

Response Card 1- Demographic
Gender of Caregiver <i>(male, female)</i>
Age of Caregiver
Age of Identified Child
Gender of Identified Child <i>(male, female)</i>
Race <i>(American Indian/Alaska Native, Asian, Black/African-American, Native Hawaiian- Pacific Islander, White, Other)</i>
Ethnicity <i>(Hispanic, non-Hispanic)</i>
Number of Children Living in the Home
Family Living Arrangements <i>(two parent home, one parent home, other)</i>
Relationship to Identified Child <i>(Mother, Father, Grandparent, Foster Parent, Aunt/Uncle, Other)</i>
Family household Income <i>(0-15,000, 15,000-30,000, 30,000-45,000, 45,000-60,000, >60,000)</i>
Have you seen your current family support worker?
How many times have you seen you current family support worker?
Level of Education Completed <i>(Some high school, high school graduate, associate degree, bachelor's degree, master's degree, doctoral degree, other)</i>

Response Card 2a SACA Baseline
Now I would like to ask you some questions about any treatment or help your child may have received for behavioral, emotional, drug or alcohol problems. When answering these questions, you should not include treatment for medical problems, such as going to the hospital for a broken arm.
<i>Has your child ever had to stay overnight or live outside the home due to behavioral, emotional, drug or alcohol problems?</i>
<i>Has your child every gone to a(n)....</i>
1. Psychiatric Hospital?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
2. Psychiatric or medical unit in a general hospital?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
3. Drug or alcohol treatment unit?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
4. Residential treatment center?
<i>How many times? What was the total number of days? What age was your child when</i>

<i>this happened?</i>
5. Group home?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
6. Foster home?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
7. Treatment in Foster Care?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
8. Emergency Shelter?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
<i>Now I would like to find out if your child has received outpatient treatment for behavioral, emotional, drug or alcohol problems.</i>
9. Community mental health center or other outpatient mental health clinic?
<i>How many sessions/times? What age was your child when this happened?</i>
10. Psychologist, psychiatrist, social worker, or family counselor in Private Practice?
<i>How many sessions/times? What age was your child when this happened?</i>
11. Partial hospitalization or day treatment program?
<i>How many sessions/times? What age was your child when this happened?</i>
12. Drug or alcohol treatment clinic?
<i>How many sessions/times? What age was your child when this happened?</i>
13. In-home therapist or counselor?
<i>How many sessions/times? What age was your child when this happened?</i>
14. Emergency room?
<i>How many sessions/times? What age was your child when this happened?</i>
15. Pediatrician or family doctor?
<i>How many sessions/times? What age was your child when this happened?</i>
16. Probation or juvenile corrections officer, or court counselor?
<i>How many sessions/times? What age was your child when this happened?</i>
17. Priest, minister, rabbi, healer, or other spiritual healer?
<i>How many sessions/times? What age was your child when this happened?</i>
18. Acupuncturist or chiropractor?
<i>How many sessions/times? What age was your child when this happened?</i>
19. Any self-help group like Alcoholics Anonymous, Narcotics Anonymous, or peer counseling?
<i>How many sessions/times? What age was your child when this happened?</i>
<i>How many sessions/times? What age was your child when this happened?</i>
<i>"Have you as a parent/caregiver worked with..."</i>
20. A family peer advocate or family partner?
<i>Have you seen a family peer advocate or family partner in the past 5 years?</i>
<i>In total, how many sessions in the past five years? More than 5 years ago? What age</i>

<i>was your child when this happened?</i>
<i>"Has your child gone to a(an)..."</i>
21. Detention center / jail?
<i>How many times? What was the total number of days? What age was your child when this happened?</i>
<i>"I just asked you a number of questions about the types of services your child may have received. Now I would like to ask you a few questions about any treatment or help you personally may have received. When answering these questions, you should not include treatment for medical problems."</i>
22. Have you been in any other counseling or therapy for your own difficulties in the past year?
<i>Are you still in counseling or therapy?</i>
23. Have you received medication for emotional or psychiatric difficulties in the past year?
<i>Are you still receiving medication?</i>
<i>"Has your child...?"</i>
24. ever been in the Waiver program before?
<i>How many sessions/times? What age was your child when this happened?</i>
25. ever received case management before? (eg: Children's Intensive Case Management "ICM", Children's Blended Case Management "BCM", Children's Supportive Case Management "SCM")
<i>How many sessions/times? What age was your child when this happened?</i>

Response Card 3 CGSQ				
Please think back over the past 6 months and try to remember how things have been for your family. We are trying to get a picture of how life has been in your household over that time.				
For each question, please tell me which response (which number) fits best.				
In the past 6 months...				
1 Not at all	2 A little	3 Somewhat	4 Quite a Bit	5 Very Much
1. Interruption of personal time resulting from your child's emotional or behavioral problem?				
2. Your missing work or neglecting other duties because of your child's emotional or behavioral problem?				
3. Disruption of family routines due to your child's emotional or behavioral problem?				
4. Any family member having to do without things because of your child's emotional or behavioral problem?				
5. Any family member suffering negative mental or physical health effects as a result of your child's emotional or behavioral problem?				
6. Your child getting into trouble with the neighbors, the school, the community, or law enforcement?				
7. Financial strain for your family as a result of your child's emotional or behavioral problem?				
8. Less attention paid to other family members because of your child's emotional or behavioral problem?				
9. Disruption or upset of relationships within the family due to your child's emotional or behavioral problem?				
10. Disruption of your family's social activities resulting from your child's emotional or behavioral problem?				
11. How isolated did you feel as a result of your child's emotional or behavioral problem?				
12. How sad or unhappy did you feel as a result of your child's emotional or behavioral problem?				

13. How embarrassed did you feel about your child's emotional or behavioral problem?
14. How well did you relate to your child?
15. How angry did you feel toward your child?
16. How worried did you feel about your child's future?
17. How worried did you feel about your family's future?
18. How guilty did you feel about your child's emotional or behavioral problem?
19. How resentful did you feel toward your child?
20. How tired or strained did you feel as a result of your child's emotional or behavioral problem?
21. In general, how much of a toll has your child's emotional or behavioral problem taken on your family?

Response Card 4a SDQ Child Age 4-10

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior **over the past 6 months.**

0 Not True	1 Somewhat True	2 Certainly True
1. Considerate of other people's feelings		
2. Restless, overactive, cannot stay still for long		
3. Often complains of headaches, stomach-aches or sickness		
4. Shares readily with other children, for example toys, treats, pencils		
5. Often loses temper		
6. Rather solitary, prefers to play alone		
7. Generally well behaved, usually does what adults request		
8. Many worries or often seems worried		
9. Helpful if someone is hurt, upset or feeling ill		
10. Constantly fidgeting or squirming		
11. Has at least one good friend		
12. Often fights with other children or bullies them		
13. Often unhappy, depressed or tearful		
14. Generally liked by other children		
15. Easily distracted, concentration wanders		
16. Nervous or clingy in new situations, easily loses confidence		
17. Kind to younger children		
18. Often lies or cheats		
19. Picked on or bullied by other youth		
20. Often offers to help others		
21. Thinks things out before acting		
22. Steals from home, school or elsewhere		
23. Gets along better with adults than with other youth		
24. Many fears, easily scared		
25. Good attention span, sees chores or homework through to the end		
26. Do you have any other comments or concerns?		
27.	FOLLOWUP ONLY	Since coming to the Waiver program, are your child's problems? Much worse (5), a bit worse (4), about the same (3), a bit

		better (2), or much better (1)		
28.	FOLLOWUP ONLY	Has coming to the Waiver program been helpful in other ways, e.g. providing information or making the problems more bearable? Not at all (0), Only a little (1), Quite a lot (2), A great deal (3)		
0 No	1 Yes- Minor Difficulties	2 Yes- Definite Difficulties	3 Yes- Severe Difficulties	
29. Overall do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get on with other people?				
1 Less Than a Month		2 1-5 months	3 6-12 months	4 Over a year
a. How long have these difficulties been present?				
0 Not at all	1 Only a Little	2 Quite a lot	3 A Great deal	
b. How do the difficulties upset or distress your child?				
c. How do the difficulties interfere with your child's everyday life in the following areas:				
i. Home life				
ii. Friendships				
iii. Classroom learning				
iv. Leisure activities				
d. Do the difficulties put a burden on you or the family as whole?				

Response Card 4b SDQ Youth age 11-17		
For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behavior over the past 6 months .		
0 Not True	1 Somewhat True	2 Certainly True
1. Considerate of other people's feelings		
2. Restless, overactive, cannot stay still for long		
3. Often complains of headaches, stomach-aches or sickness		
4. Shares readily with other youth, for example CD's, games, food		
5. Often loses temper		
6. Would rather be alone than with other youth		
7. Generally well behaved, usually does what adults request		
8. Many worries or often seems worried		
9. Helpful if someone is hurt, upset or feeling ill		
10. Constantly fidgeting or squirming		
11. Has at least one good friend		
12. Often fights with other youth or bullies them		
13. Often unhappy, depressed or tearful		
14. Generally liked by other youth		
15. Easily distracted, concentration wanders		
16. Nervous in new situations, easily loses confidence		
17. Kind to younger children		
18. Often lies or cheats		
19. Picked on or bullied by other youth		
20. Often offers to help others		
21. Thinks things out before acting		
22. Steals from home, school or elsewhere		
23. Gets along better with adults than with other youth		
24. Many fears, easily scared		
25. Good attention span, sees chores or homework through to the end		
26. Do you have any other comments or concerns?		
27.	FOLLOWUP ONLY	Since coming to the Waiver program, are your child's problems? Much worse (5), a bit worse (4), about the same (3), a bit better (2), or much better (1)
28.	FOLLOWUP ONLY	Has coming to the Waiver program been helpful in other ways, e.g. providing information or making the problems more bearable?

	Not at all (0), Only a little (1), Quite a lot (2), A great deal (3)		
0 No	1 Yes- Minor Difficulties	2 Yes- Definite Difficulties	3 Yes- Severe Difficulties
29. Overall do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people?			
	1 Less Than a Month	2 1-5 months	3 6-12 months
e. How long have these difficulties been present?			
0 Not at all	1 Only a Little	2 Quite a lot	3 A Great deal
f. How do the difficulties upset or distress your child?			
g. How do the difficulties interfere with your child's everyday life in the following areas:			
i. Home life			
ii. Friendships			
iii. Classroom learning			
iv. Leisure activities			
h. Do the difficulties put a burden on you or the family as whole?			

Response Card 5 CIS

This survey asks questions about how you think your child is doing overall. Please answer the questions on a scale from 0 to 4, with "0" being "no problem" and "4" being "very bad problem." If the question does not apply to your child, please check the box for N/A.

In general, how much of a problem do you think your child has with:

0 No Problem	1	2	3	4 Very Bad Problem	Not Applicable
1. Getting into trouble?					
2. Getting along with his/her mother?					
3. Getting along with his/her father?					
4. Feeling unhappy or sad?					
5. Behavior at school/on the job?					
6. Having fun?					
7. Getting along with adults other than his/her parents?					
8. Feeling nervous or worried?					
9. Getting along with brothers/sisters?					
10. Getting along with other kids his/her age?					
11. Getting involved in activities like sports or hobbies?					
12. Schoolwork/job?					
13. Behavior at home?					

Response Card 6 PSEEEKS

Below are some statements that caregivers sometimes say when they talk about their child’s mental health. Please answer how much you agree or disagree with each statement as it relates to you and your child.

1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Agree a lot	0 Not Applicable
1. Communicating with mental health providers and playing a role in decision making lead to benefits for my child.				
2. I am able to reach out to my child’s mental health providers when my child is struggling emotionally.				
3. I am confident I can find solutions when new issues come up with my child’s behavioral and emotional health.				
4. I understand the service systems that my child is involved in (e.g., mental health, education, etc.).				
5. When I feel uncomfortable about my child’s treatment, I speak with my child’s mental health providers.				
6. My efforts to participate in my child’s care lead to improvements in his/her behavioral and emotional health.				
7. I make an effort to stay in contact with mental health providers who provide services to my child.				
8. I am confident that I can help my child maintain new skills even during times of stress (e.g., anger management, coping skills, etc.).				
9. I understand the purpose of my child’s medication(s).				
10. I am confident I can speak to mental health providers about my concerns for my child, even when the mental health providers do not ask.				
11. Taking an active role in my child’s care is one of the most important things that affect his/her behavioral and emotional health outcome.				
12. I feel confident asking my child’s doctor(s) questions about my child’s medication(s).				
13. I am able to get information to help me make decisions about my child’s treatment.				
14. I know what treatments are out there for my child’s behavioral and emotional difficulties.				
15. I can identify friends and family to help with my child.				
16. I have the skills to help my child develop and grow.				
17. I am able to partner with agencies and mental health providers to decide what services my child needs.				
18. My opinion is as important as mental health providers’ when choosing services for my child.				
19. I have discussed and understand my child’s treatment options with my child’s mental health providers.				
20. I am able to manage my child’s behavioral or emotional health.				
21. I know what to do to help me cope with caring for my child (e.g., taking time for myself, dealing with feelings of self-doubt).				
22. I know how to find social supports and resources in my community for my child and family (e.g., boys and girls club, library, church groups).				

23. When needed, I take steps to look for services for my child and family.

24. I feel confident that I can follow through on treatment strategies for my child at home.

25. I have the skills to deal with the stress of caring for my child.

26. I am able to ask for help from others when I have difficulties with my child and family.

27. I know the steps to take when I am concerned my child is receiving poor services.

28. I am confident I understand my child's behavioral and emotional difficulties and what causes them.

29. I know what services my child needs.

30. I can get the emotional support I need from family and friends.

31. I know what the rights of parents and children are based on the special education laws.