CHILD WELFARE MENTAL HEALTH SCREENING INITIATIVE

*EVALUATION PROGRESS REPORT**

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OVERVIEW

The child welfare mental health screening initiative, sponsored by the Indiana Family and Social Services Administration, was developed to identify children with mental health needs who are referred to the child welfare system. The goal of this program is to provide better care to children in need of mental health services and reduce the number of failed placements. Multiple State agencies have been involved in planning and implementing this initiative. During the past year, the agencies have focused on implementing the program, including training county-level field staff on the screening tool, developing formal plans to make referrals for mental health consultations, and actually beginning the screening process. On January 1, 2005, all county agencies began screening all children referred to the State.

As part of the project, Dr. Eric R. Wright, Director of Health Policy at the Center for Urban Policy and the Environment and Associate Professor, School of Public and Environmental Affairs, IUPUI and his research staff were asked to initiate an independent evaluation of both the planning and implementation of this initiative. This report is the fourth official evaluation report required under the continuation contract. This report provides an analysis of data for children in placement during the year preceding initiative implementation and the pilot implementation.

I. EVALUATION DESIGN AND METHODS

Memorandum of Understanding. This evaluation analyzes data collected by three state agencies: the Division of Mental Health and Addiction (DMHA), the Department of Child Services (DCS) and the Office of Medicaid Policy and Planning (OMPP). In compliance with the Memorandum of Understanding (MOU), signed into effect on November 22, 2004, each agency provided the evaluation team with an unidentifiable dataset, including only children who were in placement during the reporting period. The data includes an Enterprise Client Identifier (ECI), assigned by Data Transformation Services (DTS), whose sole purpose is to match the individual datasets into a single data file. Each agency provided the evaluation team with pre-screening implementation benchmark data for the reporting period of July 1, 2003 through June 30, 2004. These data were used to setup statistical models, as well as provide as a comparison group to post-screening implementation data. DCS and DMHA provided data for the six months of the pilot implementation, July 1, 2004 through December 31, 2004

Data. All data received from the aforementioned state agencies is analyzed and managed using SPSS and Microsoft SQL Server. The analysis of benchmark data focuses on constructing measures comparable to post-screening implementation data in order to demonstrate the effectiveness and inclusiveness of the screening initiative. Each variable was checked for outliers and missing values and transformed appropriately. Post-implementation pilot data was evaluated in the same manner and compared to benchmark data. To ensure confidentiality, the data provided did not include any identifying information. All three datasets were merged together using the Enterprise Client Identifier (ECI). This number, assigned by DTS, allows the evaluation team to recognize the same individual across the three separate data systems without providing identifying characteristics.

DCS Data. The data provided by DCS includes all children who were in substitute care during the benchmark period, the year prior to pilot implementation of July 1, 2003 to June 30, 2004, the period of July 1, 2004 through December 31, 2004, the six months of the pilot implementation, and the period of January 1, 2005 through March 31, 2005, the first quarter of full implementation. Only children who were removed or declared a CHINS during the reporting period were selected in order to provide a longitudinal comparison of future data. Furthermore, if a child was declared a CHINS or removed from their home in more than one reporting period; due to the nature of the data analysis, the child was only included as a DCS contact in the latter period. Contacts in previous periods are included as measures of recidivism and stability.

DCS data includes information regarding demographics, current and previous CHINS and removal dates, the total number of removals, and the number of placements within the current case. Additional variables were computed based upon the data provided. These include a multiple CHINS and removal indicator. If a child had an initial CHINS date that occurred before the current CHINS date, the multiple CHINS indicator was coded as a 1 indicating multiple CHINS have occurred. If the initial and current CHINS dates are the same, the variable was coded as a 0, indicating that this is the first occurrence. The multiple removal indicator was coded in the same manner, but based upon the number of previous removals recorded in the data. If a child has 1 or more previous removals, the removal indicator was coded as a 1; a code of 0 was used otherwise. Race was also recoded into a dichotomous measure for statistical purposes. This variable was coded as white (0) and nonwhite (1). In addition, the variable indicating screening results of children who were screening during the pilot period was recoded to collapse like categories. The resulting variable is coded as 1 'Urgent Referral', 2 'Refer for follow-up, 3 'Re-screen' and 4 'No Identified risk.' The results were further collapsed into a dichotomous variable indicating whether or not a risk was identified in the screening.

DMHA Data. DMHA also provided data for those children placed into substitute care who had received services through their agency during the two reporting periods. A variable indicating whether the child had received DMHA services was computed and coded as a 1 if DMHA data existed on the child. A variable indicating if the DMHA enrollment date is before or after the initial CHINS date was also computed.

OMPP Data. The Office of Medicaid Policy and Planning (OMPP) also provided data on children with a DCS placement with regard to behavioral health services that the child had received during the benchmark and pilot periods. The nature of this data required significant transformations be performed before being analyzed. The data was aggregated to create a single record for each child per reporting period. The first service date variable was aggregated to select the earliest date within all records pertaining to each child. The last service date was aggregated to select the latest date for each child. The amount paid was aggregated as a sum of all behavioral health records for each child. Finally, the category of service and procedure codes were aggregated to count each episode of mental health or addiction care provided.

II. DATA ANALYSIS

Client Flow—Benchmark Period.

Using data primarily from DCS, client flow was analyzed with regard to changes in placement during the benchmark periods (N=1742). A descriptive analysis of recidivism shows that 17.0% of children removed or declared a CHINS during the benchmark period had one or more previous contacts. The results also show that 13.9% of children declared a CHINS or removed during the benchmark period had one or more previous removals. Table 1 provides a descriptive analysis of these characteristics.

Further analysis of client flow reveals that of the 1742 children declared a CHINS or removed, 296 (17.0%) received behavioral health services paid by OMPP or DMHA within 60 days after their last DCS contact. This number does not include children who have received services prior to their last CHINS/removal in order to isolate the potential causal relationship between the DCS contact and the receipt of services. Table 2 is provided to show this analysis for all periods.

Mental Health Services. Analysis of DMHA data reveals that 992 (25.7%) of children declared a CHINS or removed during the three periods received services through the agency at some point during this time. In the benchmark period, 535 (30.7%) children received such services. Descriptive statistics regarding the level of function of this group is provided in Table 3.

In addition to DMHA, Medicaid data shows that an additional 480 children declared a CHINS or removed in the benchmark period received mental health or addiction treatment at some point. When data from both DMHA and OMPP are merged, the data show that 1015 (58.3%) unique children declared a CHINS during the benchmark period received mental health or addiction services, of which 193 (11.1%) received these services prior to their contact with DCS.

Recidivism and Stability. To measure recidivism and stability, five variables were used. These variables include initial CHINS date, current CHINS date, initial removal date, current removal date, and total number of removals. The presence of multiple CHINS, as defined by an initial CHINS date occurring before the current CHINS date, indicates a pattern of recidivism. The analysis shows that 296 (17.0%) children removed during the benchmark period had a previous CHINS. A logistic regression model was also utilized, using the multiple CHINS indicator as the dependent variable and age, race, gender, a variable indicating that a child received DMHA services prior to their initial CHINS, and a variable indicating that a child received behavioral health services paid by OMPP. The results of the regression show that age and whether or not a child received services paid by OMPP, are significantly associated with recidivism. More specifically, older children were more likely to experience recidivism and children who have received behavioral health services prior to DCS contact are less likely to experience recidivism than those who have not had behavioral health services. The complete results of this model are displayed in Table 4.

In addition to recidivism, a measure of placement stability was computed based upon the number of removals as well as the dates of the initial and current removals. If a child had more than a single removal or their initial removal date occurred prior to their current removal date, a

variable indicating such was coded as 0. If a child had only a single removal, the stability measure was coded as a 1. This measure indicates that the child is experiencing placement stability. The data show that 243 (13.9%) children removed during benchmark period had a previous removal. The same logistic regression model used to analyze recidivism was used to analyze the stability measure. The results indicate that one of the significant predictors of multiple removals is age. This is to say that older children are more likely to have multiple removals than younger children. Of greater interest, however, is that the other significant variables in the model, whether or not they receive mental health/addiction treatment paid by OMPP, shows that children receiving such services are more likely to experience stability. The full results of the regression model are presented in Table 4.

Service Expenditures. The third series of analyses examines the expenditures for services provided to clients. Using expenditure data provided by OMPP, the evaluation team examined the costs associated with mental health and addiction treatment during the benchmark period. The data show that of the 1742 children removed or declared a CHINS during the benchmark period, 655 (56.8%) children received mental health or addiction services paid by Medicaid dollars in the benchmark period. The total dollar amount spent for these services, for children enrolled with DCS, was $2,641,133, averaging to $4,032 per child receiving services. As a comparison, the total dollars spent on behavioral health services for all children during the benchmark period was $118,438,414 for 53,710 children, averaging $2,205 per child.

Client Flow—Pilot Implementation Period.

Using data from DCS, client flow was also analyzed with regard to the pilot implementation (N=1292) periods. Our analysis shows that there is little significant difference between the demographics of both the benchmark and pilot periods other than age. The difference in age is attributable to an increase in the number of children removed under one year of age. Furthermore, a descriptive analysis of recidivism shows that during the pilot implementation periods, 18.5% had previous contact with the child welfare system in the pilot period while 17.0% during the benchmark period. During the pilot period, 18.5% of children had a previous CHINS. The results also show that 13.3% of children removed or declared a CHINS during the pilot period had one or more previous removals. Table 1 provides a descriptive analysis of these characteristics.

Further analysis of client flow reveals that of the 1292 children declared a CHINS or removed, 436 (33.7%) were screened for mental health or addiction needs during the pilot period. Furthermore, of these 436 screened children, 167 (38.3%) had an identified risk. A total of 177 (13.7%), of the 1292 CHINS/removals, children received behavioral health services paid by OMPP or DMHA within 60 days after their last DCS contact. Of those children who received services, 29 (16.4%) were screened and were identified as having a risk. These numbers do not include children who have received services prior to their last CHINS/removal in order to isolate the potential causal relationship between the DCS contact and the receipt of services. Table 2 is provided to show this analysis for all periods.

Mental Health Services. Analysis of DMHA data for the pilot implementation reveals that 277 (21.4%) children received such services during the pilot period, a significantly smaller

proportion than benchmark period (t=5.733; $p \leq .001$). Descriptive statistics regarding the level of function of this group is provided in Table 3.

Medicaid data shows that during the pilot period 352 (27.2%) children received behavioral health services paid by OMPP, a significantly smaller proportion from the benchmark period (t=16.973; p <= .001). Between both DMHA and OMPP, a total of 479 (37.1%) children received behavioral health services from either agency during the pilot period.

Screening. Beginning on July 1, 2004, DCS began a pilot implementation of the screening initiative. This pilot implementation included a small subset of counties within the state. During the pilot periods, a total of 1292 children were declared a CHINS or removed. Of these children, 436 (33.7%) were screened for mental health or addiction needs. Based solely on available data, the proportion of children screened within a pilot county cannot be determined. The results of the screening show that within the screening subgroup 171 (39.2%) had no identified risk, 98 (22.5%) required re-screening and 167 (48.3%) had an identified risk. Of those with an identified risk, 134 (80.2%) were identified as needing an urgent referral. Further analysis reveals that 26 (15.6%) children, having an identified risk, were referred to treatment as a result of the screening results.

Recidivism and Permanency. To measure recidivism and permanency for the pilot period, the same variables were used as in the benchmark period. These variables include initial CHINS date, current CHINS date, initial removal date, current removal date, and total number of removals. The presence of multiple CHINS, as defined by an initial CHINS date occurring before the current CHINS date, indicates a pattern of recidivism. The analysis shows that 239 (18.5%) children removed or declared a CHINS during the pilot period had a previous CHINS. A logistic regression model was also utilized, using the multiple CHINS indicator as the dependent variable and age, race, gender, a variable indicating that a child received DMHA services prior to their initial CHINS, and a dichotomous version of screening results as independent variables, to determine the probability of having multiple CHINS. The results of the regression show that age, race, and receiving DMHA services are significant variables associated with recidivism during the pilot period. More specifically, older children are more likely to experience recidivism than younger children, and those who had received behavioral health services prior to their first CHINS or removal are less likely to experience recidivism.

In addition to recidivism, a measure of permanency was computed based upon the number of removals. If a child had more than a single removal, a variable indicating such was coded as 0. This measure indicates that the child is experiencing placement stability. The data show that 172 (13.3%) children who were removed or declared a CHINS during the pilot period had a previous removal. The same logistic regression model used to analyze recidivism was used to analyze the stability measure. The results indicate that one of the significant predictors of multiple removals, during the pilot period is age. This is to say that older children are more likely to have multiple removals than younger children. In addition to age, the model also shows that if a child received services paid by OMPP or DMHA, they are more likely to experience stability. Furthermore, the results indicate that if the screening reveals an identified risk, a child is more likely to have stability in placement. This finding suggests that those with multiple removals are likely to have a need for such treatment. The full results of the regression model are presented in Table 4.

Service Expenditures. Medicaid data for the pilot periods allowed the evaluation team to examine the costs associated with behavioral health treatment. The data show that of the 660 children removed or declared a CHINS during the pilot period, 256 (38.8%) children received mental health or addiction services paid by Medicaid dollars totaling $883,200. The average dollar amount spent for these services per child was $3,450 in the pilot period. This is compared to the total dollars spent on behavioral health services for all children during the pilot period of $92,864,846 for 44,686 children, an average of $2,078 per child.

Client Flow—Full Implementation Period.

Using data from DCS, client flow was also analyzed with regard to the full implementation (N=829) period. Our analysis shows that there is a significant difference between the ages of children having contact with DCS in the first full implementation period. The difference in age is attributable to an increase in the number of children removed under one year of age from the benchmark period. Furthermore, a descriptive analysis of recidivism shows that of the children declared a CHINS or removed during the full implementation period, 21.6% had previous contact with the child welfare system. Of the children who had a DCS contact during the benchmark or pilot period, 17.0% and 18.5% had a previous DCS contact respectively. The results also show that 19.4% of children removed or declared a CHINS during the full implementation period had one or more previous removals. Table 1 provides a descriptive analysis of these characteristics.

Further analysis of client flow reveals that of the 829 children declared a CHINS or removed in the full implementation period, 622 (75.0%) were screened for mental health or addiction needs. Furthermore, of these 622 screened children, 249 (40.0%) had an identified risk. A total of 160 (19.3%) children received behavioral health services paid by OMPP or DMHA within 60 days after their last DCS contact. Of those children who received services, 80 (50.0%) were screened and were identified as having a risk. These numbers do not include children who have received services prior to their last CHINS/removal in order to isolate the potential causal relationship between the DCS contact and the receipt of services. Table 2 is provided to show this analysis for all periods.

Mental Health Services. Analysis of DMHA data for the full implementation period reveals that 180 (21.7%) children received such services during this reporting period, a significantly smaller proportion than benchmark period ($t=4.779$; $p \leq .001$). Descriptive statistics regarding the level of function of this group is provided in Table 3.

Medicaid data shows that during the full implementation period 314 (37.9%) children received behavioral health services paid by OMPP, a significantly smaller proportion from the benchmark period ($t=9.126$; $p <= .001$). Between both DMHA and OMPP, a total of 347 (41.6%) children received behavioral health services from either agency during the pilot period.

Screening. Beginning on January 1, 2005, DCS began a state wide implementation of the screening initiative. During the first three months of the full implementation period, a total of 829 children were declared a CHINS or removed. Of these children, 622 (75.0%) were screened

for mental health or addiction needs. The results of the screening show that within the screening subgroup 254 (40.8%) had no identified risk, 119 (19.1%) required re-screening and 249 (40.0%) had an identified risk. Of those with an identified risk, 194 (77.9%) were identified as needing an urgent referral. Further analysis reveals that 48 (24.7%) children, having an identified risk, were referred to treatment as a result of the screening results.

Recidivism and Permanency. To measure recidivism and stability for the full implementation period, the same variables were used as in the benchmark and pilot periods. These variables include initial CHINS date, current CHINS date, initial removal date, current removal date, and total number of removals. The presence of multiple CHINS, as defined by an initial CHINS date occurring before the current CHINS date, indicates a pattern of recidivism. The analysis shows that 179 (21.6%) children removed or declared a CHINS during the pilot period had a previous CHINS. A logistic regression model was also utilized, using the multiple CHINS indicator as the dependent variable and age, race, gender, a variable indicating that a child received DMHA or OMPP services prior to their initial CHINS, and a dichotomous version of screening results as independent variables, to determine the probability of having multiple CHINS. The results of the regression show that age, and receiving OMPP services are significantly associated with recidivism during this time period. More specifically, older children are more likely to experience recidivism than younger children, and those who had received behavioral health services prior to their first CHINS or removal are less likely to experience recidivism.

In addition to recidivism, a measure of stability was computed based upon the number of removals. If a child had more than a single removal, a variable indicating such was coded as 0. This measure indicates that the child is experiencing placement stability. The data show that 161 (19.4%) children who were removed or declared a CHINS during the pilot period had a previous removal. The same logistic regression model used to analyze recidivism was used to analyze the stability measure. The results indicate that one of the significant predictors of multiple removals, during the pilot period is age. This is to say that older children are more likely to have multiple removals than younger children. In addition to age, the model also shows that if a child received services paid by OMPP, they are more likely to experience stability. The full results of the regression model are presented in Table 4.

Service Expenditures. Medicaid data for the pilot periods allowed the evaluation team to examine the costs associated with behavioral health treatment. The data show that of the 829 children removed or declared a CHINS during the full implementation period, 253 (30.5%) children received mental health or addiction services paid by Medicaid dollars totaling $251,615. The average dollar amount spent for these services per child was $995 in this period. This is compared to the total dollars spent on behavioral health services for all children during the full implementation period of $33,611,453 for 38,480 children, an average of $873 per child.

III. DISCUSSION

This analysis provides a descriptive profile of children having contact with the child welfare system. The analyses also demonstrate that a relationship exists between mental health and/or addiction needs and the number of removals that a child has. As a result, it is anticipated that as this initiative progresses, a significantly greater proportion of children having contact with the

child welfare system will receive mental health and addiction treatment as a result of the screening. At this point in the screening initiative, however, it cannot be determined if contact with the child welfare system is a result of untreated mental health/addiction needs or if these needs are a result of the contact. Further evaluation of this project is necessary in order to clarify this relationship and determine causality. While the results of this analysis are not conclusive, they do provide a basis for comparison with regard to future longitudinal study.

Table 1: Descriptive Statistics of DCS Data

	BENCHMARK		PILOT		FULL IMPLEMENTATION		TOTAL	
DEMOGRAPHICS	N	%	N	%	N	%	N	%
Age (F=3.512, p ≤ .030)								
Less Than One Year	36	2.1%	131	10.1%	91	11.0%	258	6.7%
1 To 4 Years Old	597	34.3%	404	31.3%	240	29.0%	1241	32.1%
5 To 8 Years Old	390	22.4%	269	20.8%	172	20.7%	831	21.5%
9 To 13 Years Old	417	23.9%	255	19.7%	185	22.3%	857	22.2%
14 To 17 Years Old	302	17.3%	233	18.0%	141	17.0%	676	17.5%
Total	1742	100.0%	1292	100.0%	829	100.0%	3863	100.00%
Gender (F=1.077, p ≤ .341)								
Male	853	49.0%	643	49.8%	386	46.6%	1882	48.7%
Female	889	51.0%	649	50.2%	443	53.4%	1981	51.3%
Total	1742	100.00%	1292	100.0%	829	100.0%	3863	100.0%
Race (F=2.815, p ≤ .060)								
White	1187	68.1%	930	72.0%	588	70.9%	2705	70.0%
Non White	555	31.9%	362	28.0%	241	29.1%	1158	30.0%
Total	1742	100.00%	1292	100.0%	829	100.0%	3072	100.0%
CLIENT FLOW								
Previous CHINS (F=3.950, p ≤ .019)								
Yes	296	17.0%	239	18.5%	179	21.6%	714	18.5%
No	1446	83.0%	1053	81.5%	650	78.4%	3149	81.5%
Total	1742	100.00%	1292	100.0%	829	100.0%	3863	100.0%
Previous Removal (F=8.612, p ≤ .000)								
Yes	243	13.9%	172	13.3%	161	19.4%	576	14.9%
No	1499	86.1%	1120	86.7%	668	80.6%	3287	85.1%
Total	1742	100.00%	1292	100.0%	829	100.0%	3863	100.0%

Table 2: Client Flow Analysis

	Total Number of CHINS/Removals	Number (%) of Children Screened for Mental Health/Addiction Needs[1]	Number (%) of Children with an Identified Risk[2]	Number (%) of Children receiving Mental Health/Addiction treatment[3]
Benchmark Period (July 1, 2003-June 30, 2004)	1742	N/A	N/A	296 (17.0%)
Pilot Period (July 1, 2004-December 31, 2004)	1292	436 (33.7%)	167 (38.3%)	177 (13.7%)
Full Implementation Period (January 1, 2005-March 31, 2005)	829	622 (75.0%)	249 (40.0%)	160 (19.3%)

[1] Percentage calculated as a function of the total number of CHINS/Removals occurring during each research period.
[2] As a percentage of the total number of children screened.
[3] Only children who received services of OMPP or DMHA within 60 days of their last CHINS/removal and did not receive services prior to their first CHINS were included. The percentage is calculated as a function of the total number of CHINS/removals within each research period.

Table 3: Descriptive Statistics of DMHA Data

		Benchmark N=535	Pilot N=277	Full N=180	Overall N=992
A. Affective Symptoms					
(F=2.162 p ≤ .116)	Mean	15.2	14.6	14.5	14.9
	(S.D)	(4.3)	(4.7)	(4.8)	(4.5)
B. Suicidal Ideation/Behaviors					
(F=0.093 p ≤ .911)	Mean	6.6	6.6	6.6	6.6
	(S.D)	(1.1)	(1.2)	(1.1)	(1.1)
C. Abuse					
(F=5.823 p ≤ .003)	Mean	6.6	6.4	6.2	6.5
	(S.D)	(1.2)	(1.4)	(1.5)	(1.3)
D. Neglect					
(F=13.498 p ≤ .000)	Mean	6.4	6.3	5.7	6.3
	(S.D)	(1.5)	(1.5)	(2.0)	(1.6)
E. Health/Physical Status					
(F=2.834 p ≤ .059)	Mean	6.5	6.7	6.5	6.6
	(S.D)	(1.2)	(0.9)	(1.2)	(1.1)
F. Thinking					
(F=1.111 p ≤ .330)	Mean	10.1	10.3	9.8	10.1
	(S.D)	(3.4)	(3.4)	(3.5)	(3.4)
G. Family					
(F=1.045 p ≤ .352)	Mean	14.4	14.7	14.0	14.4
	(S.D)	(5.2)	(5.3)	(5.1)	(5.2)
H. School					
(F=2.282 p ≤ .103)	Mean	22.6	23.3	22.1	22.7
	(S.D)	(5.9)	(6.5)	(5.9)	(5.8)
I. Disruptive Behavior					
(F=4.957 p ≤ .007)	Mean	17.2	17.7	16.5	17.2
	(S.D)	(3.9)	(3.5)	(4.4)	(3.9)
J. Substance Use/Abuse					
(F=2.869 p ≤ .057)	Mean	20.6	20.3	20.4	20.5
	(S.D)	(1.6)	(2.3)	(2.0)	(1.9)

*****LOF score ranges vary based upon differing scales. Ranges are presented below. For additional questions contact the Division of Mental Health and Addiction.
A: 3-21; B: 1-7; C: 1-7; D: 1-7; E: 1-7; F: 2-14; G: 3-21; H: 4-28; I: 3-21; J: 3-21

Table 4: Logistic Regression Analysis

	Recidivism			Placement Stability		
	Benchmark	Pilot	Full	Benchmark	Pilot	Pilot – Q2
	B (S.E.E.)	B (S.E.E.)	B (S.E.E)	B (S.E.E.)	B (S.E.E.)	B (S.E.E.)
Constant	-1.640*** (.137)	-1.775*** (.148)	-1.685*** (.181)	2.264*** (0.170)	2.544*** (.182)	1.761*** (.189)
Age	0.045*** (.013)	0.074*** (.014)	0.059*** (.017)	-0.086*** (.014)	-0.103*** (.016)	-0.080*** (.017)
Nonwhite	-0.334 (.144)	-0.397* (.241)	-0.003 (.191)	0.228 (0.154)	-0.026 (.185)	-0.173 (.194)
Female	-0.229 (.129)	-0.083 (.147)	-0.124 (.174)	0.079 (0.142)	0.059 (.170)	0.152 (.183)
DMHA Services Provided	-0.076 (.583)	-1.066* (.487)	-0.267 (.451)	18.126 (6151.543)	1.592* (.737)	0.322 (.590)
Received Services Paid by OMPP	-0.904** (.280)	-0.600 (.358)	-0.673* (.314)	2.046*** (0.157)	1.206* (.530)	1.223** (.393)
Risk Identified in Screening	N/A	-0.418 (0.234)	0.447* (.189)	N/A	0.816** (.301)	0.206 (.210)
x^2	28.063***	40.707***	25.646***	75.980***	60.479***	39.276***
Nagelkerke R^2	.027	.050	.047	.077	.084	.074

***p ≤ .001 **p ≤ .01 *p ≤ .05