

Comprehensive Community Mental Health Services for Children and Their Families Program



Evaluation Findings: Executive Summary Report to Congress 2006–2008



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Evaluation Findings



Executive Summary

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U.S. Department of Health and Human Services**

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The Comprehensive Community Mental Health Services for Children and Their Families Program

2006–2008 Report to Congress

Executive Summary

The Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Child Mental Health Initiative (CMHI), is a cooperative agreement program operating under the auspices of the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services. The CMHI was authorized by legislation (Public Law 102-321) and provides funds to public entities to promote transformation of the mental health care system that serves children and youth (aged 0–21 years) diagnosed with a serious emotional disturbance and their families.

CMHI funding is provided to develop and implement systems of care in States and territories, local communities, and American Indian and Alaska Native communities. The system of care approach is predicated upon eight guiding principles for service provision:

- Family driven
- Individualized, strengths-based, and evidence-informed service plans
- Youth guided
- Culturally and linguistically competent
- In the least restrictive environment possible
- Community based
- Accessible

- Collaborative and coordinated through an interagency network

Accordingly, services should be both comprehensive and coordinated among public and private providers, consumers, and other key constituents. CMHI-funded systems of care build on the individual strengths of participating children, youth, and families to address their service needs. They also aim to reduce service disparities by promoting cultural and linguistic competence and responsiveness.

The program has grown since its inception in 1993 from initial funding of \$4.9 million to a total investment of nearly \$1.5 billion as of fiscal year FY 2010, awarding 173 grants and cooperative agreements to communities. Seven cohorts (phases) of grants/cooperative agreements were awarded from 1993 through 2008. For simplicity, CMHI-funded system of care sites are referred to in this summary as *grant communities* regardless of whether they were funded by grants or cooperative agreements. Communities initially funded from FY 1994 to FY 2002 completed their funding as of FY 2008 and are considered *alumni communities*. Phase IV grant communities funded in FY 2003 and FY 2004 are in their latter years of funding, and Phase V grant communities funded in FY 2005 and FY 2006 are in their middle years of funding. Phase VI and VII grant communities began to receive funds in FY 2008–FY 2010.

The legislation authorizing the CMHI also mandated a national evaluation to describe, monitor, and chronicle the initiative's progress. The national evaluation consists of multiple studies designed to examine the effectiveness of the CMHI at different levels. These studies examine the characteristics of all service recipients; changes in child, youth, and caregiver outcomes over time, based on interviews of caregivers and youth aged 11 and older conducted at intake and every 6 months up to 3 years; the types and amounts of services received by children, youth, and their families; families' experiences with those services; service costs and savings; the degree to which CMHI communities implement the system of care principles described above; the implementation of evidence-based treatments; and strategies used by communities to sustain their systems of care.

The 2006–2008 *Report to Congress* compiles information developed across 3 years to present findings from the national evaluation of communities initially funded from FY 1999 through FY 2006 (Phases III, IV, and V). Descriptive data were collected from 28,423 children enrolled in these CMHI grant communities. Longitudinal data were collected from 9,952 caregivers and 6,392 youth aged 11 years and older. Each analysis of the longitudinal data was based on only those caregivers and youth who provided complete information for the relevant measure at intake and at follow-up periods, so sample sizes vary by analysis.

The 2006–2008 *Report to Congress* describes

- the system of care approach, in particular the CMHI;
- the characteristics, outcomes, and service experiences of the children, youth, and families receiving services through the CMHI;

- the implementation of the system of care philosophy;
- the resources used by CMHI communities.

Description of the Children and Families

CMHI grant communities serve a diverse group of traditionally underserved children and youth. Demographic characteristics of those served by Phase IV and V communities include the following:

- 64% were male
- 59% belonged to non-White racial and ethnic groups
- 45% lived with their biological mother only, and another 25% lived with both biological parents
- More than 55% lived in poverty (as defined by the U.S. Department of Health and Human Services)

Many of these children and youth lived in family situations that put them at greater risk for later mental health challenges, including exposure to domestic violence; a family history of depression, mental illness, and substance abuse with mental illness; and physical and sexual abuse.

The Phase III, IV, and V systems of care were successful in engaging multiple community agencies. Schools and mental health agencies were the most common referral sources for system of care services.

Children and youth exhibited a range of problems when entering the system of care. The most common diagnoses were

- Mood Disorders (35%),
- Attention-Deficit/Hyperactivity Disorder (34%),
- Oppositional Defiant Disorder (nearly 25%),

- Adjustment Disorders (more than 12%).

Child, Youth, and Caregiver Outcomes

Twenty-four months after enrollment in CMHI services, children and youth demonstrated a variety of improved clinical and functional outcomes. Many caregivers (48%) reported that children showed significant reductions in their behavioral and emotional problems, and 42 percent reported that their children's behavioral and emotional strengths increased.

In addition, 25 percent of youth aged 11 and older reported that they experienced fewer symptoms of depression, and 32 percent reported fewer symptoms of anxiety. Approximately 32 percent of caregivers reported that their children's general functional impairment had decreased, and children and youth showed substantial improvements in specific types of home and community functioning 24 months after enrollment in the CMHI:

- Maintaining a single, rather than multiple, living situation in the previous 6 months increased from 65 percent to 80 percent.
- Regular school attendance (attending at least 80 percent of the time) improved from 83 percent to 90 percent.
- Receiving passing grades increased from 64 percent to 76 percent.
- Being arrested (as reported by youth aged 11 and older) decreased from 19 percent to 8 percent.

Caregivers reported improved outcomes as well:

- Almost 41 percent of caregivers reported decreased levels of strain associated with caring for their children.
- Unemployment due to a child's emotional and behavioral problems decreased from 17 percent to 13 percent.

Outcomes for Specific Populations of Focus

Outcomes for specific populations of focus improved significantly after enrolling to CMHI services:

- The number of caregivers of children and youth at risk for school-related problems who reported that poor school performance was a major problem for their child decreased from 44 percent to 27 percent after 6 months.
- Compared to children and youth who were not at risk for school-related problems, children and youth at risk for school-related problems improved significantly more with regard to school performance and school behavior after 6 months.
- Among youth referred by juvenile justice, the number reporting having engaged in property crimes decreased by nearly two thirds after 6 months.
- Behavioral and emotional problems, child functional impairment, anxiety, and depression decreased significantly for children and youth involved with child welfare and at a higher rate than for children and youth not involved with child welfare after 6 months.
- Among youth with a past history of suicide attempts, reported suicide attempts declined by about three quarters after 24 months.

Services Received, Their Associated Costs, and Caregivers' Service Experiences

CMHI systems of care provide a variety of services. The most common services include case management, individual therapy, medication monitoring, and family therapy. Children and youth experienced a decrease in residential services and an increase in community-based care.

Cost savings were achieved by decreasing the utilization of inpatient services over a 24-month period (\$913 per child served over a 24-month period) and by offsetting costs in other systems, for example, through decreased arrests for youth receiving services within systems of care (\$1,228 per youth served over a 24-month period).

Satisfaction with the range of services provided by grant communities is vital to child, youth, and family participation in services. Caregivers' perceptions about their satisfaction with services and their outcomes are also critical to meet the authorizing legislation's mandate to have parents assess the effectiveness of systems of care. Caregivers, children, and youth either agreed or strongly agreed with statements about their satisfaction with their service experience over time throughout a 24-month period, including statements about access to services, participation in treatment, cultural sensitivity, outcome of services, and overall satisfaction. Youth were least satisfied with their participation in treatment planning. Caregiver ratings of service providers within systems of care also indicated frequent use of culturally competent practices in service delivery.

System-Level Assessment of the CMHI

National evaluation results are used to strengthen program efforts at all levels and are shared with the Federal program, communities, and technical assistance providers. Four studies contributed data to the assessment of the system-level effectiveness of the CMHI:

- The System of Care Assessment explored how communities implemented the system of care principles over the course of their CMHI funding.
- The Sustainability Study examined how grant communities prepare and continue to sustain system of care infrastructure and services after CMHI funding ends.
- The Evidence-Based Treatment Survey examined how well communities funded in 2002–2004 were implementing evidence-based practices.
- The Culturally Competent Practices Survey examined providers' level of competence in several domains of cultural competence in system of care sites funded in 2002–2004.

Findings from these studies indicate that grant communities tend to be increasingly successful over the course of their funding in implementing the eight guiding principles of system of care. Further, grant communities used a variety of strategies aimed at increasing system of care sustainability beyond CMHI funding. In particular, successes reported by grant communities included implementing the principles of family-focused, individualized, collaborative/coordinated, accessible, and community-based and least restrictive care.

The Evidence-Based Treatment Survey revealed widespread use of a broad array of evidence-based and promising practices in the treatment of children and youth served within systems of care. Systems of care adapted evidence-based practices to respond to identified cultures within their communities. However, service providers reported being less adaptable and less willing to try new ideas and practices than administrators, highlighting the need for education, training, coaching, and other approaches to improve practice.

Findings from the Culturally Competent Practices Survey indicate that providers rated highly the relevance of culture and incorporation of families' beliefs into service provision. Service providers within systems of care rated these elements of cultural competence in service delivery to diverse populations as significantly more important than did providers from partner agencies.

Opportunities for improvement in effecting system-level change remain, however. Community leaders noted the following areas as needing additional attention: ensuring culturally competent care; maintaining interagency involvement, particularly in the service delivery domain; and ensuring that service providers attain a better understanding of how to implement evidence-based practice.

Conclusions

Results from the national evaluation of the CMHI indicate that children, youth, and families made gains in clinical outcomes and general functioning. National evaluation data also indicate that CMHI grant communities are

- reaching many children and youth typically underserved by the mental health system,
- improving outcomes for children and youth,
- enhancing family outcomes,
- expanding the availability of effective supports and services,
- continuing to implement and maintain fidelity to system of care principles,
- developing and successfully using sustainability strategies.

As in any system transformation effort, CMHI grant communities face challenges in sustaining their efforts and effecting broad system-level changes, including building a culturally and linguistically competent workforce, addressing challenges to cross-agency collaboration to support an efficient multi-agency structure that serves the needs of children and families, and implementing evidence-based practices. Despite these challenges, CMHI-funded communities continue to move forward in developing and implementing appropriate and tailored services and supports for children, youth, and their families.

