

Comprehensive Community Mental Health Services for Children and Their Families Program



Evaluation Findings: Executive Summary Annual Report to Congress 2005



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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U.S. Department of Health and Human Services



**THE COMPREHENSIVE COMMUNITY MENTAL
HEALTH SERVICES FOR CHILDREN AND
THEIR FAMILIES PROGRAM**

EVALUATION FINDINGS



Executive Summary
Annual Report to Congress
2005

Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

U.S. Department of Health and Human Services

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EXECUTIVE SUMMARY

The Comprehensive Community Mental Health Services for Children and Their Families Program (Children's Mental Health Initiative, or CMHI) funds communities to establish a comprehensive mental health service system that is based on system of care principles. The program theory is that outcomes for children, youth and families will improve when service delivery organizations collaborate to provide coordinated services that are family focused, individualized, culturally competent and provided in easily accessible, community-based, and least restrictive service settings. The national evaluation of the CMHI gathers longitudinal data that track the extent to which the system of care principles are implemented over time in each funded community as well as data that track over time the clinical and functional outcomes of the children and youth who receive services in those communities.

The CMHI is based on the system of care concept and philosophy and provides an opportunity to examine, develop, and refine approaches toward identifying those in need so that successful outcomes for children and their families can be achieved. Children enrolled in the program range in age from birth to age 21 and currently have, or at any time during the past year had, a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV*; American Psychiatric Association [APA], 1994), that resulted in functional impairment that substantially interferes with or limits one or more major life activities. Because of the diverse array of communities and populations, funded system of care programs provide excellent learning opportunities for using evidence-based treatments, confronting mental health disparities, working with and pulling together resources across child-serving agencies, creating unique service options, and finding ways to sustain systems of care.

The CMHI has five primary goals: (a) expand community capacity to serve children and adolescents with serious emotional disturbance; (b) provide a broad array of effective services, treatments, and supports; (c) create a case management team with an individualized service plan for each child; (d) deliver culturally and linguistically competent services for racial and ethnic populations represented in the communities; and (e) promote full participation of families and youth in service planning and development of local services. These goals generally state the need for community-level availability of effective services to minimize out-of-home or out-of-community placement of children who need mental health services and whose families need support services.

CMHI program goals emphasize achievement at the infrastructure, service delivery, and child and family outcomes levels. Goals include developing and sustaining system of care infrastructure; increasing non-mental health referrals; increasing cross-agency individualized care planning; reducing utilization of high-cost inpatient or residential services in favor of increased utilization of community-level services and supports; and at the child or youth level, improving behavioral, emotional, and functional indicators.

This report describes characteristics of the children and families served by the CMHI and their outcomes as a result of their participation in the program. Also documented and discussed is the effectiveness of selected program practices and interventions and system-level change. The major findings in this report are presented as a retrospective analysis of data collected over the 6-year funding cycles of 45 communities. Nine communities were funded in FY 1997, 14 were funded in FY 1998, 20 were funded in FY 1999, and 2 were funded in FY 2000. As a group, the grant communities served approximately 19,931 children and youth and their families across their 6-year span of grant funding.

Part I of the report presents findings from retrospective analyses conducted across years of program development for 45 system of care communities initially funded in 1997, 1998, 1999, and 2000, beginning with their second year of funding and followed through to their final year of funding. Data from all four funding cohorts were collapsed into program development program years so the trend of progress across the grant-funding cycle could be illustrated on a year-to-year basis according to the communities' age in the grant-funded program. Findings from the sixth year should be interpreted with caution because the data collected during that year were from small sample sizes.

Part II of the report presents early child and family descriptive and child clinical and functional outcomes data for children and families served by 25 communities initially funded in 2002 and 2003, beginning with their second year of funding. As a group, these communities had served approximately 3,577 children and youth at the time of this report.

This Executive Summary of the report presents findings from four types of evaluation data, described as follows:

- Data on child and family outcomes. The data include both clinical and functional outcomes. These data were collected only on children, youth, and families who voluntarily agreed to participate in the longitudinal outcome study. The number of children, youth, and families for whom data were collected and were available for analyses varied across measures and across time. Not all children, youth, and families served by the programs participated in the longitudinal outcome study, and not all study participants provided data across all measures at all times of data collection. These data are presented in both Part I and Part II of the report, including the retrospective analyses of program development over the funding cycles of system of care communities initially funded in 1997, 1998, 1999, and 2000, and the early findings from current system of care communities initially funded in 2002 and 2003.
- Descriptive data about the children and families participating in system of care communities. These data were collected on children, youth, and families through the intake process upon their entry into the system of care program. System of care communities attempted to collect these data on all children, youth, and families served by their programs. These data are presented in both Part I and Part II of the report, including the retrospective analyses of program development over the funding cycles of system of care communities initially funded in 1997, 1998, 1999, and 2000, and the early findings from current system of care communities initially funded in 2002 and 2003.

- Consumer satisfaction data about how program practices and interventions support the children and families served. These data were collected only on children, youth, and families who voluntarily agreed to participate in the longitudinal outcome study. The number of children, youth, and families for whom data were collected and were available for analyses varied across measures and across time. Not all children, youth, and families served by the programs participated in the longitudinal outcome study, and not all study participants provided data across all measures at all times of data collection. These data are presented only in Part I of the report, the retrospective analyses of program development over the funding cycles of system of care communities initially funded in 1997, 1998, 1999, and 2000. Data on these topics from communities initially funded in 2002 and 2003 were not available at the time this report was completed.
- Data about the system-level achievements in infrastructure and service delivery. These data were collected through periodic site visits to the system of care communities across their years of grant funding. These data are presented in only Part I of the report, the retrospective analyses of program development over the funding cycles of system of care communities initially funded in 1997, 1998, 1999, and 2000. Data on these topics from communities initially funded in 2002 and 2003 were not available at the time this report was completed.

The format of the Executive Summary presents brief findings followed by corresponding graphs or tables. Findings of change over time are reported as change occurring from time of entry into services to subsequent data collection times. The Executive Summary concludes with a list of the grant communities initially funded in 1997, 1998, 1999, 2000, 2002, and 2003.

FINDINGS FROM THE RETROSPECTIVE ANALYSES OF SYSTEM OF CARE COMMUNITIES INITIALLY FUNDED IN 1997, 1998, 1999, AND 2000

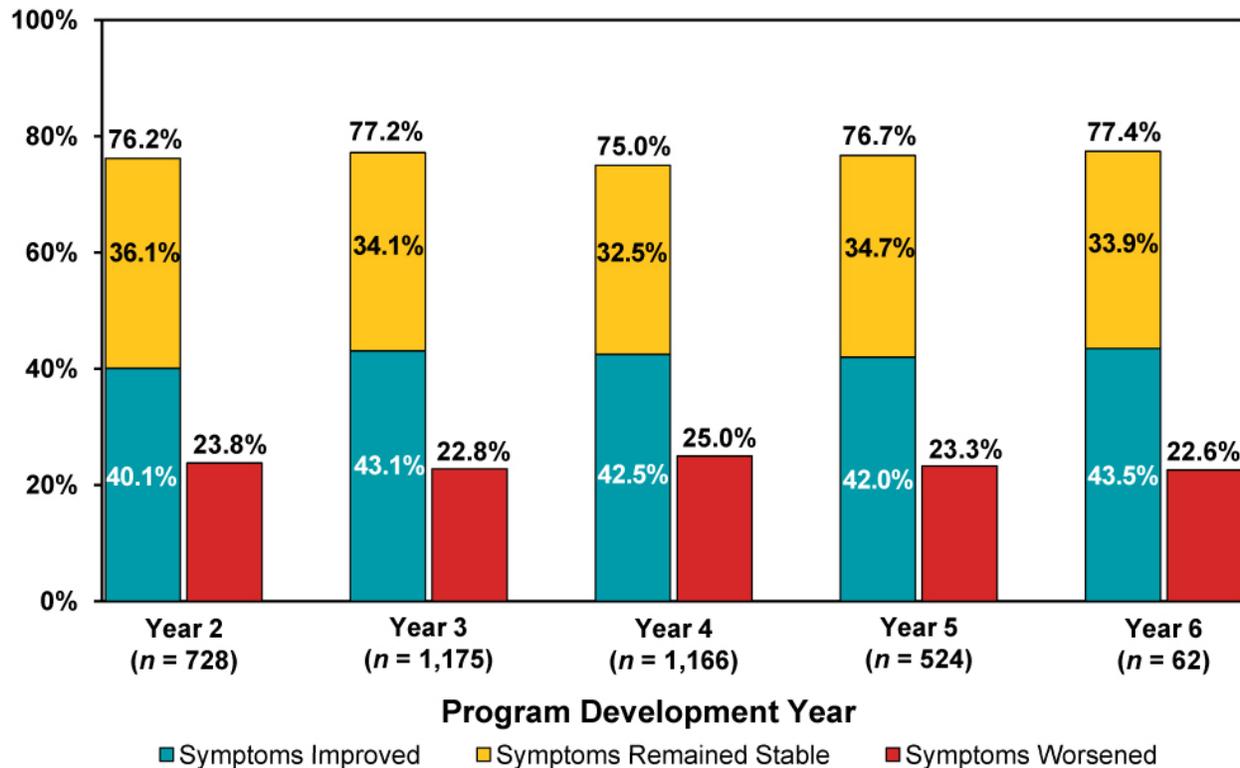
CHILD, YOUTH, AND FAMILY OUTCOMES

Child and Youth Outcomes

Behavioral and Emotional Strengths Increased

During each year of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000, between 40 percent and 45 percent of children and youth who participated in the longitudinal outcome study and for whom data were available on this measure (the number varied from year to year, as noted in the figure below) exhibited clinically significant improvements in their strengths 12 months after enrolling in system of care services, as measured by the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998). An additional one third exhibited stable levels of strengths. Overall behavioral and emotional strengths, measured by the Strength Index, improved from a mean score of 86.3 at intake to 90.4 at the 12-month followup.

Figure 1
Reliable Change Index (RCI) for BERS Strength Quotient
from Intake to 12-Month Followup by Program Development Year

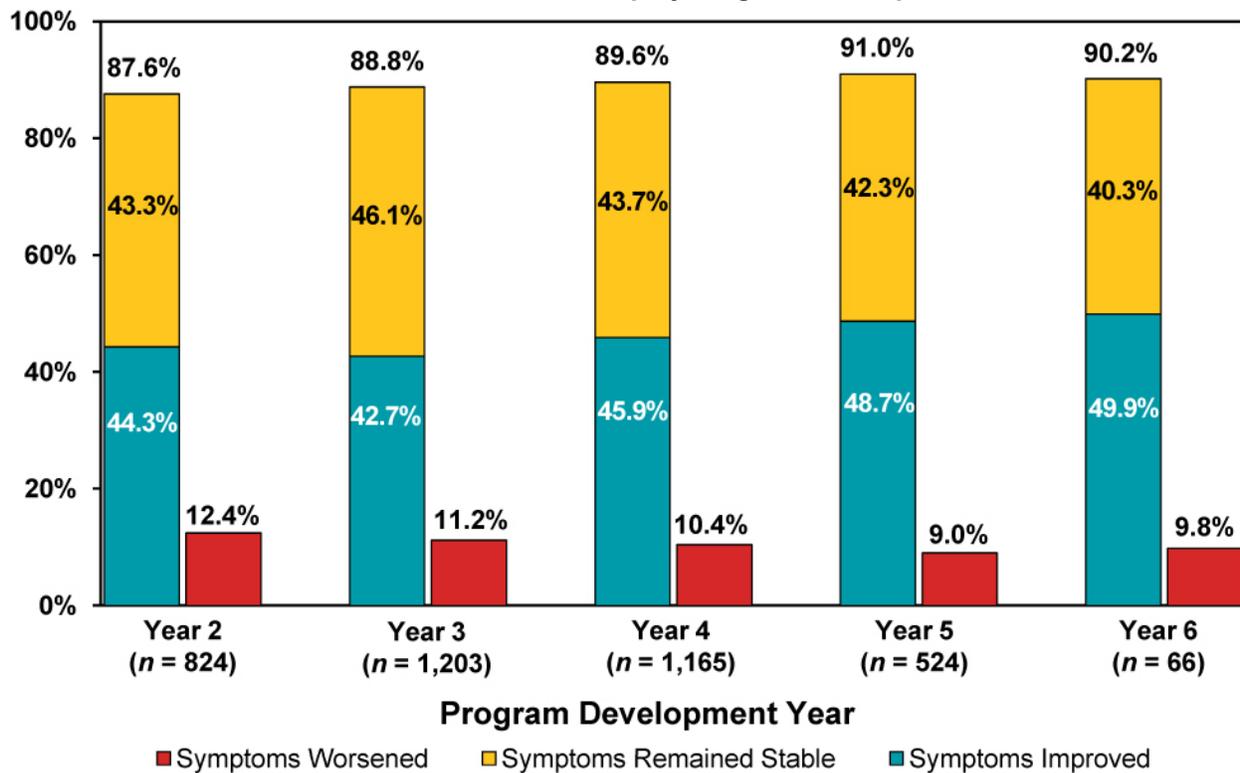


RCI x Year: $\chi^2(4) = 1.77, p > .05$.

Behavioral and Emotional Problems Were Reduced

Over years of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000 between 40 percent and 50 percent of children and youth who participated in the study and for whom data were available each year exhibited a clinically significant decrease in their behavioral and emotional problems during the 12 months following entry into system of care services, as measured by the Child Behavior Checklist (CBCL; Achenbach, 1991). An additional 40 percent to 45 percent exhibited stable levels of problems. Another trend was that the percentage of children who showed improvement increased over program development years. Thus, 88 percent either remained stable or demonstrated clinically significant improvement. The average Total Problem T-score on the Child Behavior Checklist 4–18 (CBCL 4–18) decreased from 71.0 at intake to 65.7 at the 12-month followup.

Figure 2
Reliable Change Index (RCI) for CBCL Total Problems
from Intake to 12-Month Followup by Program Development Year

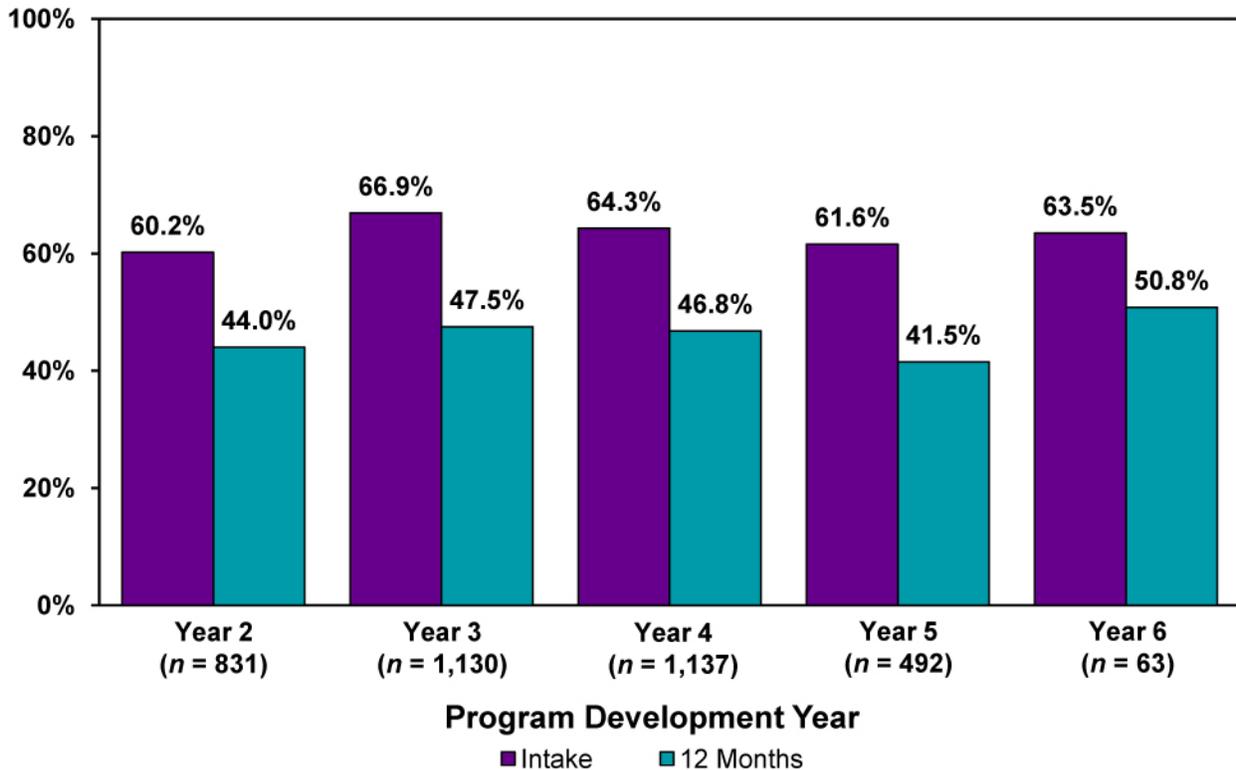


RCI x Year: $\chi^2(4) = 7.83, p > .05$.

Clinical Functioning Improved

Children's overall functioning in their home, school, and community environments improved during their first year following receipt of services in the program. Across years of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000, the percentage of children and youth who participated in the study and for whom data were available each year exhibited moderate to severe functional impairment 12 months after entering system of care services decreased significantly compared to the level of impairment at entry into services, as measured by the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990). On average, the number of children with these high levels of functional impairment decreased by 17 percent. The average total CAFAS score decreased significantly from 112.4 at intake to 91.1 at the 12-month followup.

Figure 3
Percentage of Children with Moderate to Severe Functional Impairment for CAFAS Total Score at Intake and 12-Month Followup by Program Development Year

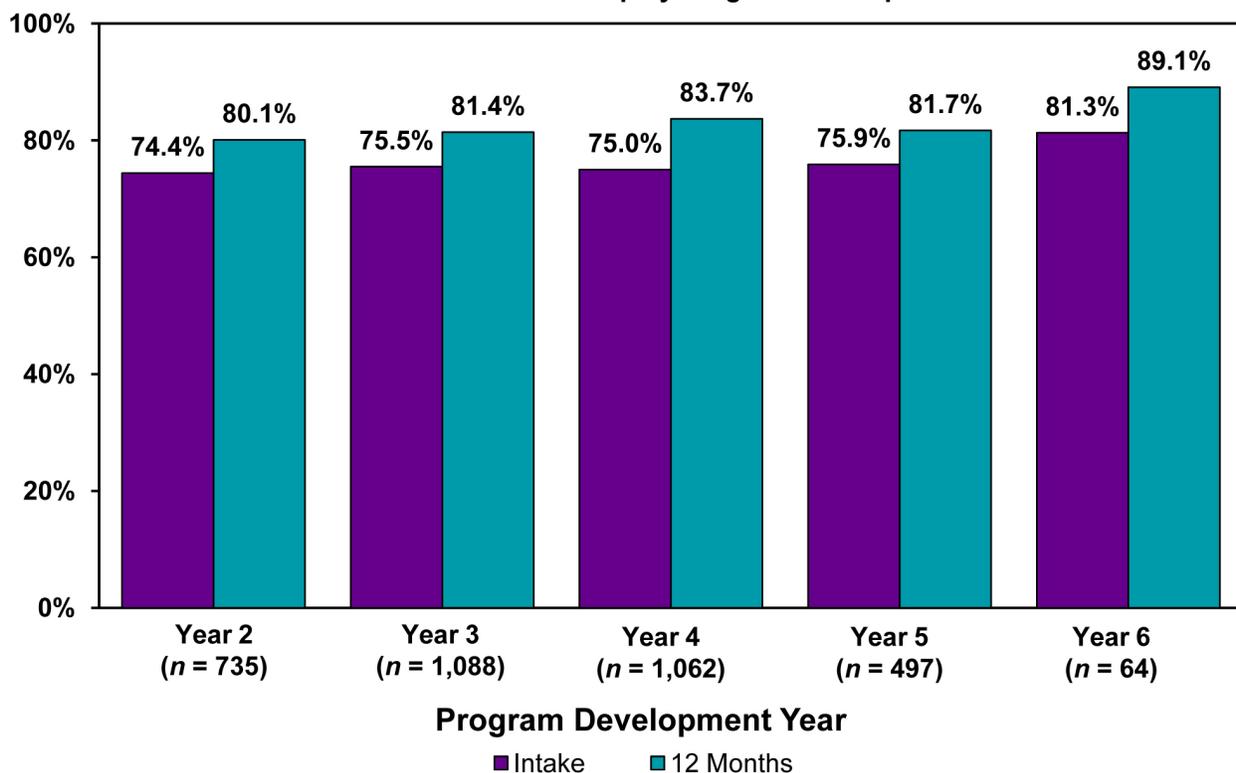


Baseline–12-month: $z = -5.65, p < .001$; Year: $z = 0.45, p > .05$; (Baseline–12-month) x Year: $z = -0.47, p > .05$.

School Attendance Improved

Although three-fourths of the children and youth who participated in the study and for whom data were available each year attended school regularly at entry into services, school attendance still increased during their first 12 months in services in system of care communities initially funded in 1997, 1998, 1999, and 2000. While not statistically significant, the increase averaged between 6 percent and 7 percent over the years of program development in these communities, with over 80 percent of children attending school regularly 12 months after entering services.

Figure 4
Percentage of Children Attending School 75 Percent of the Time or More in the Past 6 Months at Intake and 12-Month Followup by Program Development Year

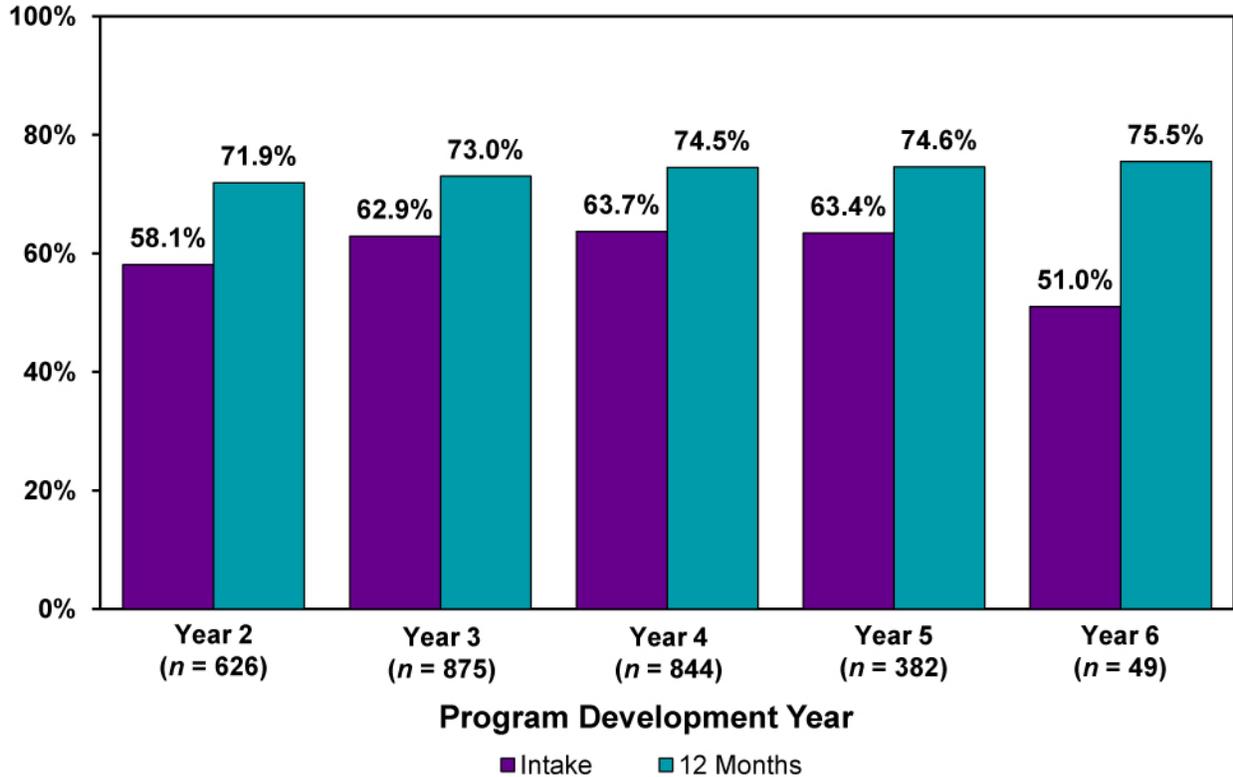


Baseline–12-month: $z = 1.95, p > .05$; Year: $z = 0.80, p > .05$; (Baseline – 12-month) x Year: $z = 0.81, p > .05$.

School Performance Improved

The percentage of children and youth who participated in the study and for whom data were available each year with academic achievement of at least a C grade point average increased significantly by an average of 14 percent from entry into services to 12 months post-entry into services in system of care communities initially funded in 1997, 1998, 1999, and 2000. This improvement was consistent across all years of program development.

Figure 5
Percentage of Children Receiving a C or Better Grade Point Average in the Past 6 Months at Intake and 12-Month Followup by Program Development Year

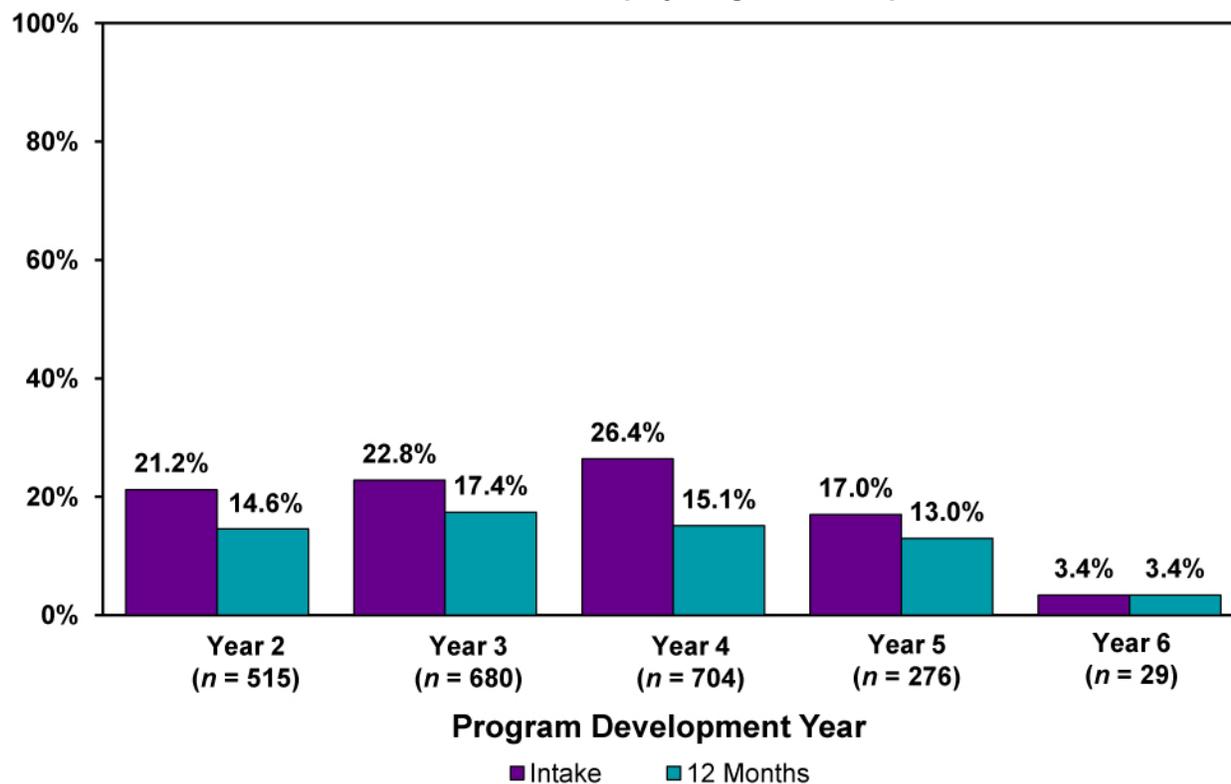


Baseline–12-month: $z = 3.58, p < .001$; Year: $z = 1.28, p > .05$; (Baseline–12-month) x Year: $z = 0.07, p > .05$.

Law Enforcement Contacts Were Reduced

Among youth who participated in the study and for whom data were available each year significantly fewer reported being arrested during the first 12 months in services in system of care communities initially funded in 1997, 1998, 1999, and 2000 than in the 6 months prior to entering services, indicating that youth showed improvement in their ability to function successfully in their communities. The greatest decrease (11 percent) was observed for the cohort of youth who entered during the fourth year of program development.

Figure 6
Percentage of Youth with Arrests in the Past 6 Months
at Intake and 12-Month Followup by Program Development Year

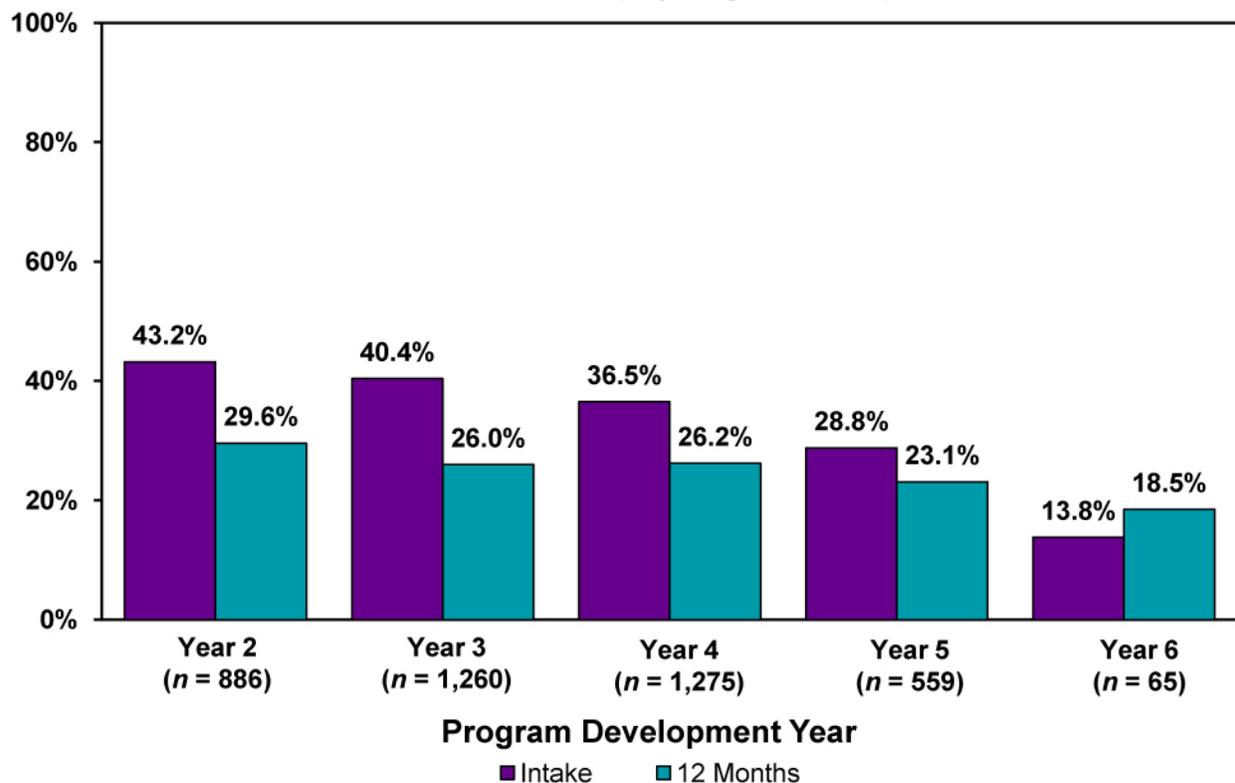


Baseline–12-month: $z = -2.03, p < .001$; Year: $z = -0.66, p > .05$; (Baseline–12-month) x Year: $z = -0.47, p > .05$.

Residential Stability Improved

The percentage of children and youth placed in two or more out-of-home settings during the 6 months before the 12-month assessment decreased significantly from intake into services in system of care communities initially funded in 1997, 1998, 1999, and 2000 by an average of nearly 8 percentage points across years of program development. In addition, there was a significant difference in the rate of decrease from intake to 12 months post-intake across program development years. Over years of program development, the percentage of children and youth with multiple out-of-home placements at intake decreased significantly more rapidly than at 12 months post-intake.

Figure 7
Percentage of Children Living in Two or More Settings in the Past 6 Months at Intake and 12-Month Followup by Program Development Year



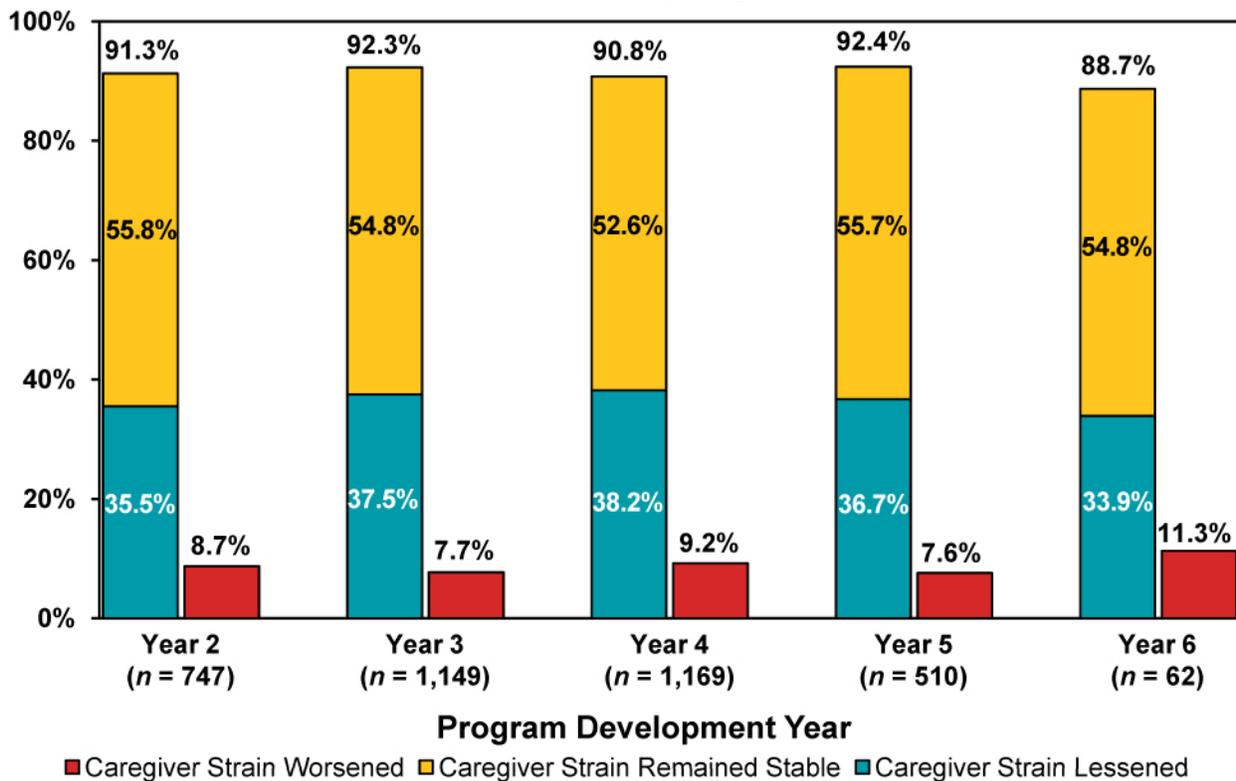
Baseline–12-month: $z = -6.50, p < .001$; Year: $z = -6.62, p < .001$; (Baseline–12-month) \times Year: $z = 2.39, p < .05$.

Family Outcomes

Caregiver Strain Decreased

One-third or more of caregivers who participated in the study and for whom data were available each year indicated the strain they experienced as a result of their caregiving responsibilities and its total impact on the family were reduced significantly from intake to 12 months after entry into services in system of care communities initially funded in 1997, 1998, 1999, and 2000. Caregiver strain was measured by the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1997). Another half or more indicated their level of strain remained stable. This finding did not vary significantly across years of program development in these communities. Decreased scores may indicate reduction in negative events such as disrupted family relationships, routines, social activities, and loss of personal time.

Figure 8
Reliable Change Index (RCI) for Mean CGSQ Global Strain Scores
from Intake to 12-Month Followup by Program Development Year



RCI x Year: $\chi^2(4) = 1.89, p > .05$.

CHILD AND FAMILY CHARACTERISTICS

- **Child Gender:** Of the 19,931 children enrolled in the descriptive study of system of care communities initially funded in 1997, 1998, 1999, and 2000 and for whom data were available, 66 percent were boys and 34 percent were girls.
- **Child Average Age:** The average age of 19,856 children for whom data were available was 11.5 years; 16 percent were aged 6 years or younger, 25 percent were aged 7 to 11 years, 29 percent were aged 12 to 14 years, and 29 percent were aged 15 years or older.
- **Child Race/Ethnicity:** Of 18,400 children for whom data were available, 59 percent were White, 26 percent were African American, 11 percent were Hispanic, 9 percent were American Indian or Alaskan Native, 1 percent were Asian, 0.5 percent were Native Hawaiian or other Pacific Islander, and 1 percent were of other ethnicities.
- **Family Custody:** Of 16,587 children for whom data were available, 43 percent were in their mother's custody, 25 percent were in the custody of both parents, 4 percent were in the custody of fathers, 4 percent were in the custody of adoptive parents, 11 percent were in the custody of foster parents or wards of the State, 7 percent were in the custody of grandparents, and 6 percent were in other types of custody.
- **Family Poverty:** Data on family incomes for 12,290 families for whom data were available showed that 57 percent of the children's families reported incomes below poverty, 9 percent were at poverty, and 34 percent were above poverty according to poverty guidelines by family household size.
- **Clinical Diagnosis:** Of 12,793 children for whom data were available, 37 percent had a clinical diagnosis of attention-deficit/hyperactivity disorder (ADHD), 33 percent mood disorders and depression, 27 percent oppositional defiant disorder, 12 percent adjustment disorders, and 12 percent conduct disorder.
- **Co-Occurring Mental Health Disorders:** Of the children for whom data were available, 54 percent had multiple mental health diagnoses.

**Table 1
Child and Family Demographic Characteristics at Intake**

Gender	(n = 19,931)
Male	66%
Female	34%
Average Age	11.5 years (n = 19,856)
Birth to 3 years	6%
4 to 6 years	11%
7 to 11 years	25%
12 to 14 years	29%
15 to 18 years	28%
19 to 21 years	1%
Race and Ethnicity^a	(n = 18,400)
American Indian or Alaskan Native	9%
Asian	1%
Black	26%
Native Hawaiian or Other Pacific Islander	0.5%
White	59%
Hispanic Origin	11%
Multi-Racial	7%
Other	1%
Custody^b	(n = 16,587)
Mother	43%
Two Parents	25%
Ward of State	10%
Grandparents	7%
Father	4%
Adoptive Parent(s)	4%
Foster parent(s)	1%
Other ^c	6%
Family Poverty^d	(n = 12,290)
Below poverty	57%
At poverty	9%
Above poverty	34%
Most Frequent Clinical Diagnoses^e	(n = 12,793)
Attention-Deficit/Hyperactivity Disorder	37%
Mood Disorders and Depression	33%
Oppositional Defiant Disorder	27%
Adjustment Disorders	12%
Conduct Disorder	12%

^a Because individuals may claim more than one racial background, the race variable may add to more than 100 percent.

^b Custody status refers to legal status and may not reflect living arrangement.

^c Other includes siblings, aunts/and/or uncles, adult friend, and other caregivers.

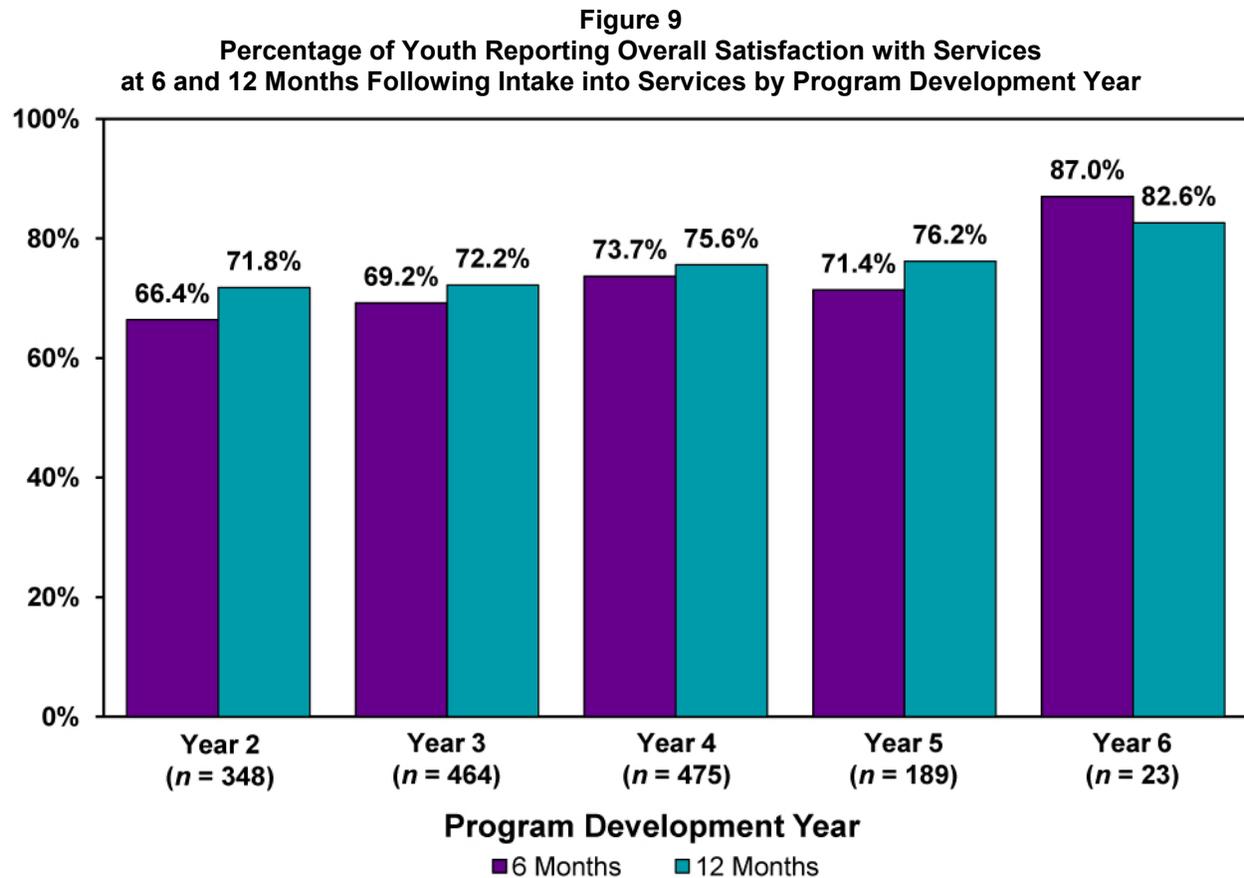
^d The poverty threshold is \$18,500 for a family of four according to the 2004 Health and Human Services Poverty Guidelines (U.S. Department of Health and Human Services, 2004).

^e Because children may have more than one diagnosis, the diagnosis variable may add to more than 100 percent.

PROGRAM PRACTICES AND INTERVENTIONS

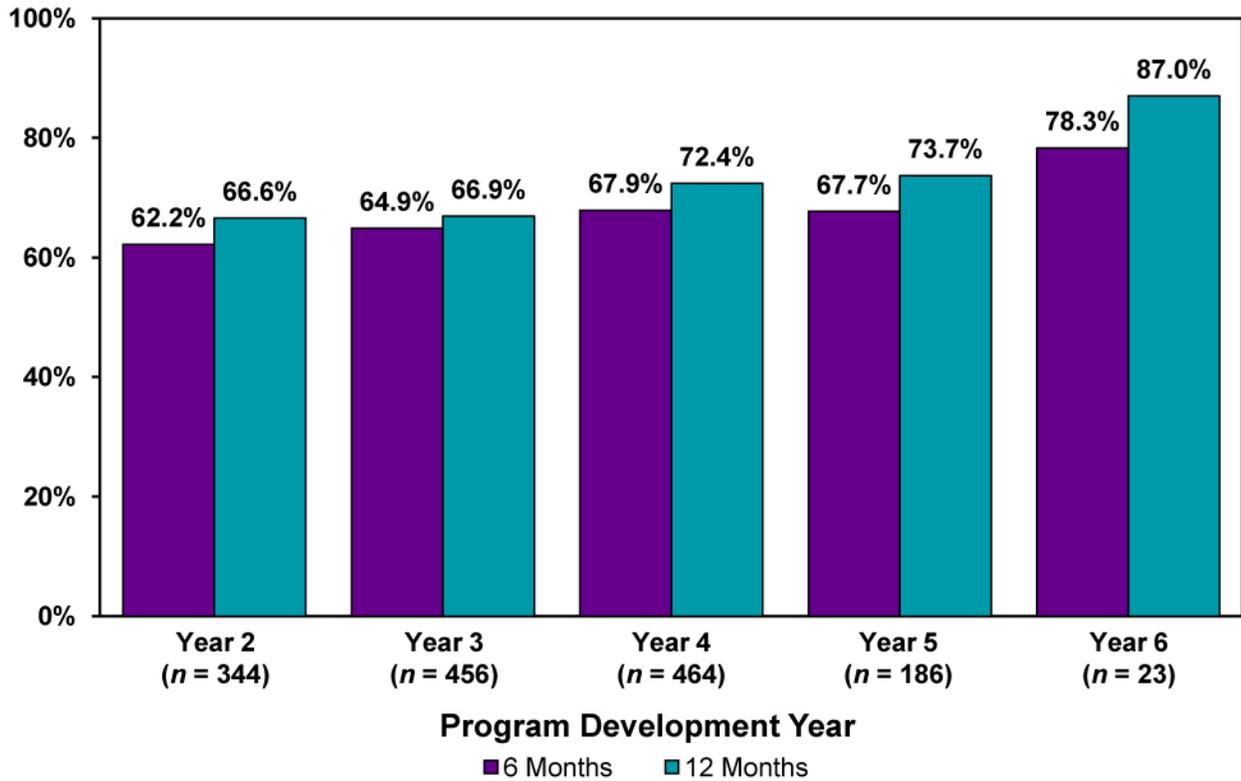
Youth Satisfaction with Services Improved across Program Development Years

For children and youth who participated in the longitudinal outcome study and for whom data were available, overall satisfaction with services and with their involvement in treatment planning increased significantly across program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000. Youth satisfaction with overall services, with their own progress, and with their involvement in treatment planning remained relatively stable at 6 months and 12 months after service intake.



6-month–12-month: $z = 1.23, p > .05$; Year: $z = 2.45, p < .05$; (6-month–12-month) x Year:
 $z = -0.46, p > .05$.

Figure 10
Percentage of Youth Satisfied with Involvement in Service Planning
at 6 and 12 Months Following Intake into Services by Program Development Year

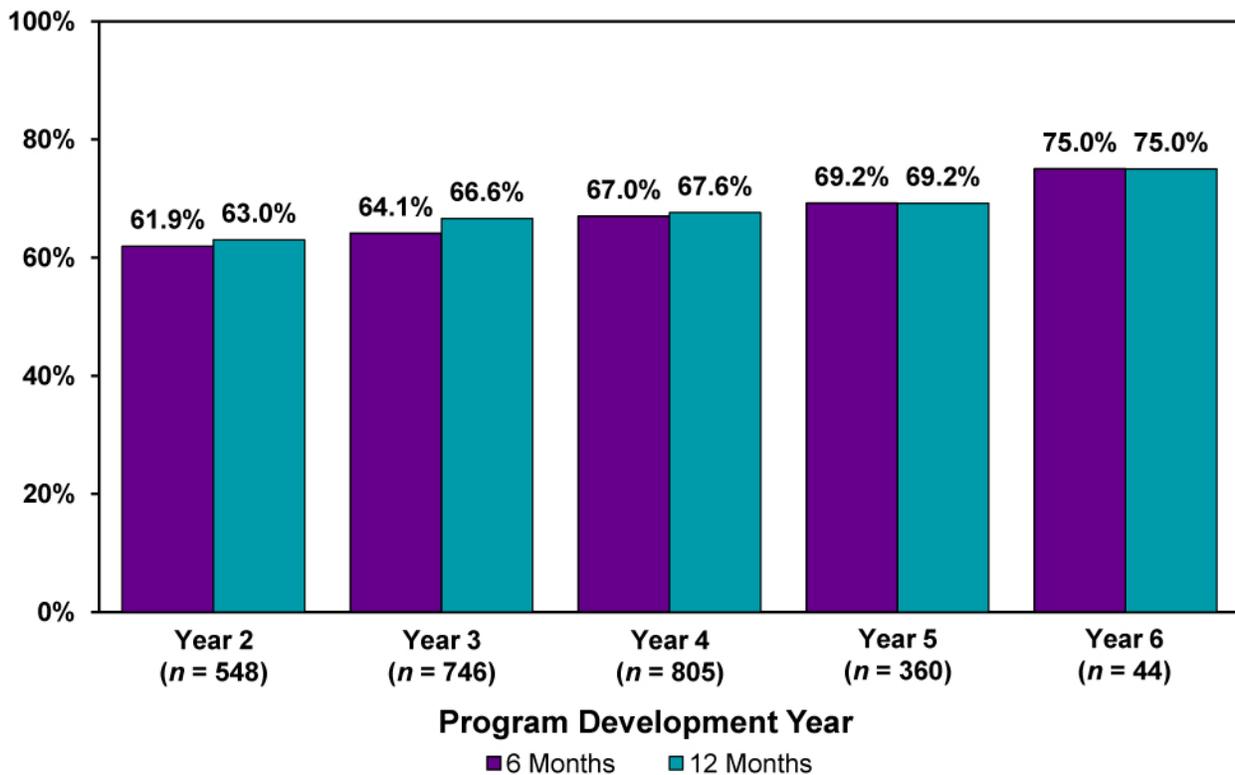


6-month–12-month: $z = 0.39, p > .05$; Year: $z = 2.03, p < .05$; (6-month–12-month) \times Year: $z = 0.58, p > .05$.

Caregiver Satisfaction with Services Improved across Program Development Years

For caregivers who participated in the outcome study and for whom data were available each year, satisfaction with the progress of their child increased significantly across program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000, while their overall satisfaction with services, with their child’s progress, and with their involvement in treatment planning remained relatively stable at 6 months and at 12 months after service intake.

Figure 11
Percentage of Caregivers Satisfied with Child’s Progress
at 6 and 12 Months Following Intake into Services by Program Development Year

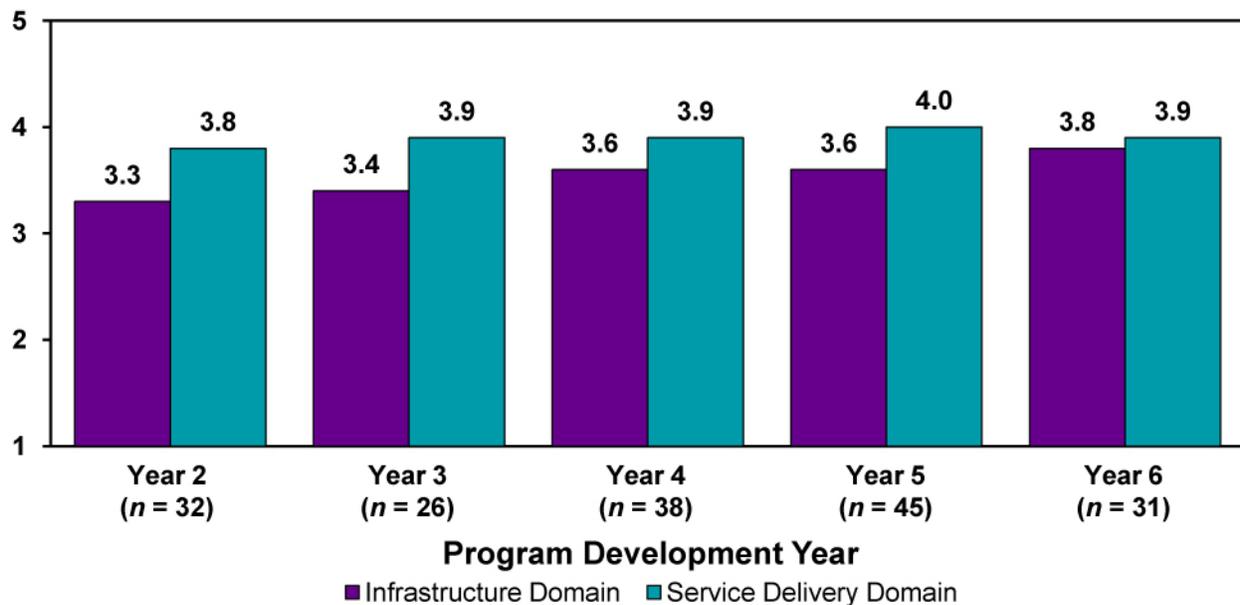


6-month–12-month: $z = 0.70, p > .05$; Year: $z = 2.88, p < .05$; (6-month–12-month) x Year: $z = -0.38, p > .05$.

System of Care Communities Provided Individualized Services and Case Management in the Least Restrictive Settings

According to system of care assessment ratings, system of care communities initially funded in 1997, 1998, 1999, and 2000 were successful and showed improvement over program developmental years in developing and monitoring individualized services and in building infrastructures to support individualized services. System of care communities were also successful in providing case management services to a large majority of children and their families across program development years. Receipt of case management services remained relatively high across program development years. System of care communities also demonstrated the ability to serve families in the least restrictive settings, with the percentage of children who received services in residential treatment facilities remaining consistently low (i.e., approximately 10 percent) across program development years. This is an important finding in that many of the children and youth served by grant communities were deemed to be at risk of residential placement.

Figure 12
Mean System of Care Assessment Ratings of Individualized Services in Infrastructure and Service Delivery by Program Development Year

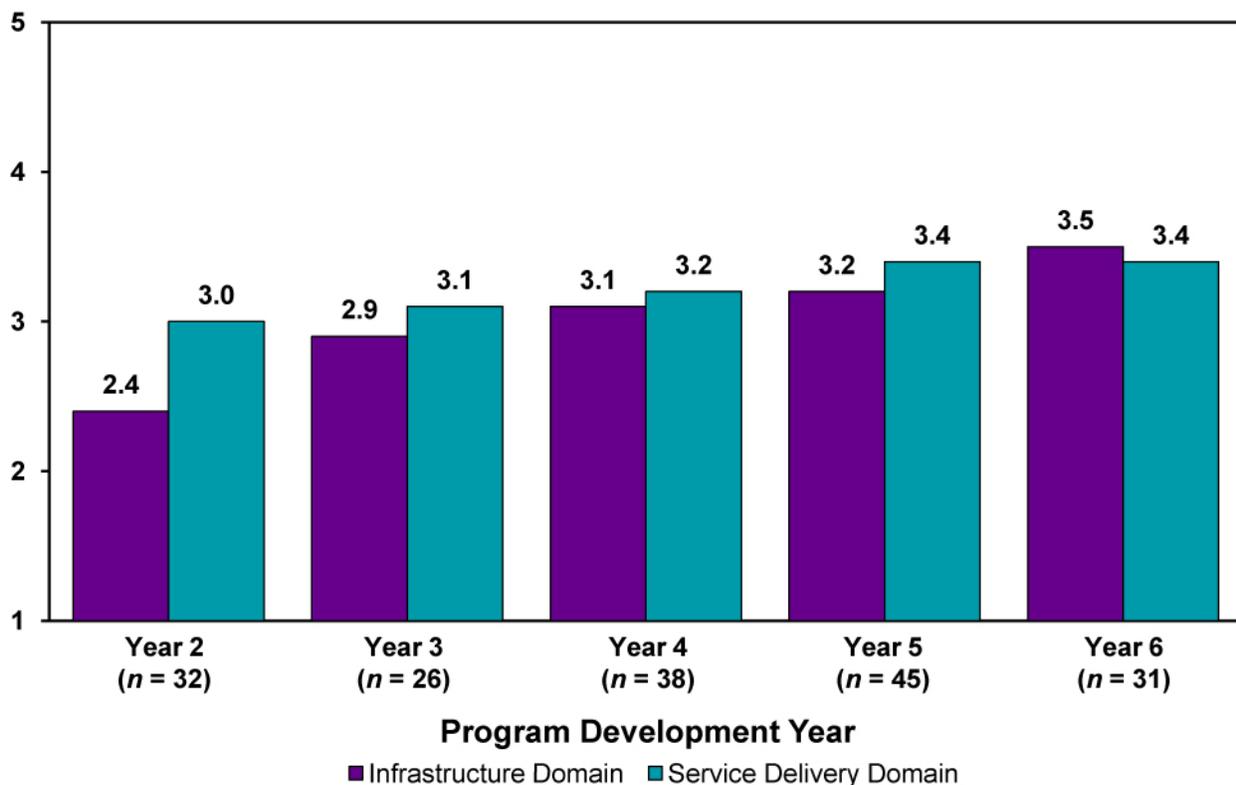


Note: *n* represents the number of communities with system of care assessment ratings for each program development year. System of care assessment ratings range from 1 to 5. A rating of 1 = no efforts have been made in this area; 2 = efforts made are in the early stage of development and have been minimally effective; 3 = efforts made are in developmental stages and moderately effective; 4 = efforts made in this area have been effective, but not sufficient; 5 = efforts made in this area have been effective and sufficient and the intended goals have been met. Communities funded from 1997–2000 are included in the analysis. The information presented above illustrates patterns of success and is not amenable to aggregate statistical analyses because the periodicity of assessments varies among the different groups of system of care communities, which results in inconsistent data that are available in any given program development year.

System of Care Communities Improved in Cultural and Linguistic Competence

According to system of care assessment ratings, system of care communities initially funded in 1997, 1998, 1999, and 2000 improved across program development years in delivering culturally competent services and building a culturally competent system of care infrastructure. In addition, according to satisfaction ratings of caregivers who participated in the longitudinal outcome study and for whom data were available each year, caregivers were satisfied both with their care coordinators' or other providers' efforts to refer them to culturally relevant services and with their providers' understanding of cultural issues. The percentage of caregivers satisfied in these areas was consistently at or above 75 percent.

Figure 13
Mean System of Care Assessment Ratings on Cultural Competence
in Infrastructure and Service Delivery Domains by Program Development Year



Costs Related to Inpatient Hospitalization and Involvement with Law Enforcement Decreased

Across all program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000, the average number of days per child spent in inpatient hospital care during the previous 6 months decreased significantly after 12 months of service compared to intake into services. Given the costs associated with inpatient hospitalization, this translates into cost savings and suggests a significant program impact. Similarly, there was positive trend in reducing the number of arrests per child across program development years, with fewer average arrests per child in each program development year at 12 months after service intake compared to at intake. This also translates into significant cost savings for system of care communities.

Table 2
Cost Savings Associated with Change from Intake to 12 Months
in Number of Days of Inpatient Hospital Care within the Previous 6 Months

Program Development Year ^a	# of Days at Intake	Average # Days per Child	# of Days at 12 Months	Average # Days per Child	Difference in Average # Days	Cost Savings per Child ^b
Year 2 (n = 842)	3,826	4.54	1,944	2.78	-1.76	\$3,355
Year 3 (n = 1,116)	4,179	3.74	1,989	2.60	-1.14	\$2,946
Year 4 (n = 1,136)	3,114	2.74	1,578	1.66	-1.08	\$2,030
Year 5 (n = 462)	1,711	3.70	715	1.33	-2.37	\$3,236

Intake–12-month: $z = -2.37, p < .05$; Year: $z = -1.87, p > .05$; (6-month–12-month) x Year: $z = 0.51, p > .05$.

^a Includes cases with complete data at intake and 12 months for communities in development year.

^b Average cost per day in inpatient hospital care = \$1,501.

Table 3
Costs Savings Associated with Change from Intake to 12 Months
in Number of Arrests within the Previous 6 Months^a

Program Development Year ^a	# of Arrests at Intake	Average # Arrests per Child	# of Arrests at 12 Months	Average # Arrests per Child	Difference in Average # Arrests per Child	Cost Savings per Child ^b
Year 2 (n = 506)	221	0.44	162	0.24	-0.20	\$483.78
Year 3 (n = 690)	339	0.49	218	0.31	-0.18	\$727.58
Year 4 (n = 713)	406	0.62	195	0.27	-0.35	\$1,227.83
Year 5 (n = 296)	101	0.34	72	0.24	-0.10	\$378.46
Year 6 (n = 34)	7	0.21	3	0.08	-0.13	\$488.12

Intake–12-month: $z = -1.45, p > .05$; Year: $z = -0.41, p > .05$; (6-month–12-month) x Year: $z = -0.61, p > .05$.

^a Includes cases with complete data at intake and 12 months for communities in each development year.

^b Average cost per juvenile arrest is \$4,149. Cost savings per child were calculated by multiplying the difference in total number of arrests between intake and 12 months by \$4,149 and dividing by the total number of cases for each year

Evidence-Based Practices (EBPs) Are Being Utilized in System of Care Communities

Based on the results from the Evidence-Based Practices Survey conducted among system of care communities initially funded in 1997 and 1998 and two non-funded comparison communities, most providers reported providing an EBP during the course of their work. The types of EBPs used varied greatly, as did providers' training experiences and decision to fully implement treatment protocols.

Table 4
Most Commonly Reported Evidence-Based Treatments Used by Providers in the Course of Work

Evidence-Based Treatment	Percent of Providers Reporting Use of EBT (n = 446)
Cognitive Behavior Therapy (CBT)	65.0%
Wraparound	18.4%
Anger Management	14.3%
Social Skills Training	13.9%
Family Education and Support (FES)	13.5%
Case Management	12.1%

SYSTEM ACHIEVEMENTS IN INFRASTRUCTURE AND SERVICE DELIVERY

System of care communities initially funded in 1997, 1998, 1999, and 2000 demonstrated an overall increase in their “systemness” in that they were successful in integrating system of care principles into practices and interventions, specifically, the extent to which services were individualized to meet the unique needs of children, youth, and families participating in the program, and the extent to which children, youth, and families received coordinated, clinically useful, and cost effective services, as indicated above. System of care communities showed improvement in involving children, youth, and families in service planning and provision; involving partner child-serving agencies in system of care activities, particularly those related to service delivery; and providing a broad array of accessible services that had sufficient capacity to meet the need and that were provided in the least restrictive environments that were therapeutically appropriate within the home communities of the children, youth, and families served by the programs. Significant program efforts were focused on increasing the cultural competence of program services, and the data show that cultural competence in system of care infrastructure and service delivery improved each year. A more detailed description of efforts and achievements follows.

Family Involvement in Service Planning and Provision Improved: System of care communities initially funded in 1997, 1998, 1999, and 2000 improved over time in involving families in the service planning process and in including them in service provision activities. Communities made the most dramatic improvement in involving families in the case review process where planning was conducted to meet special service needs of their children.

Youth Involvement in Case Review and Service Planning Improved: Youth involvement in the case review process improved across program development years, although fully involving youth in this particular process continues to be a challenge for system of care communities. Youth involvement in service planning saw a general trend toward improvement across program development years. Care coordinators reported more favorably than did caregivers about youth involvement in their own service planning.

Interagency Involvement Improved: Overall, system of care communities improved in establishing partnerships among child-serving agencies to develop and implement infrastructure that supported their systems of care and in providing direct services to the children and families served by the program. Communities were more successful in involving partner agencies in service delivery activities such as creating cross-agency intake opportunities for children and families, jointly developing and implementing individualized service plans, and having a multi-agency case review process, than they were in achieving cross-agency governance, program management and operations, service provision, or quality monitoring partnerships (infrastructure level).

The Ability To Provide a Complete Array of Required Services Increased across Program Development Years: The percentage of system of care communities that provided a complete array of services that were required by law or regulation increased across program development years. By the sixth year, 93 percent of communities provided all grant-required services. The percentage of grant communities that provided additional services increased from years 2 to 3 and years 5 to 6, but decreased in the fourth year. Qualitative data results indicate that of the

required services, system of care communities experienced more difficulty in continuously providing intensive day treatment, therapeutic foster care, and transition-to-adult services in their service arrays across all program development years.

Service Capacity Improved for Some Services and Remained Stable for Others: The majority of care coordinators indicated sufficient capacity for approximately half of the required service array. In each of the six years of program development examined (Years 2 through 6), over 75 percent of care coordinators reported that, in their experience, the array of services in their communities included enough capacity to meet the needs of the children, youth, and families they served for 6 of the 11 required services. Communities were most successful in meeting the need for professional consultation, emergency services, medication management, case management, diagnostic and evaluation services, and outpatient individual, group, and family counseling; they were less successful in meeting the need for intensive home-based services, transition-to-adult services, and intensive day treatment, and they experienced the most difficulty in meeting the need for respite care and therapeutic foster care.

Communities Were Successful in Providing Accessible Services: System of care communities were most successful in providing financially accessible services, providing services in convenient locations, and providing transportation assistance. They also improved in providing services in home communities and providing services and conducting service planning meetings in convenient locations (although a decrease was evident in year 6); they were least successful in providing services and conducting service planning meetings at convenient times.

Communities Improved in Providing Least Restrictive Services, and Remained Stable in Providing Community-Based Services: System of care communities improved in providing services in least restrictive environments across each program development year, but particularly in years 5 and 6. Some programs were already providing services to some extent within the home communities of the children and families served when they received their grant funds and continued to do so across program development years.

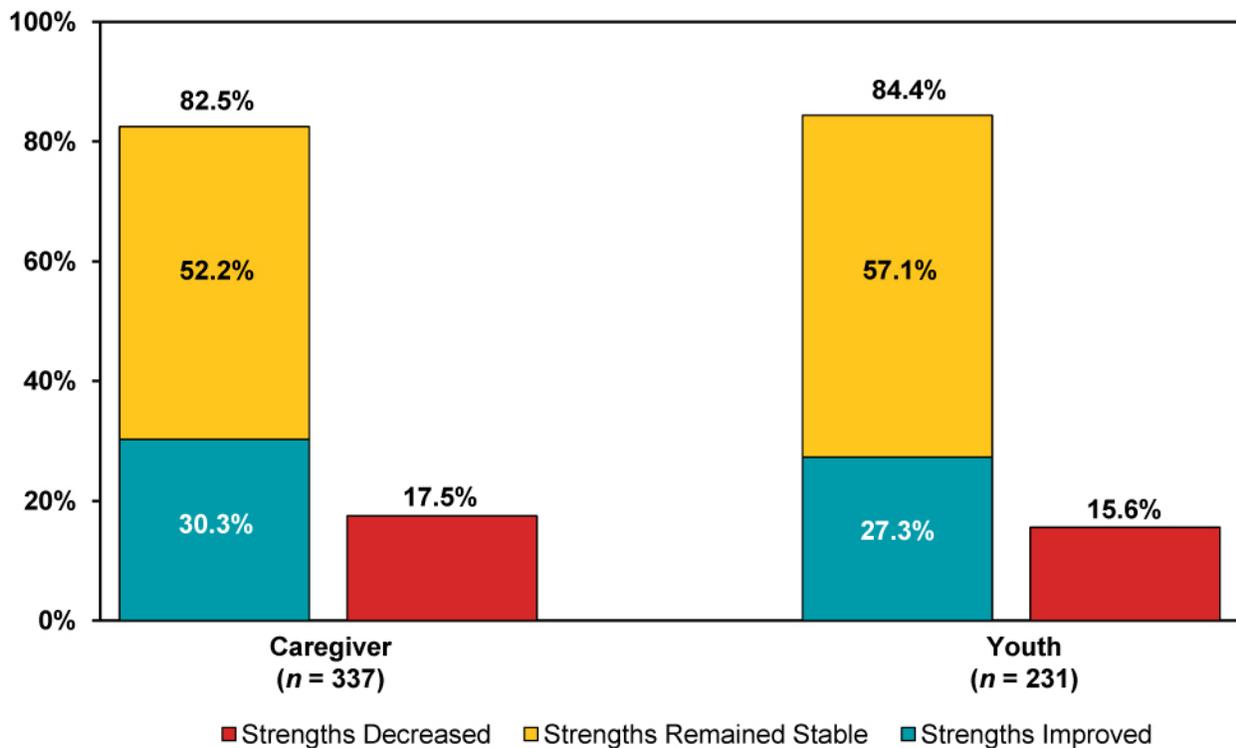
EARLY FINDINGS FROM SYSTEM OF CARE COMMUNITIES INITIALLY FUNDED IN 2002 AND 2003

CHILD CLINICAL AND FUNCTIONAL OUTCOMES

Behavioral and Emotional Strengths Improved

Caregiver and youth ratings of behavioral and emotional strengths indicated similar numbers of children showed clinically significant improvement from intake to 6 months. About 30 percent of caregivers and about 27 percent of youth rated behavioral and emotional strengths as improved, and an additional 52 percent of caregivers and 57 percent of youth reported stable levels of strengths over the first 6 months of services. Caregivers' average rating of children's behavioral and emotional strengths increased from 77.3 at intake to 80.8 after 6 months of treatment, while the average self-rating of youth 11 years and older increased from 90.2 at intake to 93.2 after 6 months of treatment. BERS scores below 90 indicate below average strengths.

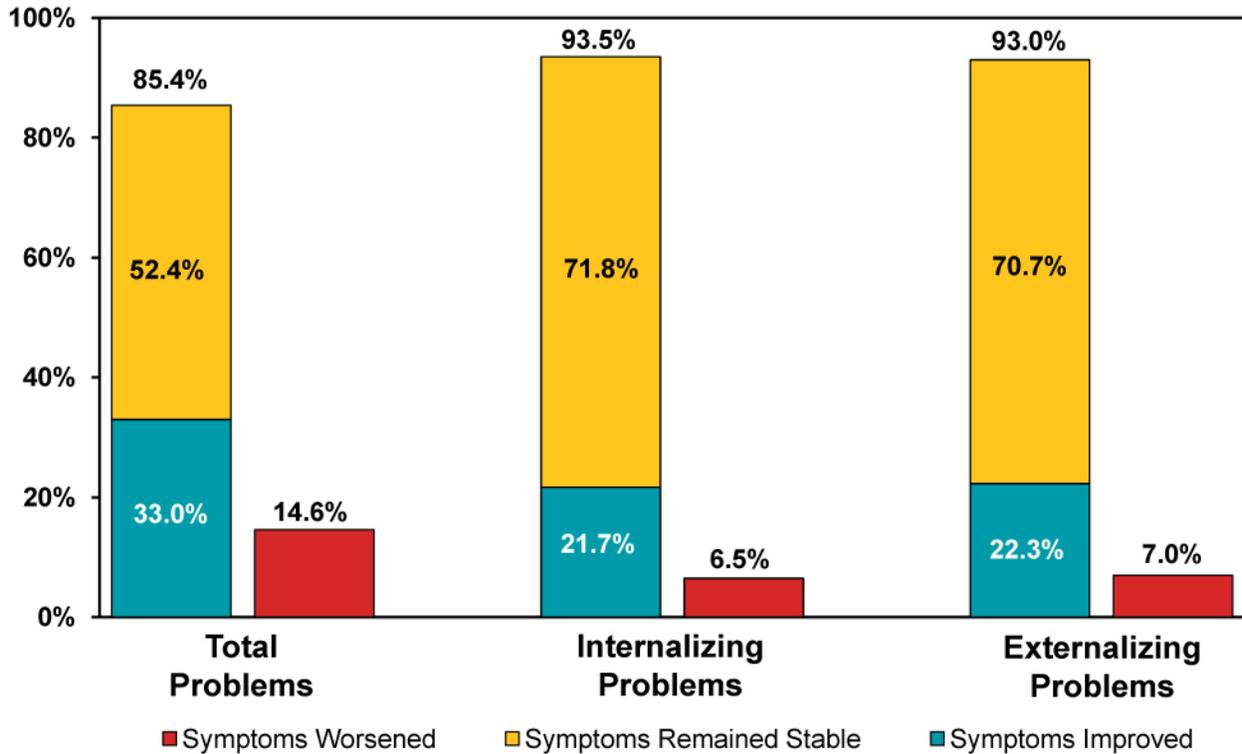
Figure 14
Change in Caregiver and Youth Report of Behavioral and Emotional Strengths from Intake to 6 Months



Behavioral and Emotional Problems Improved

Over 85 percent of children showed improvement or maintained stability in their symptomatology following intake into services. For children with complete data at intake and 6 months, 33 percent showed clinically significant improvement in their CBCL Total Problem scores following intake into system of care services. Almost 22 percent showed improvement in internalizing problems, which include anxiety and somatic problems, and over 22 percent showed improvement in externalizing problems, which include rule-breaking and aggressive behaviors. The average Total Problem T-score on the Child Behavior Checklist 6–18 (CBCL 6–18) decreased from 70.5 at intake to 67.9 at the 6-month followup.

Figure 15
Change in Behavioral and Emotional Problems from Intake to 6 Months



Number of children = 355.

Functional Impairment, Anxiety and Adolescent Depression Decreased

Overall impairment decreased significantly from intake to 6 months (25.9 to 22.9 respectively) for children receiving services through system of care communities initially funded in 2002 and 2003. At intake, 86 percent of youth had scores that indicated clinical levels of impairment. At 6 months, the percentage with scores in the clinical range dropped to 77 percent. Youth self-reported anxiety also showed significant reduction, with an average total anxiety score decreasing from 54.8 at intake to 52.8 at the 6-month followup. At intake, one-third of youth had levels of anxiety within the range of clinical interest. At 6 months, the percentage in that range dropped to just over one fourth. Self-reported levels of depression showed a significant decrease from intake to 6-month followup as well, with average scores decreasing from 53.9 at intake to 51.5 at followup. At intake, 14 percent of youth had scores that indicated moderate to severe depression. At 6 months, the percentage of youth with scores that range dropped to 7 percent.¹

Table 5
Mean (SD) Scores for Child Functional Impairment and Anxiety and Adolescent Depression at Intake and 6 Months

Measure	Intake Mean Score	6-Month Mean Score
Columbia Impairment Scale Overall Level of Impairment ^a (n = 392)	25.9 (SD = 10.2)	22.9 (SD = 10.8)
Revised Children's Manifest Anxiety Scale Total Anxiety Score ^b (n = 246)	54.8 (SD = 11.8)	52.8 (SD = 11.6)
Reynold's Adolescent Depression Scale-2 Total Depression Score ^c (n = 257)	53.9 (SD = 10.2)	51.5 (SD = 10.0)

^a $t = 6.24, df = 391, p < .001.$

^b $t = 3.14, df = 245, p = .002.$

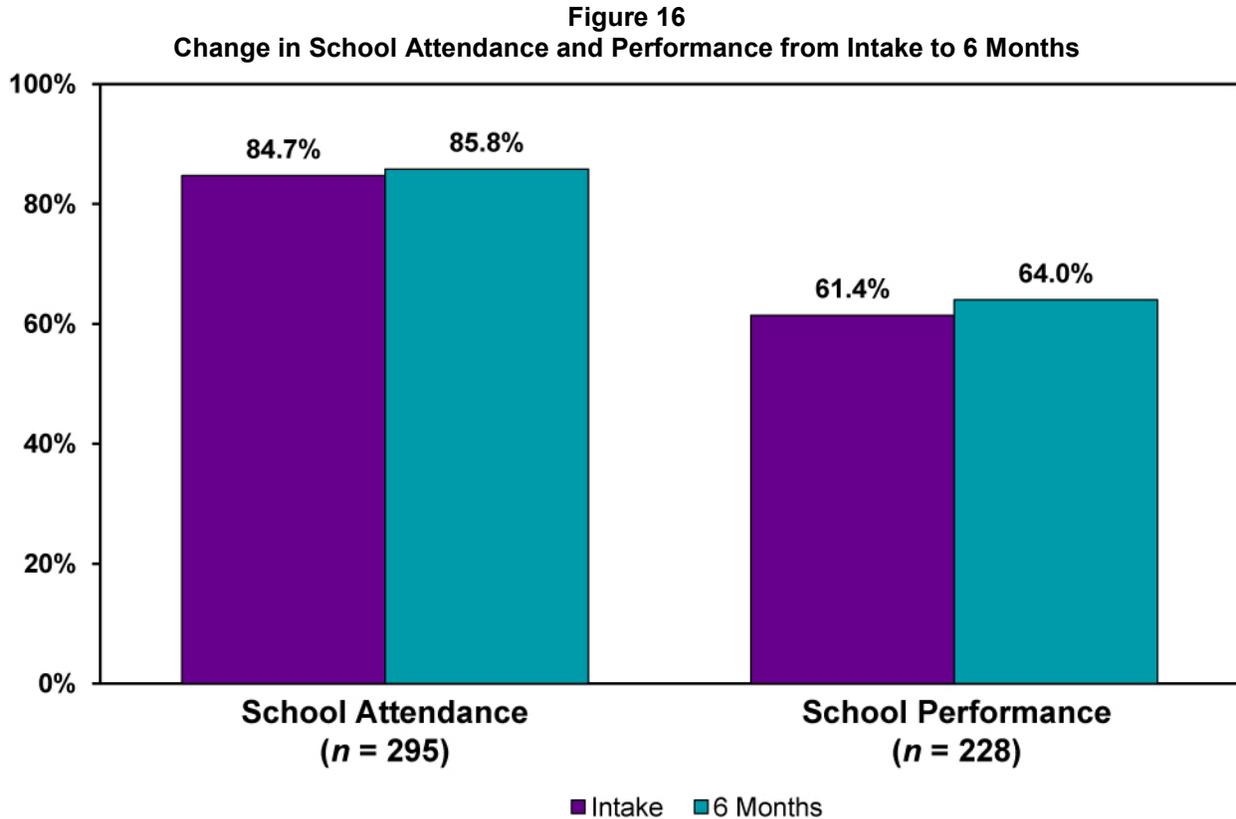
^c $t = 4.10, df = 256, p < .001.$

¹ The design was changed for this phase of the evaluation to collect data on these indicators as a result of expert review and recommendation for enhanced relevance.

School Attendance and Academic Performance Improved

Nearly 85 percent of children were attending school regularly at intake into services (defined as attending school 80 percent of the time or more) in system of care communities initially funded in 2002 and 2003. Regular school attendance remained high (improving slightly, but not significantly, to almost 86 percent) after receiving system of care services for 6 months.

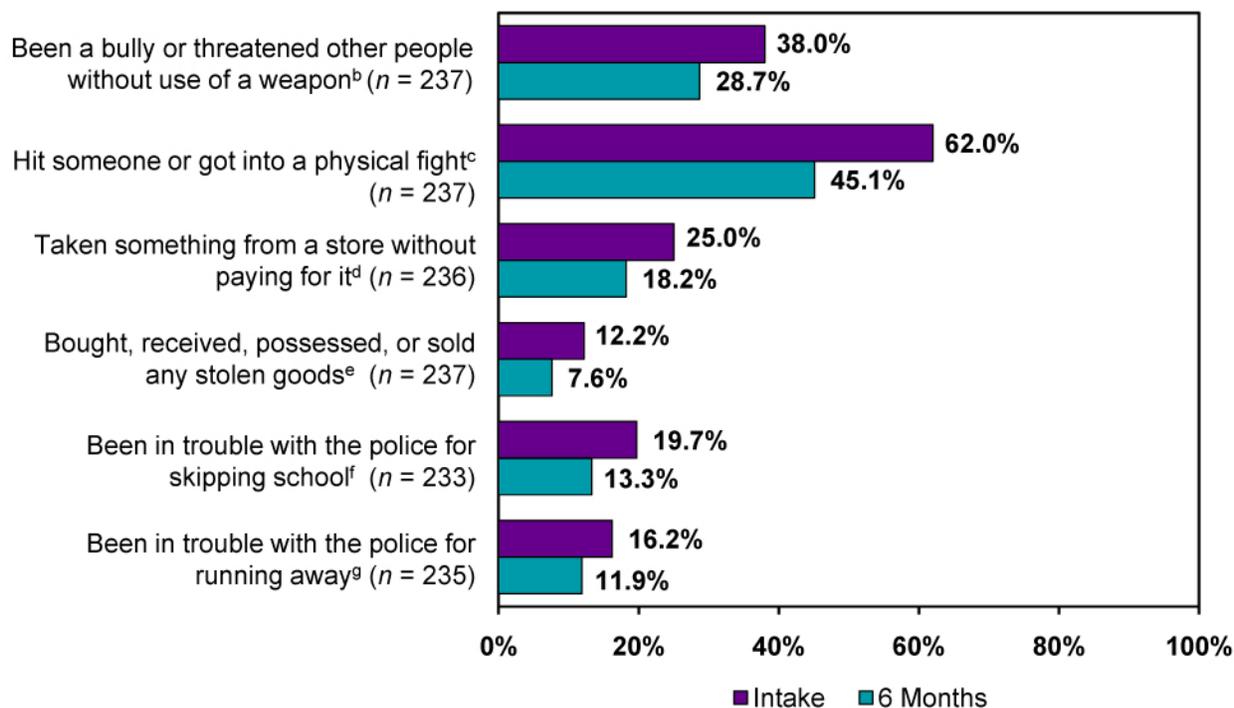
The percentage of children with passing school performance increased from 61.4 percent at intake to 64 percent after 6 months of services. This increase was not statistically significant.



Involvement with Law Enforcement and Juvenile Delinquency Decreased

There was a significant reduction in the percentage of youth who reported engaging in each of the delinquent behaviors, including bullying, physical fighting, shoplifting, and skipping school.

Figure 17
Delinquent Behavior at Intake and 6 Months^a



^a Categories represent the two most frequently reported violent crimes, property crimes, and other behaviors reported at intake.

^b $\chi^2 = 28.93, df = 1, p < .001.$ ^e $\chi^2 = 12.80, df = 1, p < .001.$

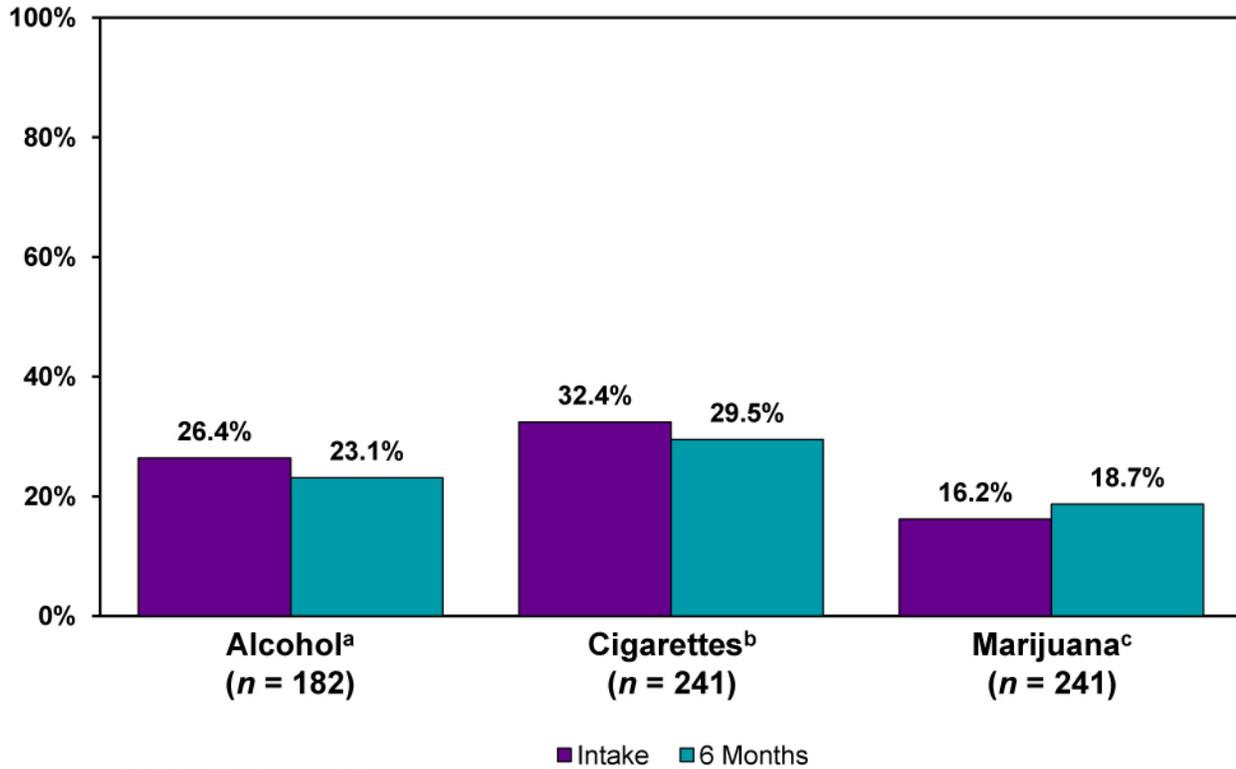
^c $\chi^2 = 43.89, df = 1, p < .001.$ ^f $\chi^2 = 38.96, df = 1, p < .001.$

^d $\chi^2 = 7.97, df = 1, p < .01.$ ^g $\chi^2 = 21.47, df = 1, p < .001.$

Tobacco and Alcohol Use Decreased

There were significant reductions in alcohol and cigarette use by youth after being in system of care services for 6 months.

Figure 18
Substance Use at Intake and 6 Months



^a $\chi^2 = 69.78, df = 1, p < .001.$

^b $\chi^2 = 131.86, df = 1, p < .001.$

^c $\chi^2 = 63.24, df = 1, p < .001.$

CHILD AND FAMILY DESCRIPTIVE INFORMATION

- **Child Gender:** Of 3,577 children enrolled in the descriptive study for whom data were available at the time of this report, 65 percent were boys and 35 percent were girls.
- **Child Average Age:** The average age of 3,554 children for whom data were available was 12.3 years; 10 percent were aged 6 years or younger, 27 percent were aged 7 to 11 years, 27 percent were aged 12 to 14 years, and 36 percent were aged 15 years or older.
- **Child Race/Ethnicity:** Of 3,520 children for whom data were available, 42 percent were White, 31 percent were African American, 23 percent were Hispanic, 8 percent were American Indian or Alaskan Native, 1 percent were Asian, 5 percent were Native Hawaiian or other Pacific Islander, and 0.7 percent were of other ethnicities.
- **Family Custody:** Of 1,010 children for whom data were available, 51 percent were in their mother's custody, 23 percent were in the custody of both parents, 5 percent were in the custody of fathers, 4 percent were in the custody of adoptive parents, 7 percent were wards of the State, 6 percent were in the custody of grandparents, and 4 percent were in other types of custody.
- **Family Poverty:** Data on family incomes showed that 53 percent of 887 families for whom data were available reported incomes below poverty, 9 percent were at poverty, and 38 percent were above poverty according to poverty guidelines by family household size.
- **Clinical Diagnosis:** Of 2,719 children for whom data were available, 27 percent had a clinical diagnosis of attention-deficit/hyperactivity disorder (ADHD), 33 percent mood disorders and depression, 21 percent oppositional defiant disorder, 13 percent adjustment disorders, and 5 percent conduct disorder.

Table 6
System of Care Communities Funded through the Comprehensive Community Mental Health Services for Children and Their Families Program, 1997–2003

Phase II (grants awarded in 1997 and 1998) Project Name	Phase II (grants awarded in 1997 and 1998) Catchment Area	Phase II (grants awarded in 1997 and 1998) State
The Jefferson County Community Partnership	Jefferson County	Alabama
Children’s Mental Health Services Initiative	San Diego County	California
Tampa-Hillsborough Integrated Network for Kids (THINK) System	Hillsborough County	Florida
Kentucky Bridges Project	3 Appalachian regions	Kentucky
Kmihqitahasultipon (“We Remember”) Project	Passamaquoddy Tribe Indian Township	Maine
Mno Bmaadzid Endaad (“Be in good health at his house”)	Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Ojibwa Indian Community; Chippewa, Mackinac, and Schoolcraft Counties	Michigan
Southwest Community Partnership	Detroit	Michigan
Partnership With Families	St. Charles County	Missouri
Families First and Foremost	Lancaster County	Nebraska
Nebraska Family Central	22 central counties	Nebraska
Neighborhood Care Centers	Clark County	Nevada
North Carolina Families and Communities Equal Success (FACES)	Blue Ridge, Cleveland, Guilford, and Sandhills	North Carolina
Sacred Child Project	Fort Berthold, Standing Rock, Spirit Lake, and Turtle Mountain Indian Reservations	North Dakota
Clackamas Partnership	Clackamas County	Oregon
Community Connections for Families	Allegheny County	Pennsylvania
Project Hope	Statewide	Rhode Island
The Children’s Partnership	Travis County	Texas
Utah Frontiers Project	Beaver, Carbon, Emery, Garfield, Grand, and Kane Counties	Utah
Children’s UPstream Services	Statewide	Vermont
Children and Families in Common	King County	Washington
Clark County Children’s Mental Health Initiative	Clark County	Washington
Northwoods Alliance for Children and Families	Forest, Langlade, Lincoln, Marathon, Oneida, and Vilas Counties	Wisconsin
With Eagle’s Wings	Wind River Indian Reservation	Wyoming

Table 6
System of Care Communities Funded through the Comprehensive Community Mental Health Services for Children and Their Families Program, 1997–2003 continued

Phase III (grants awarded in 1999 and 2000) Project Name	Phase III (grants awarded in 1999 and 2000) Catchment Area	Phase III (grants awarded in 1999 and 2000) State
Yuut Calilriit Ikaiyuquulluteng (“People Working Together”) Project	Delta region of southwest Alaska	Alaska
Project MATCH (Multi-Agency Team for Children)	Pima County	Arizona
A-KO-NES Wraparound System of Care	Humboldt and Del Norte Counties	California
Spirit of Caring Project	Contra Costa County	California
Colorado Cornerstone System of Care Initiative	Denver, Jefferson, Clear Creek, and Gilpin Counties	Colorado
Families and Communities Together (FACT) Project	Statewide	Delaware
Family HOPE (Helping Organize Partnerships for Empowerment)	West Palm Beach	Florida
Kidsnet Rockdale	Rockdale and Gwinnett Counties	Georgia
Circle Around Families	East Chicago, Gary, and Hammond	Indiana
Dawn Project	Marion County	Indiana
Community Kids	Montgomery County	Maryland
Worcester Communities of Care	Worcester	Massachusetts
PACT (Putting All Communities Together) 4 Families Collaborative	Kandiyohi, Meeker, Renville, and Yellow Medicine Counties	Minnesota
COMPASS (Children of Mississippi and Their Parents Accessing Strength-Based Services)	Hinds County	Mississippi
CARE NH: Community Alliance Reform Effort	Manchester, Littleton, and Berlin	New Hampshire
Burlington Partnership	Burlington County	New Jersey
Westchester Community Network	Westchester County	New York
North Carolina System of Care Network	11 counties	North Carolina
Gateways to Success	Greenwood County	South Carolina
Nagi Kicopi–Calling the Spirit Back Project	Oglala Sioux Tribe, Pine Ridge Indian Reservation, Pine Ridge	South Dakota
Nashville Connection	Nashville	Tennessee
Mountain State Family Alliance	12 counties	West Virginia

Table 6
System of Care Communities Funded through the Comprehensive Community Mental Health Services for Children and Their Families Program, 1997–2003 continued

Phase IV (grants awarded initially in 2002 and 2003) Project Name	Phase IV (grants awarded initially in 2002 and 2003) Catchment Area	Phase IV (grants awarded initially in 2002 and 2003) State
Ch'eghutsen' A System of Care	Fairbanks Native Association	Alaska
Glenn County Children's System of Care	Glenn County	California
La Familia Sana	Monterey County	California
OASIS (Obtaining and Sustaining Independent Success)	Sacramento County	California
San Francisco Children's System of Care	San Francisco	California
Urban Trails	Oakland	California
Project BLOOM	El Paso, Fremont, and Mesa Counties, and the City of Aurora	Colorado
Partnership for Kids (PARK) Project	Statewide	Connecticut
D.C. Children Inspired Now Gain Strength (D.C. CINGS)	Districtwide	Washington, District of Columbia
One Community Partnership	Broward County	Florida
l'Famagu'onta (Our Children)	Territorywide	Guam
Building on Each Other's Strengths	Statewide	Idaho
System of Care Chicago	Chicago	Illinois
Louisiana Youth Enhanced Services for Children's Mental Health (LA-YES)	Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany Parishes	Louisiana
Show Me Kids Project	Barry, Christian, Green, Lawrence, Stone, and Taney Counties	Missouri
Transitions	St. Louis County and City	Missouri
Coordinated Children's Services Initiative (CCSI)/The Family Network	New York City	New York
Tapestry	Cuyahoga County	Ohio
Choctaw Nation CARES	Choctaw Nation of Oklahoma	Oklahoma
Great Plains Systems of Care	Beckham, Canadian, Kay, Oklahoma, and Tulsa, Counties	Oklahoma
Columbia River Wraparound	Gilliam, Hood River, Sherman, and Wasco Counties	Oregon
Puerto Rico Mental Health Initiative for Children	Llorens Torres Housing Project in San Juan, Municipality of Gurabo	Puerto Rico
YouthNet	Chester, Lancaster, and York Counties and Catawba Indian Nation	South Carolina
Border Children's Mental Health Collaborative	El Paso County	Texas
Community Solutions	Fort Worth	Texas

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