doing very good.*
Dislike: *I do not know.*
Anything else: *No comment*

Youth #125

Respectful: No comment
Doing now: No comment
Like: Nothing
Dislike: Boring
Anything else: Boring

Youth #126

Respectful: No comment
Doing now: No comment
Like: Someone to hang out with.
Dislike: nothing
Anything else: nothing

Youth #134

Respectful: No comment

Doing now: No comment
Like: I had someone to talk to when I was depressed
Dislike: No comment
Anything else: No comment

Youth #135
Respectful: No comment
Doing now: No comment
Like: Counseling
Dislike: Getting up for Doctors Appointments
Anything else: No comment

Youth #136
Respectful: No comment
Doing now: 1st visit
Like: [Name] was really nice.
Dislike: nothing really.
Anything else: No comment

Youth #137
Respectful: *No comment*
Doing now: *No comment*
Like: *They care about your needs. they make sure you are cared about.*
Dislike: *N/A*
Anything else: *Our counselor was outstanding - always helpful - never made you feel like you were unimportant. always available to take you phone call - Made time for you. very good with my son.*

Youth #138
Respectful: No comment
Doing now: No comment
Like: The group people has more problems then me and worse than me. It wasn't that bad at all.
Dislike: No comment
Anything else: No comment

Youth #139
Respectful: No comment
Doing now: No comment
Like: He is really nice to me. I think the SASS program is helping.
Dislike: Nothing it's all good.
Anything else: No comment

Youth #141
Respectful: No comment
Doing now: No comment
Like: That it helped me a little
Dislike: Not a thing.
Anything else: No comment

Youth #142
Respectful: No comment
Doing now: I cope much better with my problems than I did before
Like: I got, to talk about my problems without being judged.

Dislike: We stayed in one room the whole day.
Anything else: No comment

Youth #143

Respectful: No comment
Doing now: No comment
Like: Going to the hospital.
Dislike: Don't know.
Anything else: No comment

Youth #144

Respectful: No comment
Doing now: No comment
Like: Basketball ried my bick
Dislike: No comment
Anything else: [Name] not hall ut me ny more and me ried my bick,

Youth #145

Respectful: Don't know
Doing now: gameboy
Like: No comment
Dislike: don't know
Anything else: No comment

Youth #150

Respectful: No comment
Doing now: No comment
Like: They let me talk and they listen to me
Dislike: NA it was ok
Anything else: There very respectful to me & very kind

Youth #151

Respectful: The SASS worker was as respectful a probily can be.
Doing now: I love it know because I get to get more priviliges and rewards.
Like: I loved how I had reminder sheet to get up and remind me of my goals.
Dislike: I didn't like getting hospitalized.
Anything else: She was very nice. I thought she was know [cant read] knew what she was doing. I loved working with her.

Youth #159

Respectful: No comment
Doing now: No comment
Like: hes nice and he talks about my felings
Dislike: nothing
Anything else: No comment

Youth #160

Respectful: No comment
Doing now: No comment
Like: Solving the problem to why I was so angry.
Dislike: Sitting the whole time and talking
Anything else: No comment

Youth #161

Respectful: No comment

Doing now: No comment

Like: talking to him

Dislike: nothing

Anything else: good here

Youth under 12

Key to comments

Like refers to the question: What did you like most about your experience in SASS?

Dislike refers to the question: What didn't you like about your experience in SASS?

Anything else refers to the question: Is there anything else you would like us to know about your SASS experience?

CENTRAL

Youth #1

Like: Coming to see me at school

Dislike: Nothing

Anything else: No

Youth #4

Like: Nothing

Dislike: Nothing

Anything else: [Child's name] says she doesn't remember the lady that much

Youth #14

Like: *Them girls is nice.*

Dislike: *Nothing*

Anything else: *We need a new trailer.*

Youth #15

Like: *She is nice.*

Dislike: *Nothing.*

Anything else: *No comments*

Youth #16

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #17

Like: She ask me question and let me draw

Dislike: I liked everything about her.

Anything else: no

Youth #20

Like: *Love my counselor she was great.*

Dislike: *N/A*

Anything else: *No comments*

Youth #21

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #25

Like: The games were cool

Dislike: me being in trouble

Anything else: It's cool!

Youth #26

Like: I like the part where I have someone to talk to and to trust

Dislike: No comments

Anything else: My sass worker is great.

Youth #29

Like: *I'm much happier*

Dislike: *nothing*

Anything else: *It's fun*

Youth #32

Like: play games

Dislike: No comments

Anything else: No comments

Youth #36

Like: She was nice to me.

Dislike: none

Anything else: No comments

Youth #37

Like: Helped me not be angry

Dislike: No comments

Anything else: I like [name]

Youth #38

Like: No comments

Dislike: Too short. Needed more time.

Anything else: She gave us useful information. Completed with help of mom.

Youth #44

Like: [Name] was nice and it was fun too.

Dislike: Children's Home

Anything else: 1

Youth #45

Like: *No comments*

Dislike: *No comments*

Anything else: *No comments*

Youth #51

Like: *I like not yelling at my parents and being able to control my anger around everyone else*

Dislike: *having to miss sport practices, but i guess it was worth it.*

Anything else: *no*

Youth #66

Like: *No comments*

Dislike: *No comments*

Anything else: *No comments*

Youth #5

Like: No comments

Dislike: No comments

Anything else: No comments

COOK

Youth #6

Like: *I had two young ladys that was very, very nice*

Dislike: *Meeting these two very, very, very nice people*

Anything else: *Yes on 1/2/05 my son had a doctor's appointment in the office, as he and I were sitting there a woman came to me and said I was suprise when I saw you all come in. You all are not suppose to be here. I told her we had an appointment that is our reason we are here, but we will come back. She said just so you know.*

Youth #43

Like: *Not to do what I did because I know how it fale to be there*

Dislike: *that we were ____ up*

Anything else: *no*

Youth #46

Like: You are really nice

Dislike: there wasn't nothing wrong with the sessions

Anything else: no

Youth #47

Like: *She talks to me*

Dislike: *No comments*

Anything else: *she is nice!*

Youth #49

Like: This the first experience with SASS

Dislike: No comments

Anything else: no

Youth #50

Like: Nothing

Dislike: No comments

Anything else: NO

Youth #62

Like: That she helped me more and to help me.

Dislike: nothing

Anything else: nothing else

Youth #63

Like: I got me calmer

Dislike: thought it was scary

Anything else: NO

Youth #64

Like: *Well I think it was the right choice they made me feel better*

Dislike: *No comments*

Anything else: *I had big problems. I was going to a thought situation which i thought I wasn't going to make it but after meet them I felt better I think I can go through the cause it help me realize & got help to*

overcome it. They were nice and positive attitude. Thank you! SASS! I feel better a more positive! Thank to all the people who contribute to this organization. You really help people out.

Youth #71

Like: I don't know

Dislike: No comments

Anything else: no

Youth #72

Like: Listen to me not just my mom

Dislike: Going to the hospital

Anything else: No

Youth #73

Like: Having someone to talk to about my problems

Dislike: nothing

Anything else: No comments

NORTHERN

Youth #3

Like: We have fun together.

Dislike: Nothing

Anything else: I like working with my respite counselor.

Youth #7

Like: She was concerned about me. She told me I was smart and she didn't want to see me and the hospital again.

Dislike: Nothing

Anything else: No

Youth #24

Like: No comments

Dislike: not long enough. need more time!

Anything else: No comments

Youth #31

Like: The SASS worker was nice to me.

Dislike: Nothing

Anything else: I feel happy when I talk to my Sass worker not mad

Youth #33

Like: Positive

Dislike: nothing

Anything else: group is good, and she cool.

Youth #34

Like: How you help me

Dislike: All good

Anything else: I think it is good for me

Youth #35

Like: How nice and happy everyone is

Dislike: No comments

Anything else: No comments

Youth #39

Like: She listened to me and helped me

Dislike: Nothing

Anything else: No comments

Youth #40

Like: Getting pokeman cards and a nice SASS worker

Dislike: Didn't like going to the hospital.

Anything else: wants to be in SASS next year.

Youth #41

Like: She was nice and helped me with my anger

Dislike: I was scared in the beginning

Anything else: No comments

Youth #42

Like: I like her

Dislike: No comments

Anything else: No comments

Youth #48

Like: *My SASS worker was very nice.*

Dislike: *that she put me as a patient at [hospital name]*

Anything else: *no*

Youth #49

Like: This the first experience with SASS

Dislike: No comments

Anything else: no

Youth #50

Like: Nothing

Dislike: No comments

Anything else: NO

Youth #56

Like: nothing

Dislike: nothing

Anything else: No comments

Youth #57

Like: They were nice

Dislike: going to the hospital

Anything else: no

Youth #59

Like: [name] is fun.

Dislike: Nothing

Anything else: No comments

Youth #67

Like: It was ok

Dislike: concern with hospital

Anything else: Good Stuff

SOUTHERN

Youth #2

Like: She's nice

Dislike: Nothing

Anything else: No

Youth #9

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #10

Like: She took me to her office to talk to me

Dislike: N/A

Anything else: N/A

Youth #11

Like: The game and group

Dislike: Going to hospital and taking medication

Anything else: No

Youth #12

Like: *The nice people*

Dislike: *Nothing*

Anything else: *I'll probably keep in touch w/ Mr. [Name] & Ms. [Name] or at least I'd like to*

Youth #13

Like: *I could call SASS worker on phone*

Dislike: *None*

Anything else: *No comments*

Youth #18

Like: *She is nice and helpful*

Dislike: *Nothing*

Anything else: *no*

Youth #19

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #22

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #23

Like: I like my worker

Dislike: N/A

Anything else: No comments

Youth #27

Like: Getting to play

Dislike: going somewhere with the SASS worker

Anything else: She didn't help with any of my problems

Youth #28

Like: No comments

Dislike: I only like her.

Anything else: No comments

Youth #30

Like: I can talk to her

Dislike: nothing

Anything else: No comments

Youth #52

Like: going out to lunch

Dislike: I don't know

Anything else: no

Youth #53

Like: Playing games with her.

Dislike: Nothing

Anything else: no

Youth #54

Like: No comments

Dislike: No comments

Anything else: No comments

Youth #55

Like: they are really helpful person

Dislike: I liked everything

Anything else: no

Youth #58

Like: Having someone to talk to

Dislike: I don't no

Anything else: No

Youth #60

Like: going to group and playing in the sands

Dislike: when my counselor [name] left to go to another job.

Anything else: I hope that we have goldfish crackers in group and that we get to play with puppets. I come to counseling because my dad was mean and now he can't live with us. Counseling helps me talk about my feelings.

Youth #61

Like: play games

Dislike: the hospital

Anything else: No comments

Youth #65

Like: Playing

Dislike: Nothing

Anything else: Nothing