

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



## Evaluation Findings: Annual Report to Congress 2005



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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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**



**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**

Kathleen Sebelius

*Secretary*

**Substance Abuse and Mental Health Services Administration**

Eric B. Broderick, D.D.S., M.P.H.

*Acting Administrator*

**Center for Mental Health Services**

A. Kathryn Power, M.Ed.

*Director*

**Division of Service and Systems Improvement**

Fran Randolph, Dr.P.H.,

*Director*

**Child, Adolescent and Family Branch**

Gary M. Blau, Ph.D.

*Branch Chief*

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## DATA HIGHLIGHTS

### ***Summary Findings***

- The CMHI is largely successful in serving its intended population.
- Positive clinical changes were accompanied by increased stability in living arrangements, improved school performance, and decreased law enforcement contacts.
- Participation in systems of care resulted in meaningful outcomes related to recovery and quality of life for the children, youth, and families served.
- System of care communities were successful in integrating system of care principles into practices and interventions.
- System of care communities realized significant cost savings.

### ***Comments from Youth Respondents***

- This program has helped me to see myself as a helpful and caring person.
- It has helped me to grow up and not give up.
- I have gotten a new job because of my experience in this program.
- I do better in school.
- I might have been in jail if it hadn't been for this program.

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.

This report describes characteristics of the children and youth served by the CMHI and their outcomes as a result of their participation in the program. The effectiveness of selected program practices and interventions, and system-level change also are documented and discussed. The report contains two parts. Part I presents the findings from retrospective, or "looking back," analyses of data collected over the complete 6-year funding cycles of 45 system of care communities after they had completed their grant-funded cycle and all data had been collected from them that illustrate their achievements over the course of their entire grant funding time span. Among these 45 communities, 9 were initially funded in FY 1997, 14 were initially funded in FY 1998, 20 were initially funded in FY 1999, and 2 were initially funded in FY 2000. As a group, these communities served approximately 19,931 children and youth across their grant-funded years. Part II of the report presents early descriptive and clinical and functional outcomes data for children served by 25 communities initially funded in FY 2002 and FY 2003. At the

time of this report these were the only data available as the communities were continuing to receive grant funding and data collection was ongoing and could not be analyzed or presented with a retrospective view of a completed product. Part II of the report is included in response to the requirement that an annual report be prepared for Congress for all funded communities. As a group, these communities had served approximately 3,577 children and youth at the time of this report.

In the retrospective analyses presented in Part I, the findings are depicted across years of development for all system of care communities initially funded in 1997, 1998, 1999, and 2000, beginning with their second year of funding. Data from all 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.

Outcomes data represent the change from intake into services to 12 months following intake. The 12-month followup data for those children most often were collected in the following year of program development. Thus, information for each year of program development reflects change in outcomes a year after entering system of care services for all children who had available baseline and 12-month followup data. 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 the data that 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 points of data collection.

Descriptive data about the children and families participating in systems of care 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.

Other data that examined the integration of system of care values into provider practices were collected from caregivers of children enrolled in the longitudinal outcome study and from youth 11 years of age and older after they had received services for 6 months and then after 12 months. The system of care assessment data were collected according to a systematic periodicity schedule across the grant-funding cycles and measure system-level change across time.

## **FINDINGS FROM THE RETROSPECTIVE ANALYSES OF DATA COLLECTED FROM 45 GRADUATED SYSTEM OF CARE COMMUNITIES INITIALLY FUNDED IN 1997, 1998, 1999, AND 2000**

### *To What Extent Did Children's and Families' Outcomes Improve over Time?*

#### **Clinical Outcomes**

- **Behavioral and Emotional Strengths Increased:** During each year of program development, 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 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). 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. (The number of children and youth who participated in the study and the specific data gathered on each of the measures used in the study varied from year to year.)
- **Behavioral and Emotional Problems Were Reduced:** Over years of program development, between 40 percent and 50 percent of children and youth who participated in the study and for whom data were available 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). 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.
- **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, the percentage of children and youth who participated in the study and for whom data were available who 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). 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.

#### **Functional Outcomes**

- **School Attendance Improved:** Even though nearly three-fourths of the children and youth who participated in the study and for whom data were available attended school regularly at entry into services, school attendance still increased during their first 12 months in systems of care. 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.

- **School Performance Improved:** The percentage of children and youth who participated in the study and for whom data were available 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. This improvement was consistent across all years of program development.
- **Law Enforcement Contacts Were Reduced:** Significantly fewer youth among those who participated in the study and for whom data were available reported being arrested during the first 12 months in systems of care 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.
- **Residential Stability Improved:** The percentage of children among those who participated in the study and for whom data were available placed in two or more out-of-home settings during the 6 months before the 12-month assessment interview decreased significantly from intake into services 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 with multiple out-of-home placements at intake decreased significantly more rapidly than at 12 months post-intake.

### **Who Were the Children and Families Participating in Systems of Care?**

- **Child Gender:** Of the 19,931 children enrolled in the descriptive study 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.<sup>1</sup>
- **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.<sup>2</sup>

<sup>1</sup> Because individuals may claim more than one racial background, the race variable may add to more than 100 percent.

<sup>2</sup> 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).

- **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.<sup>3</sup>
- **Co-Occurring Mental Health Disorders:** Of the 12,750 children for whom data were available, 54 percent had multiple mental health diagnoses.

### ***How Did Program Practices and Interventions Support the Children and Families Served?***

- **Youth and Caregiver Satisfaction with Services Improved across Program Development Years:** For children, youth, and family caregivers 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. Youth satisfaction, with their own progress, and with their involvement in treatment planning remained relatively stable at 6 months and 12 months after service intake. Caregiver satisfaction with the progress of their child increased significantly across program development years, 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.
- **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 were successful and showed improvement over program developmental years in developing and monitoring individualized service 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.
- **System of Care Communities Improved in Cultural and Linguistic Competence:** According to system of care assessment ratings, communities 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 family caregivers who participated in the longitudinal outcome study, 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.
- **Costs Related to Inpatient Hospitalization and Involvement with Law Enforcement Decreased:** Across all program development years the average number of days per child

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<sup>3</sup> Because children may have more than one diagnosis, the diagnoses may add to more than 100 percent.

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.

- **Evidence-Based Practices (EBPs) Are Being Utilized in System of Care Communities:** Based on the results from the Evidence-Based Practices Survey, 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.

### *What Were System Achievements in Infrastructure and Service Delivery?*

- **Family Involvement in Service Planning and Provision Improved:** Communities 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.

### **A Case Example of a System of Care Community's Effort to Sustain Itself**

Many system of care communities have been successful in sustaining their programs. Below is one example of one community's efforts and important achievements toward success. Worcester Communities of Care in Worcester, Massachusetts, received grant funding from 1999 to 2005. The information presented below is drawn from its final system of care assessment report to highlight program achievements.

#### ***Achievements***

Worcester Communities of Care noted several accomplishments over the past year. In spite of funding and structural changes, it has maintained delivery of strengths-based wraparound services to meet the needs of the majority of children and families it serves. Outcomes data show that children have improved over time and that youth have been empowered through a youth development initiative. Through the combined efforts of Worcester Communities of Care and the family advocacy organization, families have found support and have learned to advocate for themselves. Furthermore, continued work by Worcester Communities of Care with families from an Asian community through a special project has strengthened overall service provision to that particular community.

Another major achievement has been the development of a functioning "interagency community" evidenced by collaboration across agencies, shared system of care values, and a commitment to listen and work with the families they serve. Respondents credit Worcester Communities of Care with playing a key role in bringing together heads of agencies, providing training to agency staffs, and serving as a model for wraparound, strengths-based, and family-

focused practices. In addition, the anti-stigma campaign has created a greater awareness concerning children with serious mental health issues, and the child and family teams have further increased understanding and support in the community.

Accomplishments related to specific agencies include extensive training with the Massachusetts Department of Social Services to assist staff in developing a strengths-based wraparound service model; helping establish Positive Behavioral Interventions and Supports (PBIS) in the schools and training school personnel in delivering wraparound services; and helping prepare juvenile justice personnel to integrate system of care practices. Several agencies noted that the development of a diversity guide and the Asian community initiative are important aids in supporting families from different racial and ethnic backgrounds.

Providers reported that they like the strengths-based, family-focused team approach, as it helps them accomplish their work in helping families. Some said that the experience has strengthened an existing preference for a strengths-based, family-centered approach, while others said that this was their introduction to such system of care principles. Service providers found working as a team helpful and supportive. In addition, providers said they have learned how to be creative and to “work outside the box,” which has had an influence on their provider organizations.

This concludes Part I, the retrospective analyses section of the Data Highlights. The preliminary findings of early data collection from currently funded system of care communities who received their initial funding in 2002 and 2003 follow. For these cohorts of communities, instruments were added to measure child anxiety and youth depression and substance use among youth.

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

### ***To What Extent Do Children’s and Families’ Outcomes Improve During the First Year of Services?***

#### **Clinical Outcomes**

- **Behavioral and Emotional Strengths Increased:** According to both caregiver and youth ratings on clinical measures gathered through the longitudinal outcome study on a subset of children, youth, and families enrolled in the systems of care, children and youth who received system of care services showed significant increases in behavioral and emotional strengths after 6 months of treatment. As measured by the Behavioral and Emotional Rating Scale (BERS–2), 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.
- **Behavioral and Emotional Problems Were Reduced:** Children and youth between the ages of 6 and 18 enrolled in the outcome study showed significant reductions in behavioral and emotional problems after receiving system of care services for 6 months. 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. 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.

- **Clinical Functioning Improved:** Children’s overall functioning, as measured by the Columbia Impairment Scale (CIS) among children and youth who participated in the outcome study, improved after receiving system of care services for 6 months. 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. The average overall score on the CIS at intake was 25.9 and was 22.9 after receiving services for 6 months.
- **Child Anxiety Decreased:** Children who participated in the longitudinal outcome study showed significant reductions in anxiety between intake into services and 6 months, as measured by the Revised Child’s Manifest Anxiety Scale. 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. The average total anxiety scored decreased from 54.8 at intake to 52.8 at the 6-month followup.
- **Adolescent Depression Decreased:** According to the total depression score of the Reynold’s Adolescent Depression Scale–2 (RADS–2), adolescents who participated in the outcome study and who received system of care services for 6 months showed significant decreases in depression. 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. The average score for adolescents at intake was 53.9 and was 51.5 after receiving services for 6 months.

### **Functional Outcomes**

- **School Attendance and Performance Improved:** Of 295 children and youth who participated in the outcome study for whom data were available, 34 percent attended school with greater frequency following 6 months of system of care services. Similarly, 31 percent of 228 children for whom data were available showed increased school performance during the same time period.
- **Violent Crimes, Property Crimes, and Status Offenses Decreased:** Youth 11 years and older who participated in the outcome study reported significant decreases in the number of violent crimes, property crimes, and status offenses committed after receiving system of care services for 6 months. For example, at intake 62 percent of 237 youth for whom data were available reported hitting someone or getting into a physical fight within the previous 6 months. This percentage decreased significantly to 45.1 percent at the 6-month followup point. At intake, 25 percent of 236 youth for whom data were available reported taking something from a store without paying for it within the previous 6 months, while 18.2 percent reported shoplifting at the 6-month followup point. Finally, 16.2 percent of 235 youth for whom data were available reported running away within the 6 months prior to intake. After 6 months of services, this percentage had decreased to 11.9 percent.

- **Alcohol and Cigarette Use Decreased:** Youth reported significant decreases in alcohol and cigarette use between intake into services and 6 months later. At intake, 26.4 percent of 182 youth 11 years old and older reported using alcohol within the previous 6 months. This percentage decreased significantly to 23.1 percent after 6 months of system of care services. At intake, 32.4 percent of 241 youth 11 years and older reported using cigarettes within the previous 6 months. This percentage also decreased significantly at the 6-month followup period to 29.5 percent.

### **Who Are the Children and Families Participating in Systems of Care?**

- **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.<sup>4</sup>
- **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.<sup>5</sup>
- **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.

In spite of all the achievements, there continue to be challenges to making the progress desired. Many people in the clinical treatment community remain very traditional in their philosophy and practice, which is a reminder that it takes time for major shifts to occur among clinicians. No clear incentives exist to motivate traditional providers to participate in collaborative services. Furthermore, limitations due to capacity of services plus shortages in key services such as child psychiatry often require teams to accept a lesser desired service as opposed to a preferred one and can result in long waits for services.

<sup>4</sup> Because individuals may claim more than one racial background, the race variable may add to more than 100 percent.

<sup>5</sup> 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).

### ***Lessons Learned***

- Training initiatives with child welfare, the schools, and juvenile justice have been effective in terms of embedding system of care principles and practices within other child-serving agencies.
- Efforts to help establish the youth and family network have strengthened the services to youth and families and have expanded those services to greater numbers of individuals and families within the community.
- The establishment of PBIS in the schools has strengthened the collaborative relationship between Worcester Communities of Care and the schools, thus reaching more children and families.
- There is still much to learn about cultural competence and how to reach out to various minority groups, but the success of the Asian community initiative has encouraged Worcester Communities of Care to continue to work toward this goal.
- In some cases, other organizations are better equipped to provide a particular service; so working for change within those organizations may be the best use of time and energy.
- It is a wise strategy to use a strengths-based approach with all people, whether child and family clients or agency-level personnel.

### ***Sustainability***

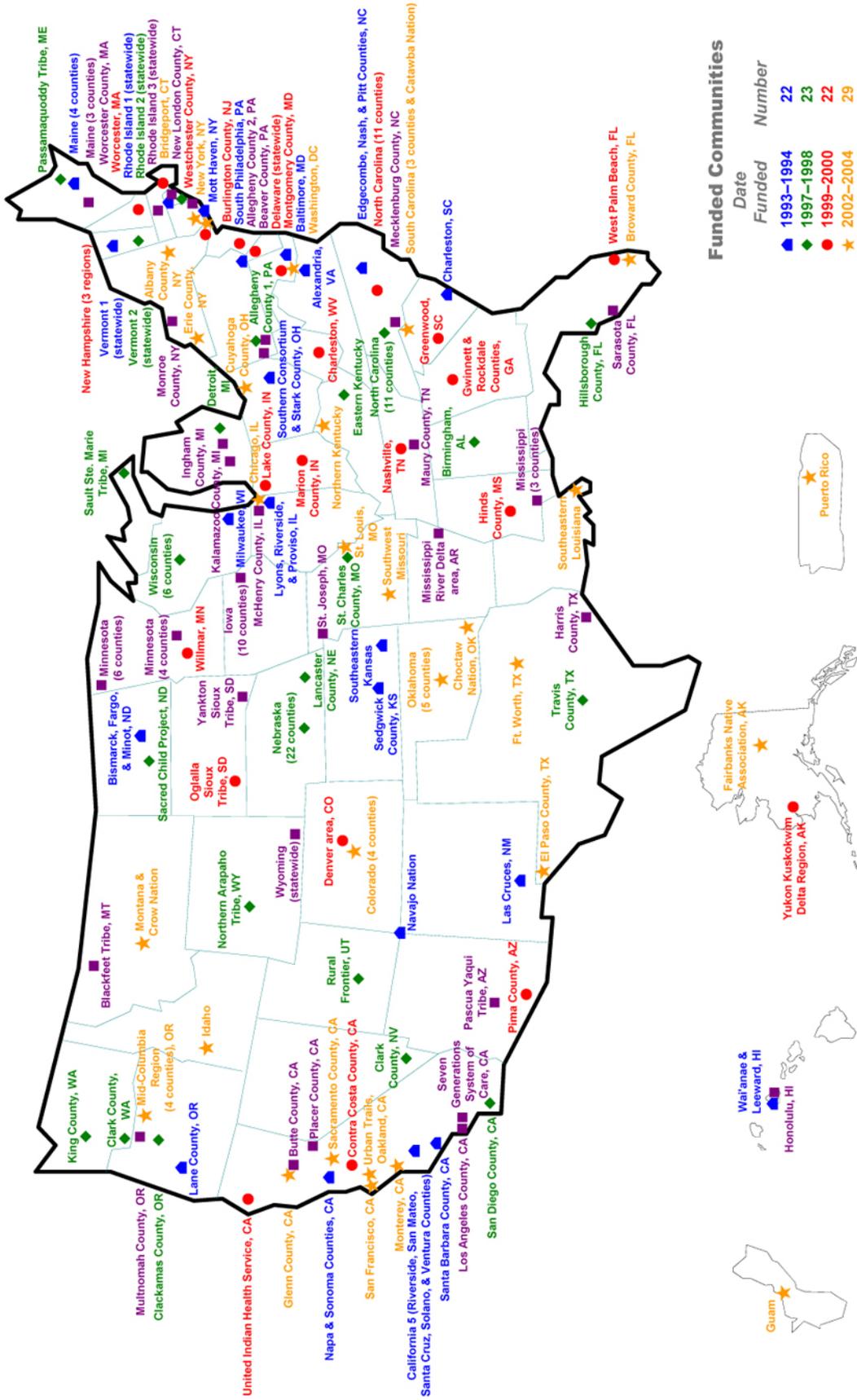
The establishment of the family-focused care consortium by the State may enable Worcester Communities of Care to sustain services to the Medicaid-eligible population in the years ahead, provided the pilot program is continued past June 2006. The Massachusetts Department of Mental Health and Medicaid are reportedly working collaboratively to define new services that qualify for Medicaid reimbursement. In order to reestablish services for non-Medicaid eligible children and families, however, additional funding sources are needed. Toward that end, efforts are underway to seek new grant funds, as well as requesting a 1-year no-cost extension to the Federal CMHS grant.

The local family organization also is working to acquire funds to support its services. For example, it is analyzing outcomes data and presenting it in a form suitable for grant applications; creating a paid training role for family members; and working with the Massachusetts Department of Mental Health to secure a contract for providing family partner services.

Other efforts toward sustainability include the provision of ongoing wraparound training for staff at partner agencies through Worcester Communities of Care's training institute, and the work to link mental health to public health through primary care.

Respondents agreed that system of care principles such as individualized/strengths-based care, family-focus, community-based care (especially in the schools), and least restrictive care have become part of the agency culture and will continue after CMHS grant funds end. The youth initiative, the youth and family network, and the initiative in the Asian community are also expected to continue. In addition, there are hopes that interagency collaboration efforts to facilitate coordinated care will be sustained.

# System of Care Communities of the Comprehensive Community Mental Health Services for Children and Their Families Program



## Funded Communities

Date Funded	Number
1993-1994	22
1997-1998	23
1999-2000	22
2002-2004	29
2005-2006	30

## INTRODUCTION

Since 1993, the Comprehensive Community Mental Health Services for Children and Their Families Program (Children’s Mental Health Initiative, or CMHI) has funded 121 communities to establish a comprehensive mental health service system. The CMHI, now in its twelfth year, promotes the development of systems of care to improve the lives of children with serious emotional disturbance and their families, by providing grants to States, communities, territories, American Indian tribes, and Alaskan Native communities. Each funding cycle has provided an opportunity for communities to develop and refine the system of care program model. Through Federal and State-based initiatives, communities across the United States have been involved with transforming the mental health system, and lessons learned from funded communities have provided a strong foundation to support the movement toward transforming the current system.

Over the past several years, national attention to children’s mental health has gained momentum. The President’s New Freedom Commission on Mental Health (NFC) evaluated the mental health service delivery system in the United States and advised the President on approaches to improve the system so that adults and children with serious mental health problems could participate fully in their communities. In response to the Commission’s Report, the Substance Abuse and Mental Health Services Administration (SAMHSA) led in the development of the *Federal Mental Health Action Agenda* (SAMHSA, 2005a), which outlines first steps that can be taken to yield immediate results in system improvement. The Action Agenda makes clear that the mental health service delivery system must focus its efforts toward achieving its primary goal of helping children with serious emotional disturbance “*achieve recovery to live, work, learn, and participate fully in their communities*” (p. 78).

The vision for children’s mental health, as developed by the Commission’s Subcommittee on Children and Family, is that “*our communities, states, and nation provide access to comprehensive, home and community-based, family-centered services and supports for children with mental health disorders and their families, while at the same time creating conditions that promote positive mental health and emotional well-being and prevent the onset of emotional problems in all children.*” This vision is in alignment with the CMHI program and consistent with SAMHSA’s vision of “A Life in the Community for Everyone” and mission, “Building Resilience & Facilitating Recovery.” It is evident that the CMHI clearly supports the agency’s priorities and has the full support of the Administration and SAMHSA’s leadership.

## PROGRAM ADMINISTRATION

The CMHI is an ongoing program designed to transform the mental health system. Funded by the Center for Mental Health Services (CMHS) and administered through the Child, Adolescent and Family Branch (CAFB) of the Substance Abuse and Mental Health Services Administration, the CMHI was shaped by several Federal and State-level initiatives beginning with the Child and Adolescent Service System Program (CASSP) in 1984. CASSP was a national effort to help States and communities build comprehensive, community-based systems of care. The system of care values and principles were first developed for CASSP (Stroul & Friedman, 1986), and this approach has become the cornerstone of many mental health service delivery programs across the country.

Although Stroul and Friedman (1986) provided the philosophical framework for developing and delivering community-based children's mental health services, it has been both public and private funding that is largely responsible for the transformation of the system of care vision into a reality. The CMHI has provided over \$950 million over the last 12 years for the development of local systems of care in 121 communities, and as a result has served over 70,000 children and their families nationwide. A list of all funded communities can be found in Appendix A.

## **PURPOSE OF THE PROGRAM**

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.

Since its inception, the program has maintained a strong evaluation component that demonstrates program effectiveness. Mandated in the statute that established the program (the ADAMHA Reorganization Act, Public Law 102-321), each funded grant community has actively participated in both national- and local-level evaluation efforts. As the program has matured, comprehensive reports of evaluation results have become publicly available (CMHS, 1997, 1998, 1999, 2000, 2001, and 2003a). Improvements in program outcomes as evidenced by the

Government Performance and Results Act (GPRA) indicators are noteworthy.<sup>6</sup> GPRA indicators including increased number of children receiving services, increased school attendance, decreased law enforcement contacts, decreased use of inpatient hospitalization, and decreased inpatient costs across program years demonstrate program achievements through the years. Long-term GPRA indicators address achievement of clinical improvement and program sustainability across grantees, and provide promising evidence that families are able to receive community-based care for their children living with serious emotional disturbance without having to relinquish legal custody in order to obtain publicly funded treatment services.

## **PROGRAM THEORY MODEL**

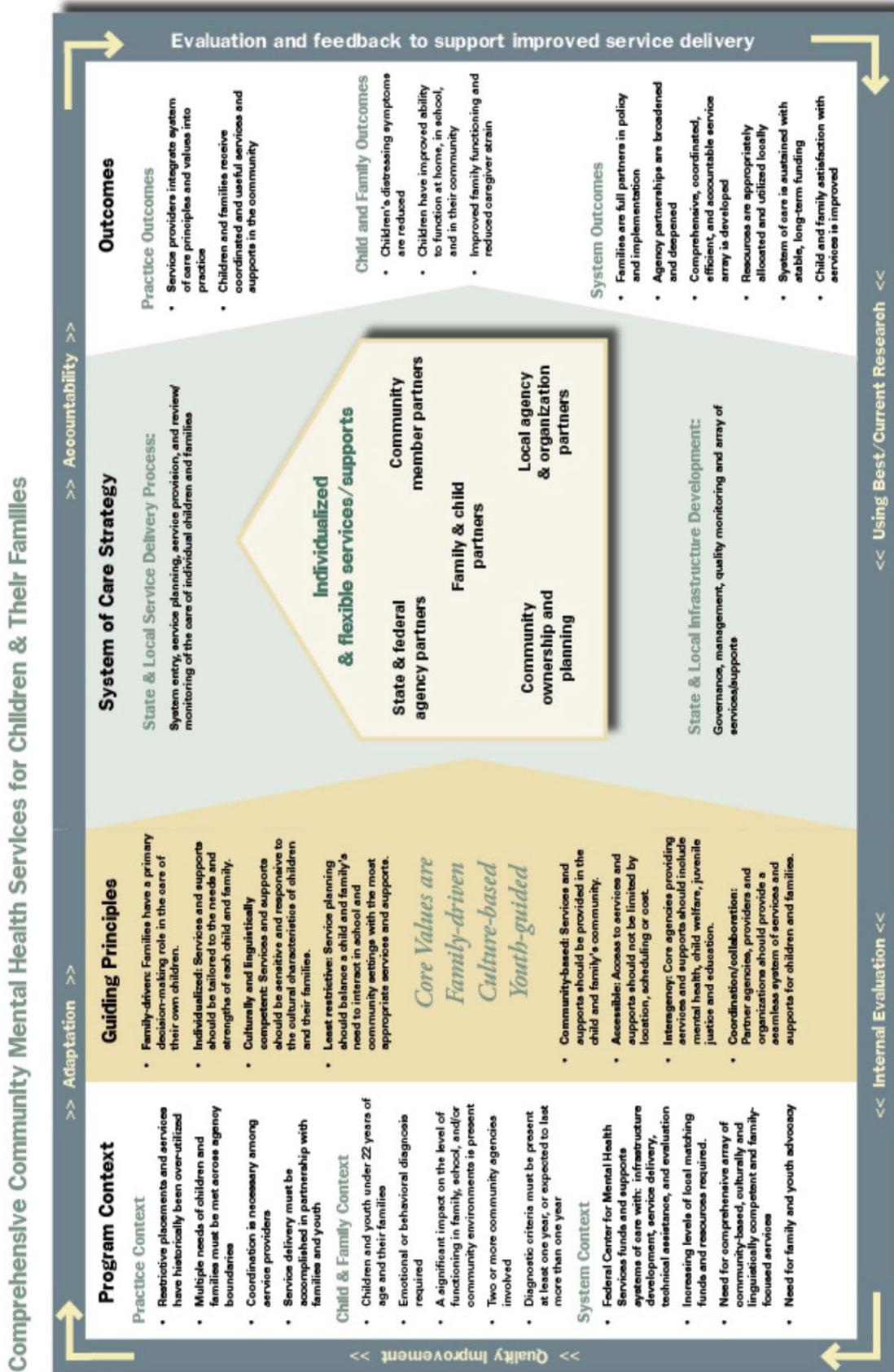
Figure 1 depicts a *theory-based framework* to describe the program that was developed with input from partners across the country. The framework articulates the underlying assumptions that guide a service delivery strategy and are believed to be critical to producing change and improvement in children and families. The framework has four core elements—program context, guiding principles, strategies, and outcomes—as well as an evaluation-and-feedback cycle.

The model and guiding principles provide a foundation upon which system of care strategies are built. These strategies are grounded in a community ownership and planning process that engages the multiple partners in work to improve the well-being of children and families. As depicted in the far right of the framework, the outcomes are organized into practice, child and family, and system categories. Finally, the framework includes an evaluation-and-feedback cycle that uses the best and most current research and incorporates concepts of internal evaluation, quality improvement, adaptation, and accountability.

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<sup>6</sup> See page 110 for recent GPRA findings.

Figure 1  
System of Care Theory-based Framework



# NATIONAL EVALUATION OF THE COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM

The national evaluation, mandated by law (Public Law 102-321), is an important component of the CMHI that examines all of the areas described above and addresses critical and emerging issues in children’s mental health. The findings from the evaluation provide information upon which to base future treatment, program funding, and policy decisions to transform the current system. The core components of the national evaluation include the individual studies listed within Table 1.

**Table 1**  
**Core Components of the National Evaluation of the**  
**Comprehensive Community Mental Health Services for Children and Their Families Program**

<b>System of care assessment study</b> examines whether programs have been implemented according to system of care program theory and documents how systems develop over time to meet the needs of the children and families they serve.
<b>Cross-sectional descriptive study</b> describes the children enrolled in the funded systems of care in terms of their demographics, functional status, living arrangement, diagnosis, risk factors, and mental health service history.
<b>Child and family outcomes study</b> examines how the system affects child clinical and functional status and family life. Outcome data are used to assess change over time in symptomatology, diagnosis, social functioning, substance use, school attendance and performance, delinquency, and stability of living arrangements.
<b>Services and costs study</b> describes the types of services used by children and families, their utilization patterns, and associated costs. The study assesses also the extent to which information about various services is captured through local management information systems (MIS).
<b>Service experience study</b> examines data of services received and child and family ratings of satisfaction with services provided.
<b>Sustainability study</b> explores the extent to which systems of care are maintained after funding from the CMHI grant program has ended. The study identifies features of systems of care that are more likely to be sustained and factors that contribute to or impede the ability to sustain the systems of care developed with grant support.

In addition to the core study components, other studies are added to the evaluation as issues emerge and the need to refine strategies becomes apparent. Ongoing current studies added to the evaluation are presented in Table 2.

**Table 2**  
**Ongoing Current Studies Added to the National Evaluation of the**  
**Comprehensive Community Mental Health Services for Children and Their Families Program**

<p><b>Treatment effectiveness studies</b> examine the effectiveness of specific evidence-based treatments provided to selected groups of children with specific diagnoses served within CMHS-funded systems of care.</p>
<p><b>Evidence-based treatment survey</b> assesses the mental health clinician’s knowledge, training, and use of evidence-based treatments in their practice.</p>
<p><b>Family-driven study</b> examines how families experience systems of care. The study is led and driven by family members, including the development of concepts, methods, and research strategies.</p>
<p><b>Wraparound fidelity study</b> examines the service mechanisms and outcomes associated with the wraparound process.<sup>7</sup> The goal of the study is to expand knowledge about service delivery processes, reliable and valid wraparound fidelity and quality assurance measures, and an adequate research base, to support future randomized clinical trials of the effectiveness of the wraparound approach.</p>
<p><b>Primary care study</b><sup>8</sup> investigates the role of primary health care providers in systems of care and examines the impact of services provided within primary care on child and family outcomes.</p>
<p><b>Culturally competent practices study</b><sup>8</sup> assesses system of care service providers’ level of competence across several domains of cultural competence, including the role that organizations and agencies play in hindering or facilitating culturally competent service provision.</p>

Detailed descriptions of the studies described in Tables 1 and 2 can be found in Appendix B.

## ABOUT THIS REPORT

### PART I: FINDINGS FROM THE RETROSPECTIVE ANALYSES

Part I of this report presents retrospective, or “looking back,” analyses of data collected over the complete 6-year funding cycles of 45 graduated system of care communities after they had completed their grant-funded cycle and all data had been collected from them that illustrate their achievements over the course of their entire grant funding time span. Among these 45 communities, 9 were initially funded in FY 1997, 14 were initially funded in FY 1998, 20 were initially funded in FY 1999, and 2 were initially funded in FY 2000. These analyses provide descriptions and characteristics of approximately 19,931 children and youth served by these communities across their 6-year spans of grant funding. The report presents clinical and functional outcomes as a result of participating in the program, a discussion of the effectiveness of selected program practices and interventions, and a description of system-level change over

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<sup>7</sup> Wraparound is a service delivery process. It is based on an unconditional commitment to a child or youth and his or her family. The child, youth, and family team develops an individualized child, youth, and family service plan. The process and the service plan are family driven and youth guided; are based on child, youth, and family strengths; and are needs driven. Services for the child, youth, and family are culturally competent and community based.

<sup>8</sup> The primary care and culturally competent practices studies were added to the national evaluation in 2003 and are being developed currently.

the life of the grant funding period. This retrospective view illustrates achievements made by the system of care communities during each year of their grant funding.

Findings from the retrospective analyses are drawn from data collected over the 6-year funding cycles of 9 communities initially funded in FY 1997, 14 communities initially funded in FY 1998, 20 communities initially funded in FY 1999, and 2 communities initially funded in FY 2000. These 45 communities were chosen for retrospective analyses of comprehensive achievement because they have completed or are in their final months of grant funding at the writing of this report and present a picture of progress made from the beginning to the end of their grant funding cycles. Thus, the retrospective analyses “look back” to the beginning of funding in these communities and report on their progress up to their final months of funding.

For all retrospective analyses presented in Part I, data from the 45 communities initially funded in 1997, 1998, 1999, and 2000 were collapsed according to their developmental program year (rather than by calendar year) beginning in their second year of funding so that the trend of progress across the grant-funding cycle could be illustrated on a year-to-year basis according to their age in the grant-funded program. Data are not collected during the first year of grant funding because local communities use that year to plan and prepare for service delivery, which begins in the second year of funding. As children and families are enrolled into the program, they also are enrolled into the national evaluation and data collection is begun to track their progress over time.

Prior to collapsing the data across the funding cohorts, analyses were conducted on each of the groups independently to determine whether there were major differences in the general trend of progress between the various groups. Finding no major differences, the decision was made to collapse the data into one presentation both for brevity of the report and to present a succinct description of overall program progress from 1997 to date for this selected group of communities. Constructing the report in this manner establishes a point from which to track continued progress over time.

Sources of data used for Part I of the report include the following:

- Descriptive data (e.g., demographic information, diagnosis, child and family history, functional characteristics, and referral sources) obtained at the time children entered system of care services across the grant funding period. System of care communities attempted to collect these data on all children, youth, and families served by their programs.
- Child and family clinical and functional outcomes data based on local program evaluations of selected groups of children who were assessed at intake, 6 months, 12 months, and 18 months, continuing up to 36 months. Data were collected at these intervals regarding the child’s clinical and social functioning, strengths, educational performance, delinquent activities and engagement with law enforcement, use of illegal substances, and the stability of their living arrangements. Data also were collected regarding family resources and on the strain that family caregivers may experience related to the care that is required for children who have serious emotional disturbance. 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 points of data collection.

- Data related to the experience children and families have with the services they receive and their satisfaction with them. 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 points of data collection.
- Data related to the cost of services that were made available by partnering agencies in system of care communities from their electronic management information systems. System of care communities voluntarily provided these data upon request to the national evaluation for analyses. Not all communities provided data and data that were provided varied across communities.
- Data related to system-level change collected through multiple comprehensive site visits that were conducted in all grant communities at regular intervals throughout the grant funding cycle. These data were collected systematically onsite by the national evaluation.

Instruments used to gather the above-listed data include those typically used in the field of children's mental health. For example, instruments used to collect data on children's clinical and functional characteristics include the Child Behavior Checklist (CBCL; Achenbach, 1991a), the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), and the Behavioral and Emotional Rating Scale (BERS; Epstein & Sharma, 1998). See Appendix C for a complete description of all measures used to collect the data used in this report.

Part I of the report includes the following sections:

#### **A. Descriptive Characteristics of Children and Families Served by the Program**

- Demographic Information
- Diagnostic Characteristics
- Behavioral and Emotional Strengths
- Behavioral and Emotional Problems
- Functional Impairment
- Involvement with Law Enforcement and Juvenile Justice
- Use of Tobacco, Alcohol, and Other Drugs
- Services Received Prior to Enrollment in the CMHI
- Referral Sources
- Family Demographics and History
- Summary

## **B. Child and Family Outcomes**

- Behavioral and Emotional Strengths
- Behavioral and Emotional Problems
- Functional Impairment
- School Attendance and Performance
- Involvement with Law Enforcement
- Family Resources
- Caregiver Strain
- Stability of Living Arrangements
- Summary

## **C. Program Practices and Interventions**

- Youth Satisfaction
- Caregiver Satisfaction
- Individualized Services
- Flexible Funds
- Case Management
- Cultural and Linguistic Competence
- Least Restrictive Care
- Inpatient Care
- Law Enforcement Costs
- Evidence-Based Practices
- Summary

## **D. System Achievements in Infrastructure and Service Delivery**

- Family Involvement
- Youth Involvement
- Interagency Involvement
- Service Array Development
- Service Capacity
- Service Accessibility
- Community-Based and Least Restrictive Care
- Sustainability Strategies and Lessons Learned

## **PART II: EARLY FINDINGS FROM CURRENT COMMUNITIES INITIALLY FUNDED IN 2002 AND 2003**

Part II of the report presents early descriptive and clinical and functional outcomes data for children served by 25 communities initially funded in FY 2002 and FY 2003 as at the time of this report, these were the only data available as the communities were continuing to receive grant funding and data collection was ongoing and could not be analyzed or presented with a retrospective view of a completed product. Part II of the report is included in response to the requirement that an annual report be prepared for Congress for all funded communities. As a group, these communities had served approximately 3,577 children and youth at the time of this report. These preliminary findings include descriptive characteristics of the 3,577 children and youth for whom data were available at the time of this report and early clinical and functional outcomes of a subset of those children and youth who voluntarily agreed to participate in the longitudinal outcome study.

Data sources used for Part II of the report include the following:

- Descriptive data (e.g., demographic information, diagnosis, child and family history, functional characteristics, and referral sources) obtained at the time children entered system of care services. System of care communities attempted to collect these data on all children, youth, and families served by their programs.
- Child and youth clinical and functional outcomes data based on local program evaluations of selected groups of children and youth who were assessed at intake and at 6 months following intake. Data were collected regarding the child or youth's behavioral and emotional strengths and problems, clinical impairment, anxiety and depression, educational attendance and performance, delinquent activities and engagement with law enforcement, and use of illegal substances. 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. Not all children, youth, and families served by the programs participate in the longitudinal outcome study, and not all study participants provide data across all measures.

Instruments used to gather the above-listed data include many of the same instruments used with communities initially funded in 1997, 1998, 1999, and 2000. However, some instruments were revised to include new items, some instruments were replaced with newer versions, and some instruments were replaced altogether. For example, revised versions of the Child Behavior Checklist (CBCL) and Behavioral and Emotional Rating Scale (BERS) were substituted for earlier versions of these measures. For the CBCL, both a young child version (for ages 1½–5 years; Achenbach & Rescorla, 2000) and an older child version (for ages 6–18 years; Achenbach & Rescorla, 2001) replaced the older version. For the BERS (Epstein, 2004), both the revised caregiver version and the new youth version were included. The Restrictiveness of Living Environments and Placement Stability Scale (ROLES) was revised and re-named the Living Situations Questionnaire (LSQ).

Measures that were dropped from the protocol for these cohorts of communities include the Child and Adolescent Functional Assessment Scale (CAFAS), the Consequences of Substance Use Scale (SUS-B), the Youth Self-Report (YSR), the Family Resources Scale (FRS; Dunst & Leet, 1985), the Family Assessment Device (FAD; Epstein, Baldwin, & Bishop, 1983), and the Youth Satisfaction Questionnaire/Family Satisfaction Questionnaire (YSQ/FSQ). Measures that were added to the protocol include the Global Appraisal of Individual Needs Quick-Substance Related Issues (GAIN Quick-R), the Family Life Questionnaire (FLQ), the Revised Children's Manifest Anxiety Scales (RCMAS; Reynolds & Richmond, 1978), the Reynolds Adolescent Depression Scale (RADS-2; Reynolds, 1986), the Youth Information Questionnaire (YIQ), the Cultural Competence and Service Provision Questionnaire (CSSP), and the Vineland Screener (VS; Sparrow, Carter, & Cicchetti, 1983). See Appendix C for a complete description of all measures used to collect the data used in this report.

Part II of the report includes the following sections:

#### **A. Descriptive Characteristics of Children and Families at Intake**

- Demographic Information
- Diagnostic Characteristics
- Use of Tobacco, Alcohol, and Other Drugs
- Involvement with Law Enforcement and Juvenile Justice
- Referral Sources
- Family Income Level
- Child Custody Arrangements
- Child Risk Factors
- Summary

#### **B. Child Clinical and Functional Outcomes at 6 Months**

- Behavioral and Emotional Strengths
- Behavioral and Emotional Problems
- Child Impairment, Anxiety, and Adolescent Depression
- School Attendance and Performance
- Involvement with Law Enforcement and Juvenile Justice
- Use of Tobacco, Alcohol, and Other Drugs
- Summary

The report concludes with **GPR program indicators for FY 2005, an overall report summary, and program recommendations.**

# **PROGRAM RESULTS PART I: RETROSPECTIVE ANALYSES OF GRADUATED COMMUNITIES INITIALLY FUNDED IN 1997, 1998, 1999, AND 2000**

## **DESCRIPTIVE CHARACTERISTICS OF CHILDREN AND FAMILIES SERVED BY THE PROGRAM**

### **Child Characteristics**

The target population for the CMHI is children and adolescents with serious emotional disturbance and their families. This population is defined by five main parameters:

- Age
- Diagnosis
- Disability
- Duration and level of intensity of the disorder
- Multi-agency need

To be eligible for the program, children must

- be under the age of 22 years;
- have a diagnosable emotional, behavioral, or mental disorder as defined by the *Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV; APA, 1994)* that is present for at least 1 year, or has the potential for lasting more than 1 year;
- display poor functioning in the contexts of the home, school, and/or community; and
- have multi-agency involvement from the core public child-serving agencies (e.g., mental health, juvenile justice, education, child welfare, public health).

Demographic and diagnostic information was collected at intake into services on children entering local grant-funded programs. Information related to services received prior to intake, referral source, and other child and family history also is collected. A subset of children enrolled in system of care services also participated in the national evaluation's longitudinal child and family outcome study. In this study, additional information describing the types and extent of behavioral and emotional problems that the children experience; their functioning in home, school, and community environments, including delinquent behavior and involvement with law enforcement and juvenile justice; and their use of illegal substances was gathered at intake. Analyses of these data provide a profile of the children served by the program ( $n = 19,931$ ) and validate the program's success in serving the target population it is mandated to serve. See Appendix B for more information on the descriptive study.

### ***Children and Youth Served across Development Years Were Predominantly Male, Between 7 and 18 Years of Age, and White or African American***

Overall, there was great consistency in the demographic characteristics of children entering systems of care across graduated communities initially funded in 1997, 1998, 1999, and 2000. For example, regardless of program development year, the majority of children were male, White or Black or African American (the terms *Black* and *African American* are used interchangeably throughout the report), and between the ages of 7 and 18. More specific changes in demographic characteristics throughout program development years are discussed below. (Note: The number of children and youth for whom data were available varied across program development years and across the various measures used to collect data. The specific number of children and youth for whom data were available is indicated in the tables and figures throughout the report.)

Although the majority of children were boys, in each development year the exact percentages of boys and girls entering systems of care differed significantly across development years.<sup>9</sup> The same finding is true for age. In each development year, the majority of children were between the ages of 7 and 18. The distribution of age categories, however, differed significantly across development years.<sup>10</sup> The percentage of children aged 7 to 18 decreased across program development years, dropping from nearly 90 percent in year 2 to almost 76 percent in year 6, while the percentage of children between birth and 6 years of age more than doubled from over 10 percent in year 2 to slightly over 23 percent in year 6. This difference also results in a significant decrease in the mean age of children over time.<sup>11</sup>

A similar pattern is true for the distribution of racial and ethnic categories. Within each year, the majority of children were either White or Black or African American, although there were significant differences in the distribution of these and other individual racial and ethnic categories over time.

The percentage of White children and children from Other racial or ethnic backgrounds differed significantly across development years,<sup>12</sup> although a consistent pattern of change over time did not emerge for either group. The percentage of Black or African American children entering systems of care reflected more consistent change over time. After an increase from development year 2 to year 3, the percentage of Black or African American children entering system of care services decreased consistently from year 3 to year 6.<sup>13</sup> Finally, the most consistent change over time was for the percentage of American Indian or Alaska Native children and children of Hispanic origin entering services. The percentage of American Indian or Alaska Native children entering services dropped consistently in each successive program development year, from 11

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<sup>9</sup>  $\chi^2 = 15.84, p < .01$ .

<sup>10</sup>  $\chi^2 = 277.23, p < .001$ .

<sup>11</sup>  $F = 32.27, p < .001$ .

<sup>12</sup>  $\chi^2 = 63.33, p < .001$ ;  $\chi^2 = 34.03, p < .001$ , respectively.

<sup>13</sup>  $\chi^2 = 61.64, p < .001$ .

percent in development year 2 to 6.3 percent in year 6,<sup>14</sup> while the percentage of children of Hispanic origin increased consistently from development year to development year.<sup>15</sup>

**Table 3**  
**Demographic Characteristics of Children Served by Program Development Year**

	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
<b>Gender<sup>a</sup></b>	<b>(n = 3,686)</b>	<b>(n = 4,912)</b>	<b>(n = 4,906)</b>	<b>(n = 4,278)</b>	<b>(n = 2,149)</b>	<b>(n = 19,931)</b>
Male	68.6	65.4	66.0	64.6	66.0	66.0
Female	31.4	34.6	34.0	35.4	34.0	34.0
<b>Age</b>	<b>(n = 3,683)</b>	<b>(n = 4,881)</b>	<b>(n = 4,892)</b>	<b>(n = 4,273)</b>	<b>(n = 2,127)</b>	<b>(n = 19,856)</b>
Mean <sup>b</sup>	12.0 years	11.6 years	11.7 years	11.1 years	10.9 years	11.5 years
Birth to 3 years <sup>c</sup>	2.7	5.3	5.5	7.6	8.9	5.7
4 to 6 years	7.7	9.6	10.9	12.6	14.3	10.7
7 to 11 years	28.2	25.1	23.2	24.1	23.6	24.8
12 to 14 years	32.7	30.7	29.1	28.0	24.3	29.4
15 to 18 years	27.9	28.2	30.3	27.0	27.9	28.4
19–21 years	0.8	1.1	1.0	0.7	1.0	1.0
<b>Race and Ethnicity<sup>d</sup></b>	<b>(n = 3,418)</b>	<b>(n = 4,397)</b>	<b>(n = 4,529)</b>	<b>(n = 4,086)</b>	<b>(n = 1,970)</b>	<b>(n = 18,400)</b>
American Indian or Alaska Native <sup>e</sup>	11.4	9.0	8.2	7.0	6.3	8.5
Asian <sup>f</sup>	0.7	0.8	1.0	1.0	0.8	0.9
Black or African American <sup>g</sup>	26.0	30.0	25.1	23.3	23.1	25.8
Native Hawaiian or Other Pacific Islander <sup>h</sup>	0.6	0.5	0.4	0.5	0.5	0.5
White <sup>i</sup>	57.1	55.6	58.4	63.3	61.5	58.9
Of Hispanic origin <sup>j</sup>	8.3	9.6	11.9	11.7	12.0	10.6
Multi-Racial <sup>k</sup>	7.2	6.2	6.4	7.7	6.6	6.8
Other <sup>l</sup>	2.1	0.7	1.3	1.2	2.0	1.3

<sup>a</sup>  $\chi^2 = 15.84$ ,  $df = 4$ ,  $n = 19,931$ ,  $p < .01$ .

<sup>b</sup>  $F = 32.27$ ,  $df1 = 4$ ,  $df2 = 19,851$ ,  $n = 19,856$ ,  $p < .001$ .

<sup>c</sup>  $\chi^2 = 277.23$ ,  $df = 20$ ,  $n = 19,856$ ,  $p < .001$ .

<sup>d</sup> Because individuals may claim more than one racial background, the race variable may add to more than 100%.

<sup>e</sup>  $\chi^2 = 62.38$ ,  $df = 4$ ,  $n = 18,400$ ,  $p < .001$ .

<sup>f</sup>  $\chi^2 = 2.97$ ,  $df = 4$ ,  $n = 18,400$ ,  $p > .05$ .

<sup>g</sup>  $\chi^2 = 61.64$ ,  $df = 4$ ,  $n = 18,400$ ,  $p < .001$ .

<sup>h</sup>  $\chi^2 = 2.15$ ,  $df = 4$ ,  $n = 18,400$ ,  $p > .05$ .

<sup>i</sup>  $\chi^2 = 63.33$ ,  $df = 4$ ,  $n = 18,400$ ,  $p < .001$ .

<sup>j</sup>  $\chi^2 = 40.99$ ,  $df = 4$ ,  $n = 18,400$ ,  $p < .001$ .

<sup>k</sup>  $\chi^2 = 8.86$ ,  $df = 4$ ,  $n = 18,400$ ,  $p > .05$ .

<sup>l</sup>  $\chi^2 = 34.03$ ,  $df = 4$ ,  $n = 18,400$ ,  $p < .001$ .

<sup>14</sup>  $\chi^2 = 62.38$ ,  $p < .001$ .

<sup>15</sup>  $\chi^2 = 40.99$ ,  $p < .001$ .

### ***The Five Most Frequently Assigned DSM–IV Diagnoses at Intake Were Consistent across All Program Development Years***

The target population to be served by the CMHI is children and adolescents who have serious emotional disturbance as defined by *DSM–IV* criteria (or its equivalent). Intake diagnostic information collected on children participating in the program is summarized in Table 4 and again documents that the children served by local systems of care fit the mandated program eligibility requirements.

The five most frequent diagnoses were consistent across all development years of communities initially funded in 1997, 1998, 1999, and 2000. Attention-deficit/hyperactivity disorder (ADHD) was the most frequently assigned *DSM–IV* diagnosis, followed by mood disorders, oppositional defiant disorder, adjustment disorders, and conduct disorder. While the exact percentages of children with ADHD, mood disorders, adjustment disorders, and conduct disorder differed significantly over time, there was no consistent pattern of change. In fact, only two diagnostic categories demonstrated consistent change over time. The percentage of children with disruptive behavior disorder increased significantly with each development year,<sup>16</sup> while the opposite was true for children with impulse control disorders.<sup>17</sup>

The predominance of the five most frequent diagnoses is consistent with other characteristics of children served. For example, the majority of children served were school aged, with schools being the second largest referral source for systems of care. This may explain the large percentage of children diagnosed with ADHD. Furthermore, with regard to multi-agency involvement, a criterion for receiving system of care services, externalizing behaviors such as those associated with oppositional defiant disorder and conduct disorder are likely to cause problems in multiple settings such as school, home, and the community, resulting in situations wherein children are being served by more than one agency.

Another consistent finding is that regardless of year of entry, more than half of the children entering system of care services were assigned more than one *DSM–IV* diagnosis. The percentages vary significantly by year,<sup>18</sup> with the largest percentages of children with co-occurring disorders seen in the latter years of program development. This increase may be reflective of the fact that as systems mature, they are capable of serving children with more complex needs.

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<sup>16</sup>  $\chi^2 = 27.00, p < .001$ .

<sup>17</sup>  $\chi^2 = 17.01, p = .002$ .

<sup>18</sup>  $\chi^2 = 30.17, p < .001$ .

**Table 4**  
**Clinical Diagnosis on Any Axis at Intake by Development Year**

Clinical Diagnosis <sup>a</sup>	Year 2 (%) (n = 2,633)	Year 3 (%) (n = 3,281)	Year 4 (%) (n = 3,132)	Year 5 (%) (n = 2,572)	Year 6 (%) (n = 1,175)	Overall (%) (n = 12,793)
Attention-deficit/hyperactivity disorder <sup>b</sup>	37.8	38.0	34.3	38.5	36.4	37.0
Mood disorders <sup>c</sup>	31.0	31.1	34.0	35.4	32.1	32.7
Oppositional defiant disorder <sup>d</sup>	27.1	27.4	26.9	27.2	25.4	27.0
Adjustment disorders <sup>e</sup>	13.6	12.1	11.9	10.8	14.0	12.3
Conduct disorder <sup>f</sup>	12.2	11.8	11.8	9.7	12.0	11.5
PTSD and acute stress <sup>g</sup>	8.8	7.5	10.0	8.9	7.7	8.7
Substance use <sup>h</sup>	6.0	6.7	9.6	6.6	10.3	7.6
V Code <sup>i</sup>	5.8	4.5	6.6	5.9	5.3	5.7
Disruptive behavior disorder <sup>j</sup>	4.6	5.2	5.8	6.6	8.3	5.8
Learning and related disorders <sup>k</sup>	5.9	4.3	4.8	4.6	7.4	5.1
Impulse control <sup>l</sup>	5.2	4.8	4.6	3.3	3.1	4.4
Anxiety <sup>m</sup>	4.6	4.3	4.8	5.5	3.5	4.6
Mental retardation <sup>n</sup>	4.3	3.6	3.5	3.6	3.1	3.7
Psychosis <sup>o</sup>	2.5	2.4	2.5	2.8	1.7	2.4
Autistic disorders <sup>p</sup>	2.1	1.9	2.0	1.7	1.3	1.9
Other <sup>q</sup>	7.2	6.4	7.6	7.8	7.8	7.3
Personality disorders <sup>r</sup>	2.4	2.0	1.2	1.4	1.4	1.7
	<b>Year 2 (%) (n = 2,622)</b>	<b>Year 3 (%) (n = 3,271)</b>	<b>Year 4 (%) (n = 3,121)</b>	<b>Year 5 (%) (n = 2,564)</b>	<b>Year 6 (%) (n = 1,172)</b>	<b>Overall (%) (n = 12,750)</b>
More than one diagnosis <sup>s</sup>	52.7	50.6	56.2	55.4	57.3	54.0

<sup>a</sup> Because children may have more than one diagnosis, the diagnosis variable may add to more than 100%.

<sup>b</sup>  $\chi^2 = 14.36, df = 4, n = 12,793, p < .01$ .

<sup>c</sup>  $\chi^2 = 18.37, df = 4, n = 12,793, p = .001$ .

<sup>d</sup>  $\chi^2 = 1.78, df = 4, n = 12,793, p > .05$ .

<sup>e</sup>  $\chi^2 = 13.34, df = 4, n = 12,793, p = .01$ .

<sup>f</sup>  $\chi^2 = 10.21, df = 4, n = 12,793, p < .05$ .

<sup>g</sup>  $\chi^2 = 14.64, df = 4, n = 12,793, p < .01$ .

<sup>h</sup>  $\chi^2 = 47.90, df = 4, n = 12,793, p < .001$ .

<sup>i</sup> V Code refers to relational problems, problems related to abuse or neglect, and additional conditions that may be a focus of clinical attention.

$\chi^2 = 13.71, df = 4, n = 12,793, p < .01$ .

<sup>j</sup>  $\chi^2 = 27.00, df = 4, n = 12,793, p < .001$ .

<sup>k</sup>  $\chi^2 = 22.92, df = 4, n = 12,793, p < .001$ .

<sup>l</sup>  $\chi^2 = 17.01, df = 4, n = 12,793, p < .01$ .

<sup>m</sup>  $\chi^2 = 8.55, df = 4, n = 12,793, p > .05$ .

<sup>n</sup>  $\chi^2 = 4.34, df = 4, n = 12,793, p > .05$ .

<sup>o</sup>  $\chi^2 = 3.94, df = 4, n = 12,793, p > .05$ .

<sup>p</sup>  $\chi^2 = 4.11, df = 4, n = 12,793, p > .05$ .

<sup>q</sup> Other includes such diagnoses as disorders due to a general medical condition, dissociative identity disorder, gender identity disorder, etc.

<sup>r</sup>  $\chi^2 = 15.74, df = 4, n = 12,793, p < .01$ .

<sup>s</sup>  $\chi^2 = 30.17, df = 4, n = 12,750, p < .001$ .

The *n*'s vary due to missing data for the multiple diagnoses calculation.

**Many Children Have a History of Previous Psychiatric Hospitalization,  
Physical Abuse, and Running Away Prior to Intake**

Table 5 presents a list of seven risk factors that predispose children to behavioral and emotional problems. The percentage of children who experienced each risk factor prior to intake into system of care services, according to caregiver report, is also reported by program development year.

As detailed in the table, according to caregiver report, among children with available data (numbers vary for each risk factor at intake), more than one-fourth of children had a history of psychiatric hospitalization, physical abuse, and running away. Roughly 1 in 5 had a history of sexual abuse and substance use, while more than 1 in 10 had attempted suicide prior to entering services. The widespread experience of multiple risk factors by children receiving services in systems of care explains why many of them enter services with clinical levels of functional impairment and emotional and behavioral problems.

**Table 5  
Percent of Caregivers Reporting on Child History by Program Development Year**

	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
History of previous psychiatric hospitalization <sup>a</sup>	34.2 (n = 3,046)	28.2 (n = 3,873)	25.4 (n = 3,754)	26.0 (n = 3,237)	25.3 (n = 1,595)	28.0 (n = 15,505)
History of physical abuse <sup>b</sup>	31.4 (n = 2,933)	25.8 (n = 3,798)	26.4 (n = 3,698)	24.5 (n = 3,274)	23.7 (n = 1,551)	26.5 (n = 15,254)
History of sexual abuse <sup>c</sup>	24.6 (n = 2,879)	20.6 (n = 3,695)	21.7 (n = 3,590)	20.1 (n = 3,221)	19.4 (n = 1,530)	21.4 (n = 14,915)
History of running away <sup>d</sup>	33.8 (n = 2,956)	32.4 (n = 3,853)	31.7 (n = 3,754)	30.3 (n = 3,331)	28.1 (n = 1,597)	31.6 (n = 15,491)
History of suicide attempt(s) <sup>e</sup>	14.4 (n = 2,933)	16.5 (n = 3,847)	14.6 (n = 3,765)	14.6 (n = 3,305)	12.9 (n = 1,598)	14.9 (n = 15,448)
History of substance abuse <sup>f</sup>	21.5 (n = 3,031)	21.6 (n = 3,893)	22.3 (n = 3,774)	19.6 (n = 3,339)	21.2 (n = 1,606)	21.3 (n = 15,643)
History of sexual abuse toward others <sup>g</sup>	8.8 (n = 2,930)	7.3 (n = 3,820)	8.0 (n = 3,741)	6.5 (n = 3,284)	8.7 (n = 1,571)	7.7 (n = 15,346)

<sup>a</sup>  $\chi^2 = 83.67, df = 4, n = 15,505, p < .001.$

<sup>b</sup>  $\chi^2 = 50.39, df = 4, n = 15,254, p < .001.$

<sup>c</sup>  $\chi^2 = 26.40, df = 4, n = 14,915, p < .001.$

<sup>d</sup>  $\chi^2 = 19.81, df = 4, n = 15,491, p < .01.$

<sup>e</sup>  $\chi^2 = 14.32, df = 4, n = 15,448, p < .01.$

<sup>f</sup>  $\chi^2 = 8.45, df = 4, n = 15,643, p > .05.$

<sup>g</sup>  $\chi^2 = 15.31, df = 4, n = 15,346, p < .01.$

**Children and Youth Entered Systems of Care  
with Below Average Behavioral and Emotional Strengths**

Table 6 provides a summary of the average standardized scores on each of the five subscales of the Behavioral and Emotional Rating Scale (BERS),<sup>19</sup> along with the average strength quotient, by program development year of communities initially funded in 1997, 1998, 1999, and 2000. With the exception of the Affective Strength subscale score in development year 6, children entering systems of care received below average scores (less than 10) on all five subscales, regardless of the year they entered services. Average scores on Interpersonal Strength, a measure of a child’s ability to control his or her behaviors and emotions in social situations, were the lowest across program development years ranging from 7.0 in Year 2 to 7.5 in Year 6 (overall  $M = 7.3$ ), while children showed the greatest strengths on the Affective Strength subscale with scores ranging from 9.5 in Year 2 to 10.1 in Year 6, which measures the child’s ability to receive and show affection (overall  $M = 9.6$ ). The Strength Quotient, based on the sum of the standard scores on the five subscales, was below average (less than 90) across all program development years, indicating the need for clinical intervention.

Interestingly, the average standardized score for all subscales increased gradually, but significantly, from year 2 to year 6.

**Table 6**  
**Mean (SD) Standardized Scores for Behavioral and Emotional Strengths at intake by Program Development Year<sup>a</sup>**

	Year 2	Year 3	Year 4	Year 5	Year 6	Overall
Interpersonal Strength <sup>b</sup>	7.0 (SD = 2.7)	7.2 (SD = 2.8)	7.3 (SD = 2.9)	7.5 (SD = 2.9)	7.5 (SD = 2.7)	7.3 (SD = 2.8)
School Functioning <sup>c</sup>	7.2 (SD = 2.7)	7.2 (SD = 2.8)	7.4 (SD = 2.9)	7.5 (SD = 2.9)	7.8 (SD = 2.6)	7.3 (SD = 2.8)
Family Involvement <sup>d</sup>	8.2 (SD = 2.8)	8.3 (SD = 2.8)	8.4 (SD = 3.0)	8.6 (SD = 3.0)	8.7 (SD = 2.8)	8.4 (SD = 2.9)
Intrapersonal Strength <sup>e</sup>	8.4 (SD = 3.0)	8.6 (SD = 3.1)	8.8 (SD = 3.1)	8.8 (SD = 3.1)	9.0 (SD = 3.0)	8.7 (SD = 3.1)
Affective Strength <sup>f</sup>	9.5 (SD = 3.4)	9.5 (SD = 3.5)	9.6 (SD = 3.4)	9.8 (SD = 3.4)	10.1 (SD = 3.3)	9.6 (SD = 3.4)
Overall Strength Quotient <sup>g</sup>	85.5 (SD = 16.3)	86.2 (SD = 17.0)	87.1 (SD = 17.6)	88.0 (SD = 17.6)	88.9 (SD = 16.4)	86.9 (SD = 17.1)

<sup>a</sup> Child behavioral and emotional strengths were measured by the BERS. For each of the strength areas (subscales) a total raw score is determined by summing the scores. The raw scores from the BERS subscales can be converted to standard scores with a mean of 10 ( $SD = 3$ ) and a range of 1 to 17. The sum of the subscale standard scores can be converted into the standardized BERS Strength Quotient with a mean of 100 ( $SD = 15$ ) and a range of 34 to 164.

<sup>b</sup>  $F = 6.05$ ,  $df1 = 4$ ,  $df2 = 7,415$ ,  $n = 7,420$ ,  $p < .001$ .

<sup>c</sup>  $F = 6.07$ ,  $df1 = 4$ ,  $df2 = 6,873$ ,  $n = 6,878$ ,  $p < .001$ .

<sup>d</sup>  $F = 5.50$ ,  $df1 = 4$ ,  $df2 = 7,309$ ,  $n = 7,314$ ,  $p < .001$ .

<sup>e</sup>  $F = 5.87$ ,  $df1 = 4$ ,  $df2 = 7,414$ ,  $n = 7,419$ ,  $p < .001$ .

<sup>f</sup>  $F = 4.39$ ,  $df1 = 4$ ,  $df2 = 7,418$ ,  $n = 7,423$ ,  $p < .01$ .

<sup>g</sup>  $F = 6.58$ ,  $df1 = 4$ ,  $df2 = 7,442$ ,  $n = 7,447$ ,  $p < .001$ .

<sup>19</sup> The BERS is comprised of five domains of behavioral and emotional strengths. The overall strength quotient has a range from 34 to 164, with scores below 90 indicating below average strength.

**Children and Youth Entered Systems of Care  
with Significant Behavioral and Emotional Problems**

Table 7 reports the average T-scores for the Child Behavior Checklist (CBCL) Internalizing Problems, Externalizing Problems, and Total Problems scales across program development years of communities initially funded in 1997, 1998, 1999, and 2000.<sup>20</sup> As seen below, the average Internalizing Problems, Externalizing Problems, and Total Problems T-scores varied significantly across years,<sup>21</sup> with lower T-scores occurring in the later development years. The enrollment of children with relatively less severe behavioral and emotional problems over program development years is similar to the trend found with behavioral and emotional strengths. Overall, however, these data indicate a need for clinical intervention, since the average T-scores on the scales were within the clinical range (i.e., > 63) in each program development year, with the exception of Internalizing Problems in year 6.

Across all program development years, the average T-scores were higher on the Externalizing Problems scale (overall  $M = 69.3$ ) than the Internalizing Problems scale (overall  $M = 64.5$ ), which is consistent with the most frequent diagnoses reported for the children served by the program (e.g., ADHD, conduct disorder, oppositional defiant disorder).

**Table 7  
Average Scores for Behavioral and Emotional Problems at Intake by Program Development Year<sup>a</sup>**

	Year 2	Year 3	Year 4	Year 5	Year 6	Overall
Internalizing Problems <sup>b</sup>	65.4 (SD = 10.8)	65.2 (SD = 11.3)	64.6 (SD = 11.3)	63.3 (SD = 11.7)	62.8 (SD = 11.9)	64.5 (SD = 11.4)
Externalizing Problems <sup>c</sup>	69.9 (SD = 10.6)	70.0 (SD = 10.2)	69.4 (SD = 10.9)	68.1 (SD = 11.1)	68.0 (SD = 11.2)	69.3 (SD = 10.8)
Total Problems <sup>d</sup>	70.7 (SD = 9.9)	70.5 (SD = 10.2)	69.9 (SD = 10.5)	68.7 (SD = 10.6)	68.1 (SD = 11.2)	69.8 (SD = 10.4)

<sup>a</sup> Child competence and behavioral and emotional problems were measured by the CBCL. The CBCL is administered to caregivers of children between the ages of 4 and 18.

<sup>b</sup>  $F = 12.23$ ,  $df1 = 4$ ,  $df2 = 7,693$ ,  $n = 7,698$ ,  $p < .001$ .

<sup>c</sup>  $F = 10.70$ ,  $df1 = 4$ ,  $df2 = 7,694$ ,  $n = 7,699$ ,  $p < .001$ .

<sup>d</sup>  $F = 13.61$ ,  $df1 = 4$ ,  $df2 = 7,683$ ,  $n = 7,688$ ,  $p < .001$ .

<sup>20</sup> The CBCL 4–18 is administered to caregivers and measures behavioral and emotional problems in children aged 4 to 18. The CBCL 4–18 produces two broadband syndrome scores: internalizing and externalizing, and a total problems score. T-scores between 60 and 63 on the Internalizing, Externalizing, and Total Problems Scales are in the borderline clinical range. T-scores of 64 or above are in the clinical range. The CBCL has been widely used in children’s mental health services research and for clinical purposes.

<sup>21</sup>  $F = 12.23$ ,  $p < .001$ ;  $F = 10.70$ ,  $p < .001$ , respectively.

### ***Children and Youth Entered Systems of Care with Marked Functional Impairment***

As summarized in Table 8, the percentage of children with moderate to severe impairment on six of the eight Child and Adolescent Functional Assessment Scale (CAFAS) subscales varied significantly across program development years of communities initially funded in 1997, 1998, 1999, and 2000.<sup>22</sup> Interestingly, the percentage of children with moderate to severe impairment increased from year 2 to year 3 on all CAFAS subscales. In fact, program development year 3 contained the largest percentage of children with moderate to severe impairment on six of the eight CAFAS subscales. The percentage of children with moderate to severe impairment in the School Role and Thinking domains of the CAFAS peaked the following year. Collectively, these percentages indicate that the program was serving the most functionally impaired children during the middle years of the development cycle.

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<sup>22</sup> The CAFAS is a widely used measure of child functioning. It assesses the degree to which a youth's mental health or substance abuse disorder is disruptive to his or her functioning in everyday life in each of eight psychosocial domains: the community, the school, the home, substance use, moods and emotions, self-harming behavior, behavior towards others, and thinking. The CAFAS is designed to assess the effects of the child's challenges and behaviors on his or her ability to function successfully in various life domains. Levels of impairment on the subscales include minimal or no impairment, mild impairment, moderate impairment, and severe impairment. Total CAFAS score is the sum of the eight subscale scores and ranges from 0 to 240. Total scores of 40 or below indicate *minimal* impairment; scores from 50 to 90 indicate *moderate* impairment, scores from 100 to 130 indicate *marked* impairment and those 140 or higher indicate *severe* impairment.

**Table 8**  
**Functional Impairment at Intake by Program Development Year**

	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
<b>Children with Moderate to Severe Impairment</b>						
School Role <sup>a</sup>	77.9 (n = 1,419)	80.0 (n = 2,038)	78.4 (n = 1,952)	78.6 (n = 1,592)	73.8 (n = 604)	78.4 (n = 7,605)
Home Role <sup>b</sup>	69.8 (n = 1,419)	73.4 (n = 2,045)	73.6 (n = 1,957)	72.1 (n = 1,595)	68.2 (n = 606)	72.1 (n = 7,622)
Behavior Towards Others <sup>c</sup>	72.3 (n = 1,422)	76.1 (n = 2,046)	74.6 (n = 1,968)	73.8 (n = 1,595)	71.6 (n = 606)	74.1 (n = 7,637)
Mood/ Emotion <sup>d</sup>	64.0 (n = 1,421)	68.8 (n = 2,046)	67.9 (n = 1,967)	68.1 (n = 1,597)	65.3 (n = 605)	67.3 (n = 7,636)
Community Role <sup>e</sup>	37.7 (n = 1,419)	40.9 (n = 2,046)	41.0 (n = 1,969)	36.7 (n = 1,597)	40.4 (n = 606)	39.4 (n = 7,637)
Self-Harmful Behaviors <sup>f</sup>	26.8 (n = 1,421)	28.8 (n = 2,047)	26.8 (n = 1,967)	26.6 (n = 1,597)	23.1 (n = 606)	27.0 (n = 7,638)
Thinking <sup>g</sup>	22.7 (n = 1,421)	23.8 (n = 2,046)	24.8 (n = 1,967)	21.2 (n = 1,596)	18.6 (n = 606)	22.9 (n = 7,636)
Substance Use <sup>h</sup>	10.4 (n = 1,414)	13.0 (n = 2,039)	12.2 (n = 1,964)	12.4 (n = 1,594)	11.8 (n = 603)	12.1 (n = 7,614)
<b>Average Total CAFAS Score</b>						
<b>Total<sup>i</sup></b>	107.3 (SD = 47.5)	113.8 (SD = 47.9)	111.9 (SD = 47.8)	109.0 (SD = 47.6)	103.8 (SD = 45.7)	110.3 (SD = 47.7)

<sup>a</sup>  $\chi^2 = 39.99$ ,  $df = 12$ ,  $n = 7,605$ ,  $p < .001$ .

<sup>b</sup>  $\chi^2 = 38.57$ ,  $df = 12$ ,  $n = 7,622$ ,  $p < .001$ .

<sup>c</sup>  $\chi^2 = 29.63$ ,  $df = 12$ ,  $n = 7,637$ ,  $p < .01$ .

<sup>d</sup>  $\chi^2 = 63.48$ ,  $df = 12$ ,  $n = 7,636$ ,  $p < .001$ .

<sup>e</sup>  $\chi^2 = 33.71$ ,  $df = 12$ ,  $n = 7,637$ ,  $p = .001$ .

<sup>f</sup>  $\chi^2 = 20.09$ ,  $df = 12$ ,  $n = 7,638$ ,  $p > .05$ .

<sup>g</sup>  $\chi^2 = 24.35$ ,  $df = 12$ ,  $n = 7,636$ ,  $p < .05$ .

<sup>h</sup>  $\chi^2 = 10.68$ ,  $df = 12$ ,  $n = 7,614$ ,  $p > .05$ .

<sup>i</sup>  $F = 7.88$ ,  $df1 = 4$ ,  $df2 = 7,640$ ,  $n = 7,645$ ,  $p < .001$ .

### **Youth Served by Systems of Care Reported High Levels of Law Enforcement and Juvenile Justice Involvement Prior to Intake**

Table 9 presents the percent of youth aged 11 years and older who self-reported involvement with the law enforcement and juvenile justice systems prior to their enrollment into the system of care program. With the exception of being on probation,<sup>23</sup> the percentage of youth who have had encounters with either system prior to entering system of care services varies significantly over program development years of communities initially funded in 1997, 1998, 1999, and 2000.

Furthermore, the percentage of youth reporting prior law enforcement encounters and juvenile justice outcomes prior to intake decreased from year 4 to year 5, but then increased from year 5 to year 6. This decrease was true for both types of law enforcement encounters and all three juvenile justice outcomes. Reductions in referrals from courts and corrections (combined) between program development years 4 and 5 may be related to the decrease in reported juvenile justice outcomes (see Table 12).

<sup>23</sup>  $\chi^2 = 5.22$ ,  $p > .05$ .

Overall, however, it is apparent that youth entering system of care services report high levels of law enforcement and juvenile justice involvement prior to intake. Excluding program development year 5 when the percentages were a bit lower, more than half of youth entering systems of care in all other program development years reported being accused by the police of breaking the law and more than two-fifths had been arrested. Roughly one-third of youth either had been found guilty of a crime or offense in court or had been in a detention center or jail for breaking the law prior to intake; approximately two-fifths reported having been on probation.

**Table 9**  
**Involvement with Law Enforcement and Juvenile Justice by Program Development Year**

	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
<b>Law Enforcement Encounter</b>						
Accused <sup>a</sup>	51.4 (n = 897)	53.0 (n = 1,354)	50.6 (n = 1,292)	45.9 (n = 987)	58.0 (n = 281)	50.9 (n = 4,811)
Arrested <sup>b</sup>	43.7 (n = 890)	47.2 (n = 1,340)	47.3 (n = 1,297)	39.7 (n = 985)	45.2 (n = 281)	44.9 (n = 4,793)
<b>Outcomes</b>						
Convicted <sup>c</sup>	32.4 (n = 880)	35.1 (n = 1,338)	35.5 (n = 1,289)	29.1 (n = 984)	35.6 (n = 281)	33.5 (n = 4,772)
Probation <sup>d</sup>	42.2 (n = 886)	40.7 (n = 1,353)	42.2 (n = 1,296)	37.9 (n = 984)	41.1 (n = 280)	40.8 (n = 4,799)
Detention/ Jail <sup>e</sup>	33.8 (n = 872)	36.9 (n = 1,332)	39.6 (n = 1,269)	31.9 (n = 956)	39.5 (n = 276)	36.2 (n = 4,705)

<sup>a</sup> $\chi^2 = 18.15$ ,  $df = 4$ ,  $n = 4,811$ ,  $p = .001$ .

<sup>b</sup> $\chi^2 = 17.01$ ,  $df = 4$ ,  $n = 4,793$ ,  $p < .01$ .

<sup>c</sup> $\chi^2 = 13.56$ ,  $df = 4$ ,  $n = 4,772$ ,  $p < .01$ .

<sup>d</sup> $\chi^2 = 5.22$ ,  $df = 4$ ,  $n = 4,799$ ,  $p > .05$ .

<sup>e</sup> $\chi^2 = 17.86$ ,  $df = 4$ ,  $n = 4,705$ ,  $p = .001$ .

### **Youth Served by Systems of Care Reported High Levels of Cigarette, Alcohol, and Marijuana Use Prior to Intake**

At intake, youth aged 11 years and older were asked whether they had ever used any of 14 different drugs. Although the percentages varied significantly by program development year, cigarettes,<sup>24</sup> alcohol,<sup>25</sup> and marijuana<sup>26</sup> were the three most frequently used substances across all program development years. To a lesser extent than the three drugs mentioned above, youth also reported comparatively high rates of psychedelic, inhalant, and over-the-counter drug use. Use of the remaining substances, however, was relatively low across all program development years of communities initially funded in 1997, 1998, 1999, and 2000.

<sup>24</sup> $\chi^2 = 42.27$ ,  $p < .001$ .

<sup>25</sup> $\chi^2 = 25.78$ ,  $p < .05$ .

<sup>26</sup> $\chi^2 = 30.48$ ,  $p < .01$ .

**Table 10**  
**Substance Use History at Intake by Program Development Year<sup>a</sup>**

Substance Used	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
Cigarettes <sup>b</sup>	61.6 (n = 903)	59.7 (n = 1,357)	56.6 (n = 1,310)	53.1 (n = 994)	51.4 (n = 284)	57.4 (n = 4,848)
Alcohol <sup>c</sup>	51.9 (n = 902)	52.4 (n = 1,358)	51.8 (n = 1,310)	49.0 (n = 996)	53.3 (n = 285)	51.5 (n = 4,851)
Marijuana or hashish <sup>d</sup>	40.8 (n = 900)	45.2 (n = 1,355)	45.8 (n = 1,306)	40.0 (n = 992)	47.7 (n = 285)	43.6 (n = 4,838)
LSD, acid, PCP, or other psychedelics <sup>e</sup>	10.5 (n = 899)	11.3 (n = 1,355)	9.3 (n = 1,307)	7.2 (n = 990)	5.6 (n = 285)	9.4 (n = 4,836)
Inhalants (e.g., spray cans) <sup>f</sup>	8.9 (n = 900)	9.6 (n = 1,355)	9.0 (n = 1,307)	6.8 (n = 991)	9.5 (n = 285)	8.7 (n = 4,838)
Non-prescription or over-the-counter drugs <sup>g</sup>	9.3 (n = 900)	9.2 (n = 1,353)	9.1 (n = 1,302)	8.8 (n = 992)	9.1 (n = 285)	9.1 (n = 4,832)
Cocaine in powder form <sup>h</sup>	7.1 (n = 900)	8.0 (n = 1,355)	6.8 (n = 1,306)	6.3 (n = 992)	7.0 (n = 285)	7.1 (n = 4,838)
Amphetamines <sup>i</sup>	5.7 (n = 901)	7.5 (n = 1,354)	7.4 (n = 1,307)	6.6 (n = 992)	7.4 (n = 285)	6.9 (n = 4,839)
Tranquilizers (e.g., Valium) <sup>j</sup>	4.6 (n = 901)	4.7 (n = 1,354)	4.7 (n = 1,306)	4.0 (n = 992)	3.9 (n = 285)	4.5 (n = 4,838)
Narcotics (e.g., morphine) <sup>k</sup>	3.9 (n = 901)	6.4 (n = 1,354)	6.4 (n = 1,306)	6.1 (n = 992)	8.4 (n = 285)	6.0 (n = 4,838)
Cocaine (crack or rock) in a hard chunk form <sup>l</sup>	3.4 (n = 901)	4.2 (n = 1,355)	3.5 (n = 1,307)	3.1 (n = 992)	4.6 (n = 285)	3.7 (n = 4,840)
Barbituates (e.g., downers) <sup>m</sup>	2.0 (n = 901)	3.5 (n = 1,354)	3.4 (n = 1,307)	3.2 (n = 992)	2.8 (n = 285)	3.1 (n = 4,839)
Heroin, smack <sup>n</sup>	2.1 (n = 900)	2.7 (n = 1,355)	2.5 (n = 1,306)	1.4 (n = 992)	0.7 (n = 285)	2.1 (n = 4,838)
Quaaludes <sup>o</sup>	0.8 (n = 901)	0.7 (n = 1,353)	0.5 (n = 1,307)	1.5 (n = 991)	0.7 (n = 285)	0.8 (n = 4,837)

<sup>a</sup> Substance use information was based on self-reports from youth 11 years and older.

<sup>b</sup>  $\chi^2 = 42.27$ ,  $df = 12$ ,  $n = 4,848$ ,  $p < .001$ .

<sup>c</sup>  $\chi^2 = 25.78$ ,  $df = 12$ ,  $n = 4,851$ ,  $p < .05$ .

<sup>d</sup>  $\chi^2 = 30.48$ ,  $df = 12$ ,  $n = 4,838$ ,  $p < .01$ .

<sup>e</sup>  $\chi^2 = 34.08$ ,  $df = 12$ ,  $n = 4,836$ ,  $p = .001$ .

<sup>f</sup>  $\chi^2 = 21.30$ ,  $df = 12$ ,  $n = 4,838$ ,  $p < .05$ .

<sup>g</sup>  $\chi^2 = 19.23$ ,  $df = 12$ ,  $n = 4,832$ ,  $p > .05$ .

<sup>h</sup>  $\chi^2 = 18.15$ ,  $df = 12$ ,  $n = 4,838$ ,  $p > .05$ .

<sup>i</sup>  $\chi^2 = 17.25$ ,  $df = 12$ ,  $n = 4,839$ ,  $p = .14$ .

<sup>j</sup>  $\chi^2 = 14.36$ ,  $df = 12$ ,  $n = 4,838$ ,  $p > .05$ .

<sup>k</sup>  $\chi^2 = 23.76$ ,  $df = 12$ ,  $n = 4,838$ ,  $p < .05$ .

<sup>l</sup>  $\chi^2 = 19.07$ ,  $df = 12$ ,  $n = 4,840$ ,  $p > .05$ .

<sup>m</sup>  $\chi^2 = 17.96$ ,  $df = 12$ ,  $n = 4,839$ ,  $p > .05$ .

<sup>n</sup>  $\chi^2 = 25.01$ ,  $df = 12$ ,  $n = 4,838$ ,  $p < .05$ .

<sup>o</sup>  $\chi^2 = 20.03$ ,  $df = 12$ ,  $n = 4,837$ ,  $p > .05$ .

### **The Majority of Children and Youth Entering Systems of Care Had Received Outpatient or School-Based Services in the 12 Months Prior to Intake**

Most children and adolescents entering the CMHI had received some type of service before being referred to system of care services. The CMHI funds systems of care for children and youth who have multiple needs, who already have experienced interventions from multiple sources, and who are at risk of out-of-home or out-of-community placement. One way to track the program's success in meeting its purpose is to identify types of services children received prior to their enrollment in the local system of care program and the proportion of children who had received these services.

Table 11 presents the percent of children who had received outpatient mental health services, school-based services, residential and day treatment services, and treatment for alcohol or drug use in the 12 months prior to intake. With the exception of day treatment,<sup>27</sup> the percentage of children receiving each service differed significantly by year of development of communities initially funded in 1997, 1998, 1999, and 2000. Overall, however, there was consistency in the frequency with which services had been used. Across all program development years, outpatient mental health services had been used most frequently before entering the system of care, followed by school-based services, residential treatment or inpatient hospitalization, day treatment, and alcohol and substance abuse therapy.

Overall, more than half of the children entering system of care services each year had utilized outpatient services or school-based services in the past year, while one fourth or more received residential treatment or inpatient hospitalization services. Fewer children, however, had participated in day treatment or alcohol or substance abuse therapy.

**Table 11**  
**Percent of Children Who Had Received Services**  
**in the 12 Months Prior to Intake by Type of Service and Program Development Year**

Service Used	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
Outpatient services <sup>a</sup>	67.3 (n = 2,947)	66.6 (n = 3,813)	64.6 (n = 3,669)	66.1 (n = 3,205)	62.2 (n = 1,524)	65.7 (n = 15,158)
School-based services <sup>b</sup>	61.0 (n = 2,895)	57.9 (n = 3,776)	53.3 (n = 3,618)	53.4 (n = 3,179)	54.0 (n = 1,511)	56.0 (n = 14,979)
Residential treatment or inpatient hospitalization <sup>c</sup>	33.1 (n = 2,983)	27.6 (n = 3,802)	26.3 (n = 3,655)	25.9 (n = 3,191)	25.4 (n = 1,525)	27.8 (n = 15,156)
Day treatment <sup>d</sup>	15.3 (n = 2,898)	15.5 (n = 3,792)	14.6 (n = 3,633)	14.5 (n = 3,172)	14.0 (n = 1,517)	14.9 (n = 15,012)
Alcohol and substance abuse therapy <sup>e</sup>	10.0 (n = 2,916)	11.8 (n = 3,799)	12.1 (n = 3,639)	8.7 (n = 3,167)	7.8 (n = 1,508)	10.5 (n = 15,029)

<sup>a</sup>  $\chi^2 = 14.96$ ,  $df = 4$ ,  $n = 15,158$ ,  $p < .01$ .

<sup>b</sup>  $\chi^2 = 58.11$ ,  $df = 4$ ,  $n = 14,979$ ,  $p < .001$ .

<sup>c</sup>  $\chi^2 = 55.92$ ,  $df = 4$ ,  $n = 15,156$ ,  $p < .001$ .

<sup>d</sup>  $\chi^2 = 2.92$ ,  $df = 4$ ,  $n = 15,012$ ,  $p > .05$ .

<sup>e</sup>  $\chi^2 = 40.65$ ,  $df = 4$ ,  $n = 15,029$ ,  $p < .001$ .

<sup>27</sup>  $\chi^2 = 2.92$ ,  $p > .05$ .

**Mental Health Agencies or Providers Were the Most Frequently Used Portals of Entry into Systems of Care in All Program Development Years**

Another method to determine whether the CMHI has served the intended target population (i.e., children and adolescents who are involved in multiple child-serving agencies) is to identify the various sources that refer children and adolescents to the local system of care programs and to determine the proportion of referrals made from each source. Information on referral sources is presented in Table 12.

While the percentages vary significantly by program development year of communities initially funded in 1997, 1998, 1999, and 2000,<sup>28</sup> there is consistency in the overall pattern of referrals. For example, in all years, most children were referred into local systems of care through mental health agencies or providers. These data support the program’s emphasis on targeting the public mental health sector for participation in systems of care. Schools were the second most frequent referral source across all years except program development year 6, when it was the third most frequent referral source.

These data also indicate the need for further efforts to engage all child-serving sectors in the CMHI, such as physical health providers. Given the fact that approximately one-third of children served in systems of care have chronic health problems (CMHS, 2004), local systems of care should pursue more diligently the active engagement of public and private health care providers.

**Table 12  
Percent of Referrals by Source and Program Development Year<sup>a</sup>**

Referral Source <sup>b</sup>	Year 2 (%) (n = 3,122)	Year 3 (%) (n = 3,856)	Year 4 (%) (n = 3,714)	Year 5 (%) (n = 3,324)	Year 6 (%) (n = 1,526)	Overall (%) (n = 15,542)
Mental Health <sup>c</sup>	27.2	31.2	34.1	37.9	35.4	32.9
School	18.5	18.7	13.9	16.8	14.7	16.7
Child Welfare <sup>d</sup>	15.1	11.0	11.8	9.7	10.9	11.7
Caregiver	11.4	9.2	8.8	8.3	7.3	9.2
Court	7.0	7.4	9.8	9.5	15.3	9.1
Corrections	3.4	6.2	9.7	5.7	2.9	6.1
Self	1.6	1.7	2.5	1.2	2.0	1.8
Physical Health <sup>e</sup>	1.5	1.2	0.9	1.6	0.5	1.2
Substance Abuse Clinic	0.1	0.2	0.1	0.0	0.1	0.1
Other <sup>f</sup>	14.2	13.3	8.3	9.2	10.9	11.2

<sup>a</sup> Referral information is taken from records.

<sup>b</sup>  $\chi^2 = 526.32$ ,  $df = 36$ ,  $n = 15,542$ ,  $p < .001$ .

<sup>c</sup> Mental health = Mental health agency, clinic, or provider.

<sup>d</sup> Child welfare = Child welfare agency or child protective services.

<sup>e</sup> Physical health = Physical health care agency, clinic, or provider.

<sup>f</sup> Other = Department of Developmental Disabilities, day treatment program, foster care agency, psychiatric emergency, friend, group home, and wraparound programs.

<sup>28</sup>  $\chi^2 = 526.32$ ,  $p < .001$ .

## **Family Demographics and History**

The CMHI is built on the belief that families must be strong and healthy to support the positive development of their children. To better understand some elements about the family context of children enrolled in the local system of care programs, data on family income, legal custody status of the child, and family history related to the risk of emotional disturbance were collected by local systems of care when children entered services. Analyses of these data are presented in the following tables.

### ***The Majority of Children and Youth Served Were from Households with Annual Incomes Below the Federal Poverty Level***

While the exact percentages vary significantly by program development year of communities initially funded in 1997, 1998, 1999, and 2000,<sup>29</sup> the majority of children enrolled in local systems of care were from households with annual incomes below the Federal poverty level. As seen in Table 13, more than half of children entering local systems of care each year were living below the Federal poverty level. Another 8–11 percent of children across the years were from households living at the poverty level. The large percentage of children living in households where the annual income was at or below the poverty level is due to the system of care programs' effective targeting of the public mental health sector.

**Table 13**  
**Poverty Level at Intake by Development Year<sup>a</sup>**

<b>Poverty Level<sup>b</sup></b>	<b>Year 2 (%) (n = 2,393)</b>	<b>Year 3 (%) (n = 3,106)</b>	<b>Year 4 (%) (n = 3,012)</b>	<b>Year 5 (%) (n = 2,625)</b>	<b>Year 6 (%) (n = 1,154)</b>	<b>Overall (%) (n = 12,290)</b>
Below poverty	54.7	57.5	59.3	55.1	53.6	56.5
At poverty	10.9	7.5	9.3	9.6	9.8	9.3
Above poverty	34.4	35.0	31.4	35.3	36.6	34.2

<sup>a</sup> Poverty categories are based on the U.S. Department of Health and Human Services (DHHS) poverty guidelines. The categories take into account calendar year, State, family income, and household size. For example, according to these guidelines, in 2004 a family of four residing in the contiguous 48 states was living in poverty if its income was below \$18,850 (DHHS, 2004).

<sup>b</sup>  $\chi^2 = 36.83$ ,  $df = 8$ ,  $n = 12,290$ ,  $p < .001$ .

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<sup>29</sup>  $\chi^2 = 36.83$ ,  $p < .001$

### **Biological Mothers Were the Most Frequent Custodial Agents of Children and Youth Served**

Over 40 percent of children were in the sole custody of their biological mothers in each program development year of communities initially funded in 1997, 1998, 1999, and 2000. Approximately one fourth were in the custody of two parents, defined as either both biological parents, or one biological parent and a step-parent. About 10 percent of children across all years were in State custody at the time of intake due to being in foster care or receiving residential treatment through child welfare, or were incarcerated through juvenile justice. On average, more grandparents had custody of children than biological fathers alone (see Table 14).

**Table 14**  
**Percent of Children According to Their Legal Custody Status by Program Development Year<sup>a</sup>**

Legal Custody <sup>b</sup>	Year 2 (%) (n = 3,179)	Year 3 (%) (n = 4,032)	Year 4 (%) (n = 4,180)	Year 5 (%) (n = 3,527)	Year 6 (%) (n = 1,669)	Overall (%) (n = 16,587)
Biological mother only	44.5	42.8	43.9	42.4	42.2	43.2
Two parents	24.1	26.5	23.9	26.9	23.6	25.2
Ward of the State	9.4	9.1	10.2	8.4	11.6	9.5
Grandparents	6.0	6.7	6.0	7.1	7.4	6.6
Biological father only	4.2	4.0	4.4	4.6	4.2	4.3
Adoptive parent(s)	3.8	4.0	4.0	4.9	4.4	4.2
Foster parent(s)	0.7	1.0	1.2	0.8	0.9	0.9
Other <sup>c</sup>	7.1	5.9	6.4	4.8	5.6	6.0

<sup>a</sup>Custody status refers to legal status and may not reflect living arrangement.

<sup>b</sup> $\chi^2 = 68.28$ ,  $df = 28$ ,  $n = 16,587$ ,  $p < .001$ .

<sup>c</sup>Other includes siblings, aunts and/or uncles, adult friend, and other caregivers.

### **The Majority of Children and Youth Served Have a Family History of Mental Illness or Substance Abuse**

Examination of family history reveals that a large percentage of children in each program development year of communities initially funded in 1997, 1998, 1999, and 2000 had been exposed to factors that put them at risk for emotional disturbance and out-of-home placement (see Table 15). For example, approximately one-half of the children had come from families with a history of domestic violence, and over one-half entering systems of care in any program development year were from families with a history of mental illness. Of these children, approximately 2 in 5 had at least one parent who had been hospitalized for psychiatric reasons.

About two-thirds of children had a history of substance abuse in their biological family. Of these children, over half had at least one biological parent who had received substance abuse treatment. Finally, more than two-fifths of children entering systems of care had at least one biological parent who had been convicted of a crime.

**Table 15  
Percent of Caregivers Reporting on Family History by Program Development Year**

	Year 2 (%)	Year 3 (%)	Year 4 (%)	Year 5 (%)	Year 6 (%)	Overall (%)
History of family violence in child's biological family <sup>a</sup>	51.6 (n = 2,834)	50.1 (n = 3,734)	50.5 (n = 3,647)	49.4 (n = 3,141)	46.5 (n = 1,517)	50.0 (n = 14,873)
History of mental illness in child's biological family <sup>b</sup>	57.8 (n = 2,781)	54.9 (n = 3,674)	52.0 (n = 3,543)	58.3 (n = 3,069)	56.3 (n = 1,490)	55.6 (n = 14,557)
Biological parent(s) had psychiatric hospitalization <sup>c</sup>	39.4 (n = 1,415)	39.9 (n = 1,877)	39.8 (n = 1,702)	40.6 (n = 1,611)	38.2 (n = 765)	39.8 (n = 7,370)
Biological parent(s) convicted of a crime <sup>d</sup>	50.3 (n = 2,700)	45.8 (n = 3,609)	47.6 (n = 3,499)	46.8 (n = 3,002)	45.0 (n = 1,473)	47.2 (n = 14,283)
History of substance abuse in child's biological family <sup>e</sup>	69.0 (n = 2,855)	65.6 (n = 3,721)	65.2 (n = 3,624)	63.9 (n = 3,111)	62.5 (n = 1,515)	65.5 (n = 14,826)
Biological parent(s) received treatment for substance abuse <sup>f</sup>	56.3 (n = 1,677)	54.6 (n = 2,179)	53.1 (n = 2,124)	54.1 (n = 1,775)	50.7 (n = 835)	54.1 (n = 8,590)

<sup>a</sup>  $\chi^2 = 11.13$ ,  $df = 4$ ,  $n = 14,873$ ,  $p < .05$ .

<sup>b</sup>  $\chi^2 = 34.00$ ,  $df = 4$ ,  $n = 14,557$ ,  $p < .001$ .

<sup>c</sup> Caregivers were asked about psychiatric hospitalization only if they reported a history of mental illness in the biological family. This accounts for the lower number of respondents on this question.  $\chi^2 = 1.36$ ,  $df = 4$ ,  $n = 7,370$ ,  $p = .851$ .

<sup>d</sup>  $\chi^2 = 16.84$ ,  $df = 4$ ,  $n = 14,283$ ,  $p < .01$ .

<sup>e</sup>  $\chi^2 = 24.75$ ,  $df = 4$ ,  $n = 14,826$ ,  $p < .001$ .

<sup>f</sup> Caregivers were asked about receiving treatment for substance abuse only if they reported a history of substance abuse. This accounts for the lower number of respondents for these questions.  $\chi^2 = 8.25$ ,  $df = 4$ ,  $n = 8,590$ ,  $p > .05$ .

## **Summary**

Analyses of the demographic characteristics of children and families entering system of care communities initially funded in 1997, 1998, 1999, and 2000 indicate that the CMHI was largely successful in serving its intended population during those years. The majority of children and youth were below age 22, with larger percentages of younger children entering systems of care in the later program development years. The program served children with a variety of *DMS-IV* diagnoses such as ADHD, mood disorders, oppositional defiant disorder, adjustment disorders, and conduct disorder. The majority of children were assigned more than one *DSM-IV* diagnosis.

Children and youth entered local system of care programs with below average strengths and competence and with levels of behavioral and emotional problems that indicated a need for intervention. Total CAFAS scores indicated that children and youth served by the communities displayed marked impairment across a variety of these domains.

Finally, examination of the service use data provides evidence that children and youth had been involved with more than one service agency prior to intake into the grant program.

## **CHILD AND FAMILY OUTCOMES**

A subset of children between 5 and 17 years of age enrolled in the program also participated in the national evaluation's longitudinal child and family outcome study in system of care communities initially funded in 1997, 1998, 1999, and 2000. Data were collected from both caregivers of the children and youth who were being served and from youth themselves who were between 11 and 17 years of age (see Appendix B for further information about the child and family outcome study).

The outcomes findings presented below are depicted across years of development for system of care communities initially funded in 1997, 1998, 1999, and 2000, beginning with their second year of funding. The data from all funding cohorts were collapsed into developmental program years so that 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. Data represent the change in outcomes from intake into services to 12 months following intake.

Data for each development year of these system of care communities represent those children whose baseline data collection at intake occurred within that particular development year. The 12-month followup data for those children most often were collected in the following year of development. Thus, information for each year of development reflects change in outcomes 1 year after entering system of care services for all children who had baseline and 12-month followup data present. Because systems typically do not begin enrolling children into program services until the second year of funding, data are presented beginning with the second development year. The number of children who would have been enrolled and completed their 12-month followup interviews within the sixth year of development is small, reflecting only those children whose baseline interviews occurred in the first month of that particular year and who also had completed a 12-month interview. As mentioned above, the number of children and youth for whom data were available varied across program development years and across the various measures used to collect data. The specific number of children and youth for whom data were available is indicated in the tables and figures presented below. Because of small sample sizes in

the sixth year of program development, the results from that year in the tables below may be anomalous and should be interpreted with caution.

Data for this section of the report were gathered through the Behavioral and Emotional Rating Scale (BERS), Child Behavior Checklist (CBCL), Child and Adolescent Functional Assessment Scale (CAFAS), Educational Questionnaire (EQ), Delinquency Survey (DS), Caregiver Strain Questionnaire (CGSQ), Family Resource Scale (FRS), and the Restrictiveness of Living Environments and Placement Stability Scale–Revised (ROLES–R) (see Appendix C for a complete description of these instruments).

## **Child Clinical Indicators**

### ***Children Improved Their Behavioral and Emotional Strengths***

A focus on clinical strengths of children and youth is an important aspect of systems of care. Clinical strengths are measured by the BERS. The BERS focuses on strengths and resiliency, identifying emotional and behavioral strengths of children and adolescents aged 5 to 18 in key areas related to school, family, relationships, and personal competence.<sup>30</sup> These strengths include their ability to control their behaviors and emotions in social situations, in the assessment of their own competencies and achievements, in their ability to receive and show affection, and in their functioning at school and at home.

During each year of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000, between 40 and 45 percent of children exhibited clinically significant improvements in their clinical strengths 12 months after enrolling in system of care services (see Figure 2).<sup>31</sup> An additional one third exhibited stable levels of strengths. The percentage of children who showed improvement in their clinical symptoms maintained a consistent level over the years of program development. 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.<sup>32</sup>

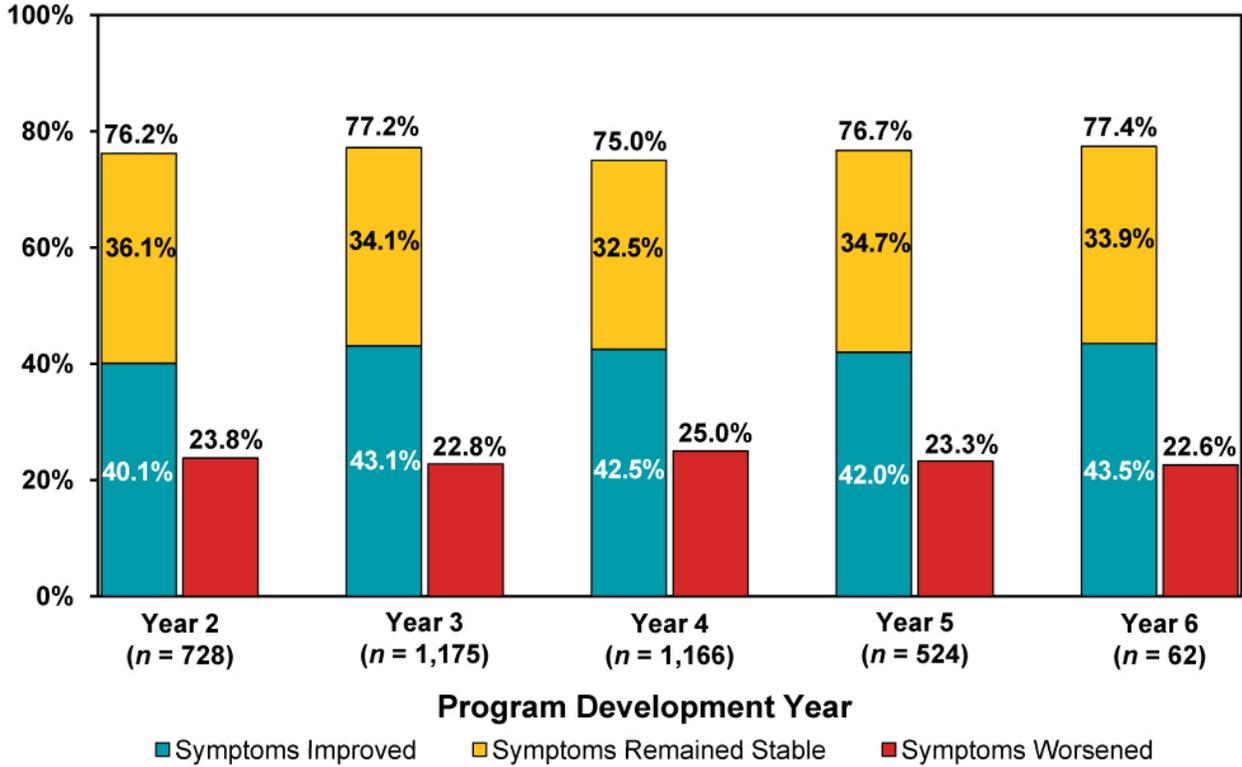
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<sup>30</sup> Behavioral and Emotional Rating Scale. For a description of this measure, see page 30.

<sup>31</sup> Because numeric change may vary in magnitude and implications for actual behavioral change are often difficult to interpret, we provide a quantitative indicator of clinical change for clinical outcome measures. The reliable change index (RCI; Jacobson, Roberts, Berns, & McGlinchey, 1999; Jacobson & Truax, 1991; Speer & Greenbaum, 1995) is used to assess whether individual behavioral and emotional change over time was clinically significant. This statistic compares a child's scores at two different points in time, adjusting for the reliability of the measure, and indicates whether a change in scores shows clinically significant improvement, stability, or deterioration. Improvement and deterioration are defined as a difference in outcome scores, adjusted for measurement error of the outcome, which exceeds the 95 percent confidence bounds around a change score of zero. In other words, a difference of that magnitude would not be expected simply due to the unreliability of the measure.

<sup>32</sup>  $t(3665) = -15.00, p < .0001$ .

**Figure 2**  
**Reliable Change Index (RCI) for BERS Strength Quotient**  
**from Intake to 12-Month Followup by Program Development Year**

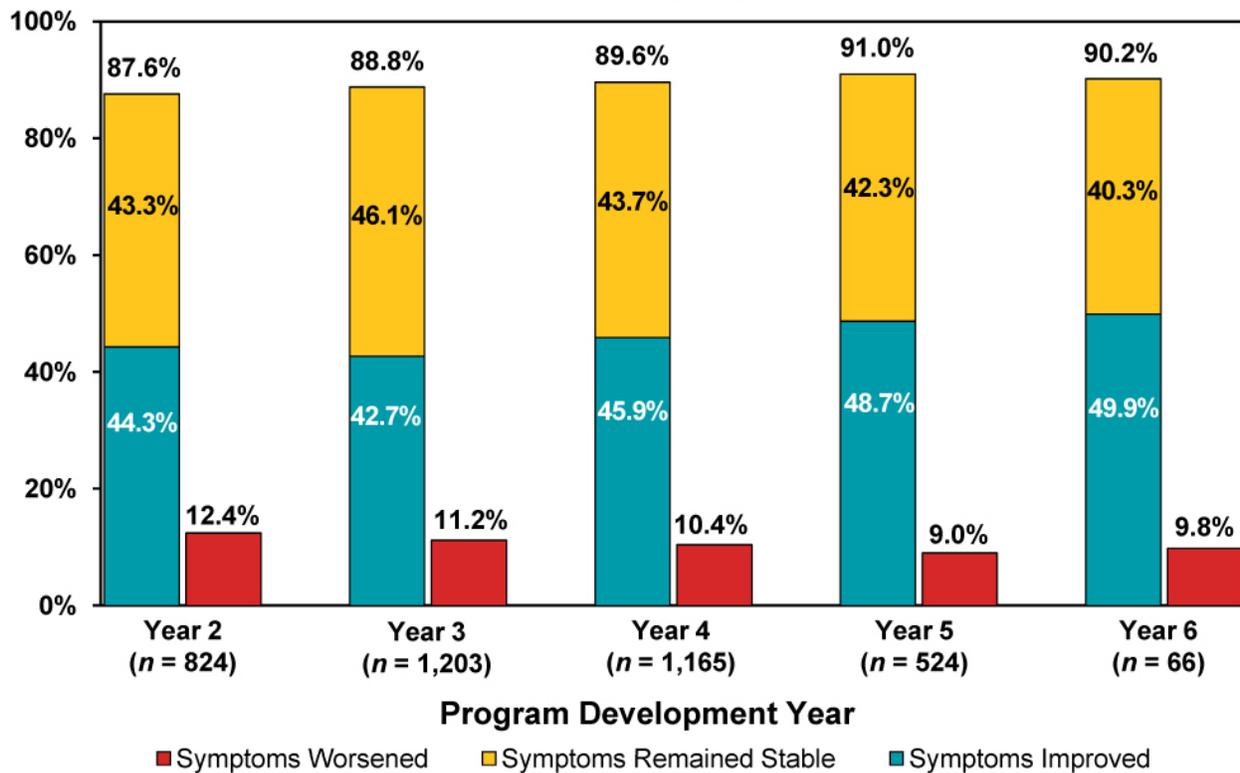


RCI x Year:  $\chi^2(4) = 1.77, p > .05$ .

### Children Exhibited Decreases in Behavioral and Emotional Problems

Across the years of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000, between 40 and 50 percent of children exhibited a clinically significant decrease in the number of reported behavioral and emotional problems during the 12 months following intake into system of care services. An additional 40 to 45 percent exhibited stable levels in the number of reported problems, as measured by the CBCL (see Figure 3).<sup>33</sup> Although the increase was not statistically significant,<sup>34</sup> an increasing trend in the percentage of children who showed improvement during the program development years was observed. 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.<sup>35</sup>

**Figure 3**  
**Reliable Change Index (RCI) for CBCL Total Problems**  
**from Intake to 12-Month Followup by Program Development Year**



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

<sup>33</sup> Child Behavior Checklist. For a description of this measure, see page 31.

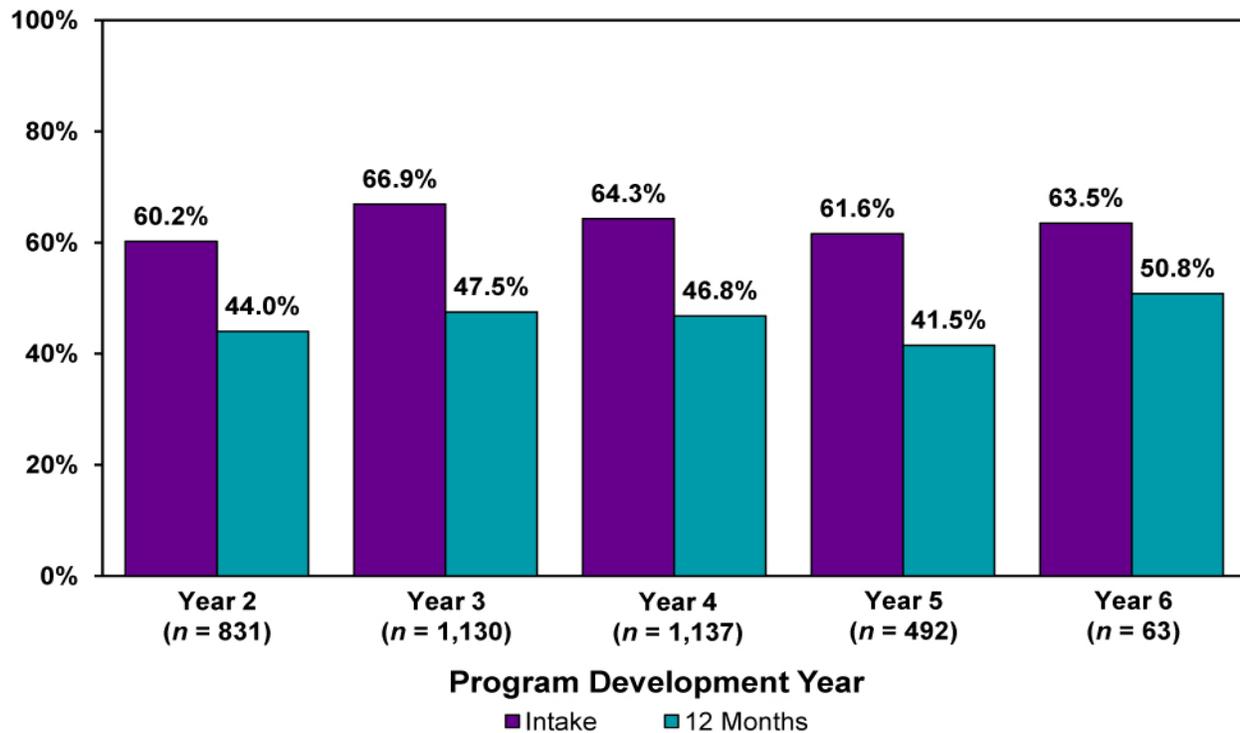
<sup>34</sup> For more information on the reliable change index, see page 42.

<sup>35</sup>  $t(3781) = 31.84, p < .0001$ .

### **Children’s Level of Functional Impairment Decreased**

Children’s overall functioning in their home, school, and community environments improved during their first year following receipt of program services. Across years of system development of system of care communities initially funded in 1997, 1998, 1999, and 2000, the percentage of children who exhibited moderate to severe functional impairment 12 months after entering system of care services decreased significantly compared to the level of impairment at intake,<sup>36</sup> as measured by the CAFAS (see Figure 4).<sup>37</sup> 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.<sup>38</sup> Although not statistically significant, there was variation in the amount of the decrease across development years. Considering the large percentage of children with moderate to severe functioning difficulties who entered the program each year and the broad range of diagnoses with which they presented (see the section on children’s descriptive characteristics), these outcomes indicate remarkable program achievements.

**Figure 4**  
**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:  $z = -0.47, p > .05$ .

<sup>36</sup>  $z = -5.65, p < .001$ .

<sup>37</sup> Child and Adolescent Functional Assessment Scale. For a description of this measure, see page 32.

<sup>38</sup>  $t(3652) = 25.96, p < .0001$ .

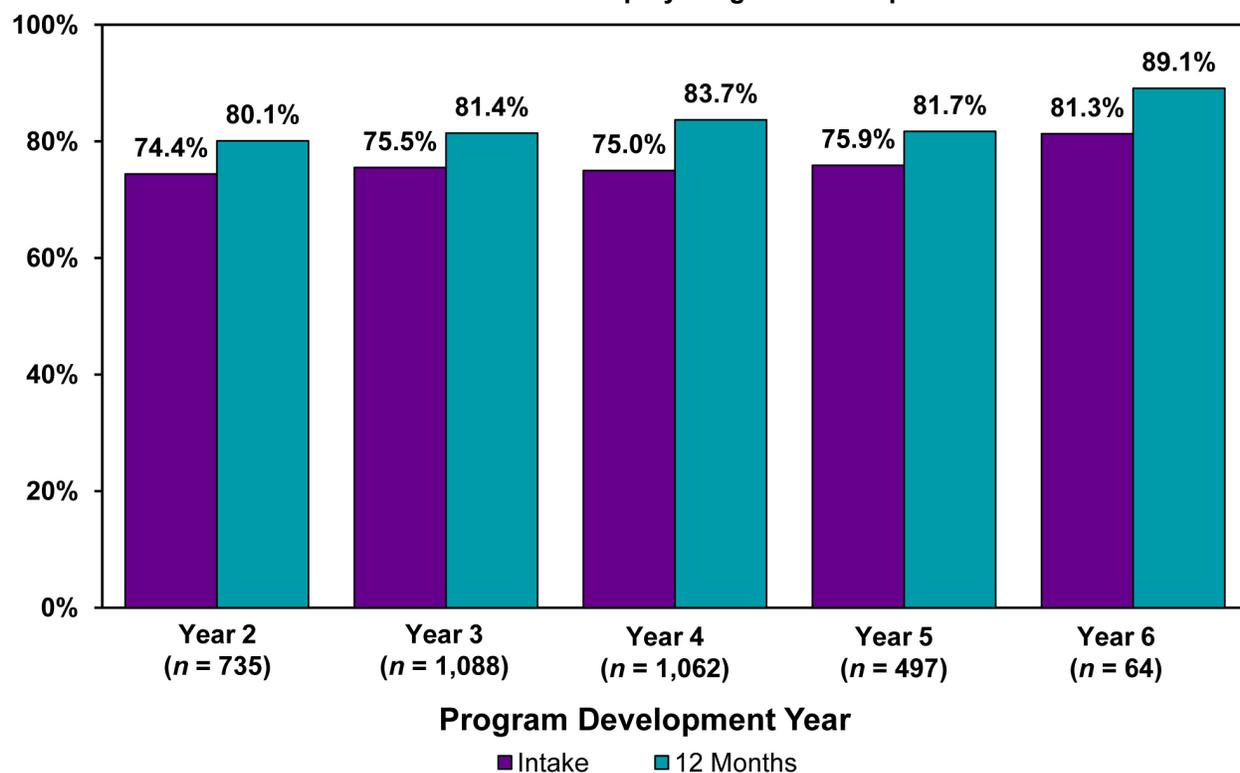
## **Child Functional Indicators**

School attendance, academic performance, and contacts with law enforcement are important indicators of children's abilities to function well in environments critical to their well-being. Improvement in these environments may reflect improvement in overall functioning. Given their importance as predictors of a child's future professional and economic success, regular school attendance and academic performance become critical indicators of programmatic success.

### ***Children Improved Their School Attendance***

Even though nearly three-fourths of the children attended school regularly at intake, school attendance increased during their first 12 months in system of care communities initially funded in 1997, 1998, 1999, and 2000, (see Figure 5). While not statistically significant, the increase averaged between 6 and 7 percentage points over the years of program development in these communities, with over 80 percent of children attending school regularly 12 months after entering services. This is a remarkable finding given the clinical history of many participating children and youth.

**Figure 5**  
**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**

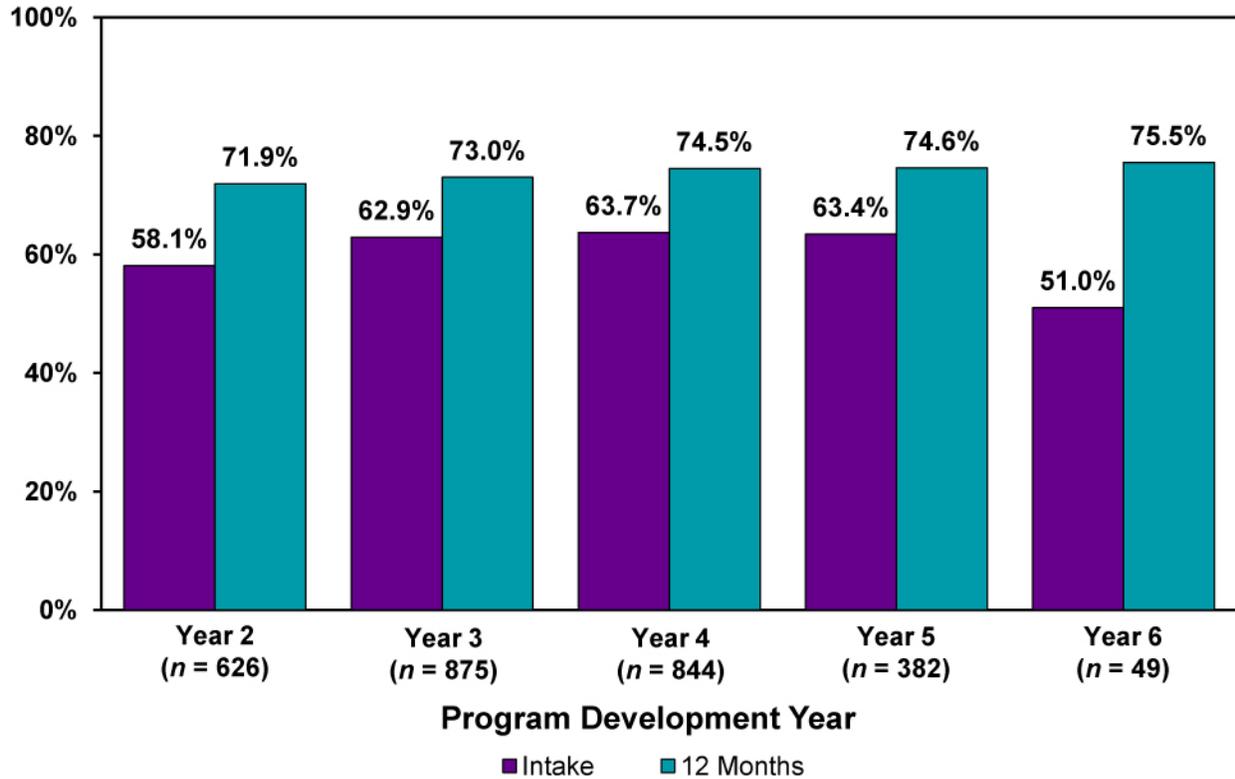


Baseline–12-month:  $z = 1.95, p > .05$ ; Year:  $z = 0.80, p > .05$ ; (Baseline – 12-month) x Year:  $z = 0.81, p > .05$ .

### Academic School Performance Improved

The percentage of children with at least a C grade point average increased significantly<sup>39</sup> by an average of 14 percentage points from intake to 12 months post-intake (see Figure 6). This improvement in school performance was consistently obtained across all years of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000.

**Figure 6**  
**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**



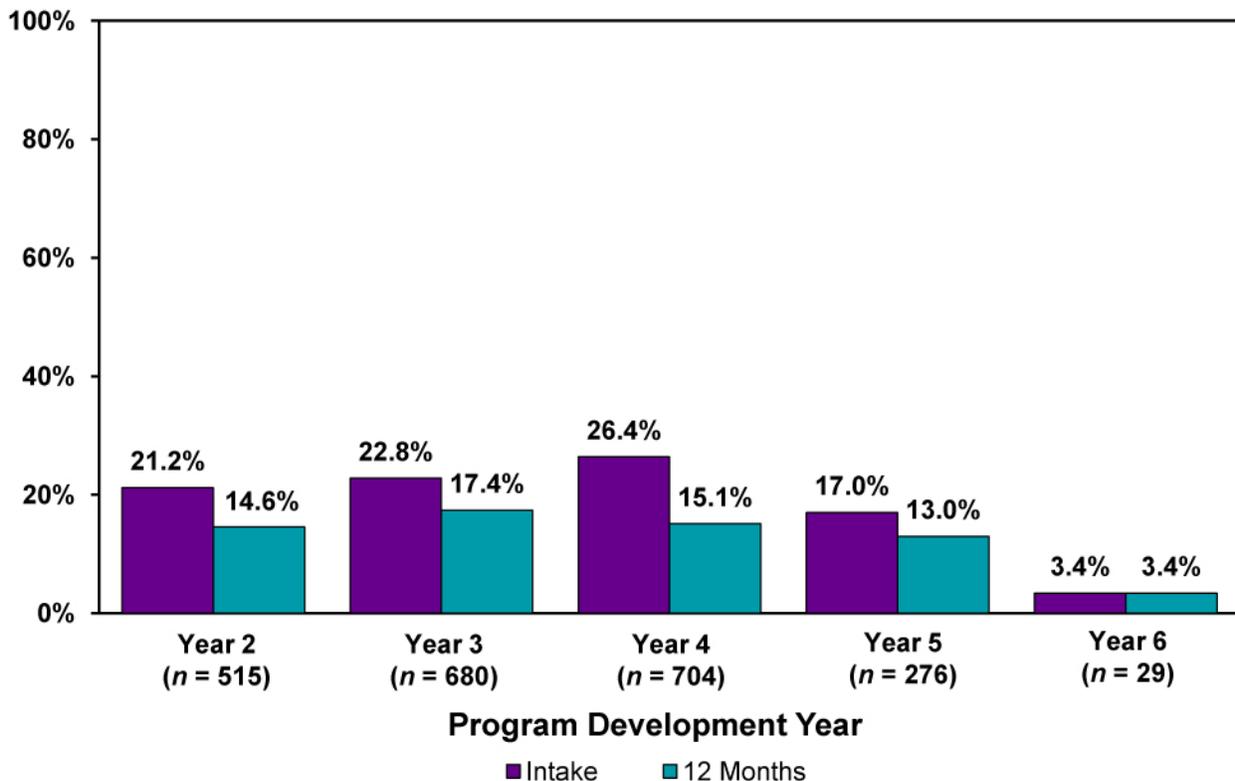
Baseline–12-month:  $z = 3.58, p < .001$ ; Year:  $z = 1.28, p > .05$ ; (Baseline–12-month) x Year:  $z = 0.07, p > .05$ .

<sup>39</sup>  $z = 3.58, p < .001$ .

### Law Enforcement Contacts Decreased

Children and youth 11 years and older self-reported on the Delinquency Survey their involvement with law enforcement during the 6 months immediately preceding their enrollment into system of care services and again after receiving services for 12 months. Fewer youth reported being arrested during the first 12 months in systems of care than in the 6 months prior to entering services,<sup>40</sup> 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 of system of care communities initially funded in 1997, 1998, 1999, and 2000 (see Figure 7).

**Figure 7**  
**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:  $z = -0.47, p > .05$ .

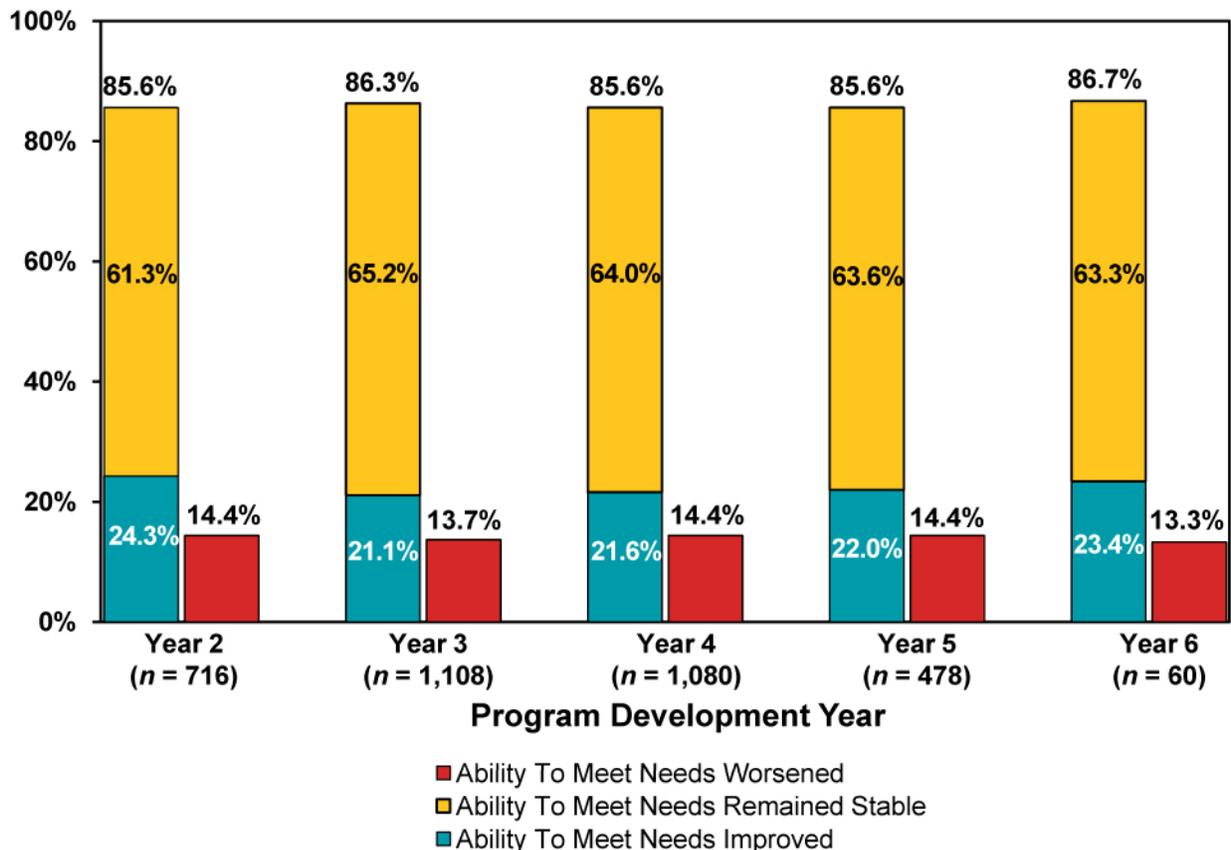
<sup>40</sup>  $z = -2.03, p < .001$ .

## Family Outcomes

### Family Resources Improved

Examination of caregivers' perceptions of the degree to which their family's basic needs were met, as measured by the Family Resource Scale (FRS), indicated that the adequacy of resources for basic needs remained stable for the vast majority of families during the first 12 months following their child's intake into system of care services (see Figure 8).<sup>41</sup> This finding was consistently obtained across program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000. While stability of basic needs is a positive outcome for families, the fact that approximately 20 percent of caregivers rated their resources for basic needs as only sometimes adequate or less than adequate indicates this is an area that remains a challenge for systems of care. This is especially true when approximately two-thirds of families report family income at or below the Federal poverty level when they enroll their children into program services (see children's descriptive characteristics section).

**Figure 8**  
**Reliable Change Index (RCI) for FRS Basic Needs Scores**  
**from Intake to 12-Month Followup by Program Development Year**



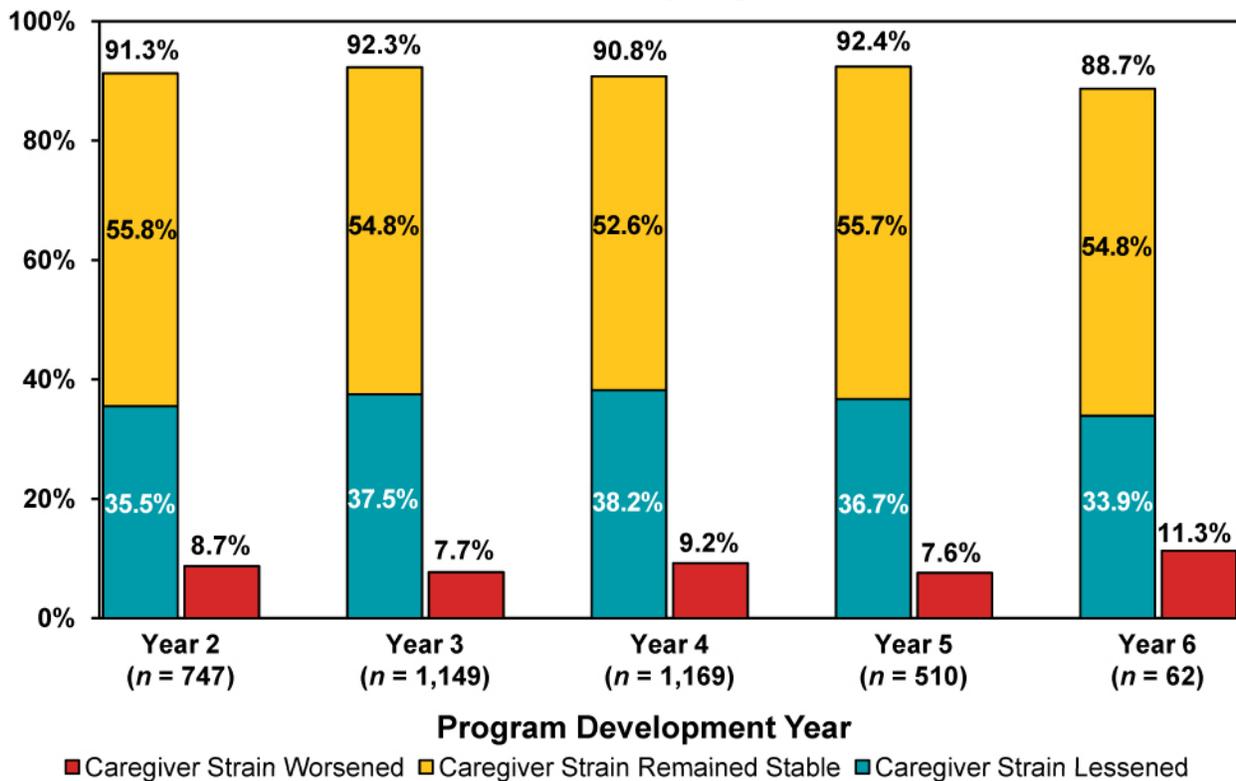
RCI x Year:  $\chi^2(4) = 2.87, p > .05$ .

<sup>41</sup> For more information on the reliable change index, please see page 42.

### Caregiver Strain Decreased

Caring for children with serious emotional disturbance can be stressful for parents, other caregivers, and siblings. The national evaluation assessed the degree of stress experienced by caregivers when they enrolled their children into services and again 12 months later using the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1997).<sup>42</sup> A third or more of caregivers indicated the strain they experienced as a result of their caregiving responsibilities and its total impact on the family was reduced significantly from intake to 12 months after entry into services. Another half or more indicated their level of strain remained stable. This finding did not vary significantly across years of program development in system of care communities initially funded in 1997, 1998, 1999, and 2000 (see Figure 9).<sup>43</sup> Decreased scores may indicate reduction in negative events such as disrupted family relationships, routines, social activities, and loss of personal time.

**Figure 9**  
**Reliable Change Index (RCI) for Mean CGSQ Global Strain Scores**  
**from Intake to 12-Month Followup by Program Development Year**



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

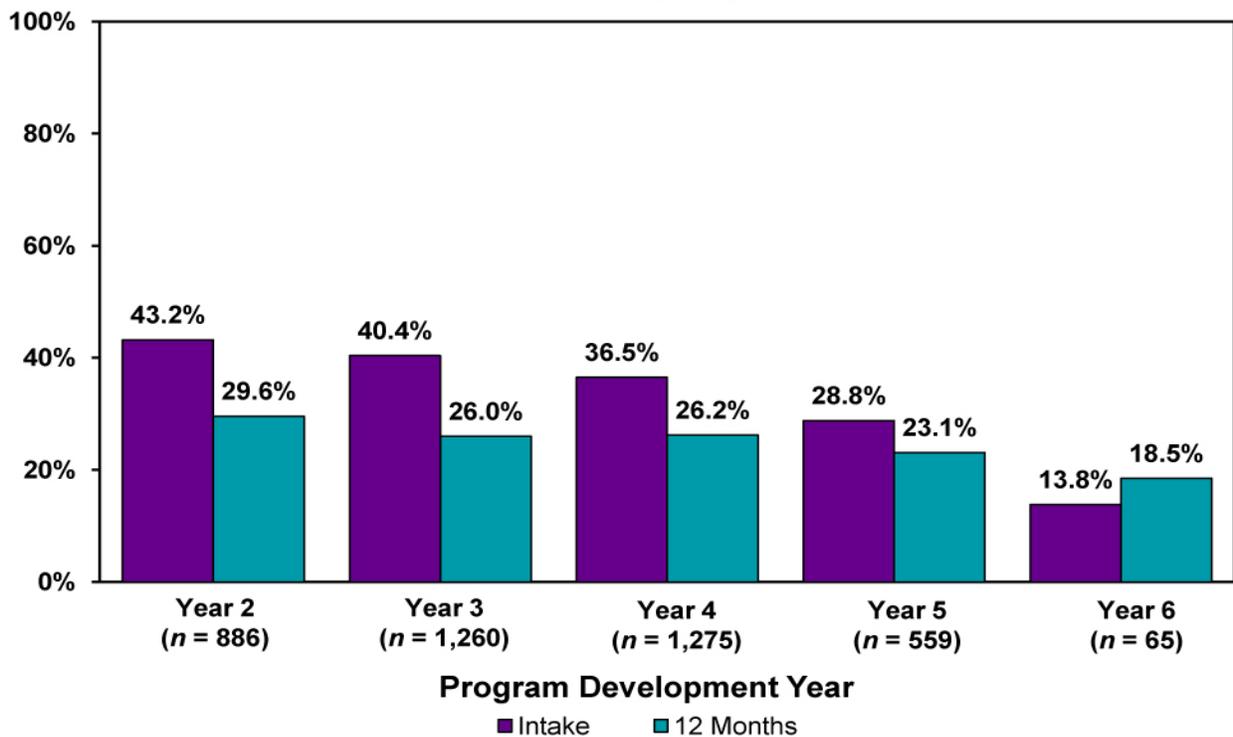
<sup>42</sup> The CGSQ assesses the extent to which caregivers are affected by the special demands associated with caring for a child with emotional and behavioral problems and the impact that participating in system of care services has on the strain caregivers and families may experience. For example, the CGSQ can be used to determine whether strain lessens over time as better services and supports are provided by the system of care.

<sup>43</sup> For more information on the reliable change index, see page 42.

### **Children Living in Multiple Settings Decreased**

One major goal of systems of care is to reduce or prevent out-of-home placements of the children served which is reflected in the number of living situations a child experienced in the previous 6 months. As shown in Figure 10, there was a significant decreasing trend in the overall percentage of children with multiple out-of-home placements across years of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000.<sup>44</sup> The percentage of children placed in two or more out-of-home settings during the 6 months before the 12-month assessment interview decreased significantly from intake into services<sup>45</sup> by an average of nearly 8 percentage points across the years of program development. The difference in the rate of decrease across years of development also was significant.<sup>46</sup> The rate of decrease over development years in the percentage of children with multiple out-of-home placements reported at intake was significantly greater than the rate of decrease over development years in the percentage of children with multiple placements reported at 12 months post-intake. This may reflect either a floor effect for reduction in the occurrence of multiple living situations in the previous 6 months or an increase in the stability of living situations at the time of entry into services for later enrollment cohorts.

**Figure 10**  
**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) x Year:  $z = 2.39, p < .05$ .

<sup>44</sup>  $z = -6.62, p < .001$ .

<sup>45</sup>  $z = -6.50, p < .001$ .

<sup>46</sup>  $z = 2.39, p < .05$ .

## **Summary**

The findings presented in this section indicate the impact of system of care communities initially funded in 1997, 1998, 1999, and 2000 on meaningful outcomes for recovery and quality of life for the children and families served. The results show that youth generally experienced meaningful improvement in important clinical and functional indicators. Their strengths, behavioral and emotional symptoms, and functional impairments improved significantly at 12 months following intake into system of care services. These positive changes were accompanied by increased stability in living arrangements, improved school performance, and decreased law enforcement contacts. Most families experienced improvement or stability in resources, and reduced strain in caring for their children.

## **PROGRAM PRACTICES AND INTERVENTIONS**

Desired mental health and related service delivery outcomes, as presented in the system of care theory-based framework (see page 16), include the integration of system of care principles and values into service provider practices and the provision of coordinated and useful services and community supports to the children and families served. Indicators of the extent to which system of care communities initially funded in 1997, 1998, 1999, and 2000 achieved these outcomes include youth and caregiver satisfaction with the program and the provision of culturally relevant individualized and community-based services supported by case management (care coordination).

As with the descriptive information and outcomes data presented in other sections of this report, the data presented in this section are depicted across years of program development for system of care communities initially funded in 1997, 1998, 1999, and 2000, beginning with their second year of funding when actual enrollment and service provision begin. Data from all four funding cohorts again were collapsed into developmental program years so that the trend of progress could be illustrated on a year-to-year basis according to the communities' age in the grant-funded program. Consumer data were collected from caregivers of all children enrolled in the longitudinal outcome study and from youth 11 years of age and older after they had received services for 6 months and again after they had received services for 12 months. As in the previous sections, the number of children and youth for whom data were available varied across program development years and across the various measures used to collect data. The specific number of children and youth for whom data were available is indicated in the figures and tables presented below. System of care assessment data were collected according to a systematic periodicity schedule across the grant-funding cycles, and other data were collected according to specific study designs (see Appendix B for a complete description of the various studies).

Consumer satisfaction data presented in this section were collected through the Youth Satisfaction Questionnaire–Abbreviated Version (YSQ–A) and the Family Satisfaction Questionnaire–Abbreviated Version (FSQ–A). Information about the types and frequency of services received was gathered through the Multi-Sector Service Contact Questionnaire (MSSC) and the Restrictiveness of Living Environments and Placement Stability Scale–Revised Version (ROLES–R) (see Appendix C for a complete description of these measures). The descriptions of program achievement in providing individualized and culturally competent services are drawn from system of care assessment data. Analyses of data collected through the Delinquency Survey (DS) and the ROLES–R, in addition to cost information from the National Center on Addiction

and Substance Abuse (CASA) at Columbia University and the Agency for Healthcare Research and Quality (AHRQ), illustrate cost effectiveness of the program in those two areas. Findings are presented from the Evidence-based Treatment Survey (EBT), and a description of the Treatment Effectiveness Studies (TES) is included in Appendix B.

### **Consumer Satisfaction**

Consumer input is a fundamental principle that guides the application of a continuous quality improvement (CQI) model. SAMHSA defines CQI as a health care model that “builds on traditional quality assurance methods by putting in place a management structure that continuously gathers and assesses data that are then used to improve performance and design more efficient systems of care” (SAMHSA, 2005b). Traditional quality assurance models that draw upon product-related data gathered on internal processes have been expanded to include quality improvement models that focus on actual experiences and preferences of the consumers (“consumer centered”) (LeVitt, 1997).

As it is the express purpose of the CMHI to improve clinical and functional outcomes for children and their families while meeting their needs and expectations satisfactorily, it is important to assess their level of satisfaction. As demonstrated earlier, clinical and functional outcomes for children and families improved over time across system of care communities initially funded in 1997, 1998, 1999, and 2000. Results documented in this report indicate that youth, parents, and other caregivers were satisfied with the program’s efforts to provide services.

### ***Youth Were Satisfied with Services***

Three areas of youth satisfaction related to services were assessed: overall satisfaction with services, satisfaction with their personal progress, and satisfaction with their own involvement in planning their own services. As shown in Figures 11 and 12, the percentage of youth who reported overall satisfaction with their services significantly increased from year to year,<sup>47</sup> as did the percentage of youth who were satisfied with their involvement in service planning.<sup>48</sup> Although satisfaction rates in any given year were similar at 6 months after service intake compared to 12 months, there was an increasing trend toward higher satisfaction among youth in both of these areas from year to year as system of care communities initially funded in 1997, 1998, 1999, and 2000 matured in their development across their funding cycles. These findings should be interpreted with caution for program development year 6 given the small number of cases. Approximately 75 percent of youth were satisfied with their own progress, a proportion that did not differ significantly from 6 months after service intake to 12 months or across developmental years.<sup>49</sup>

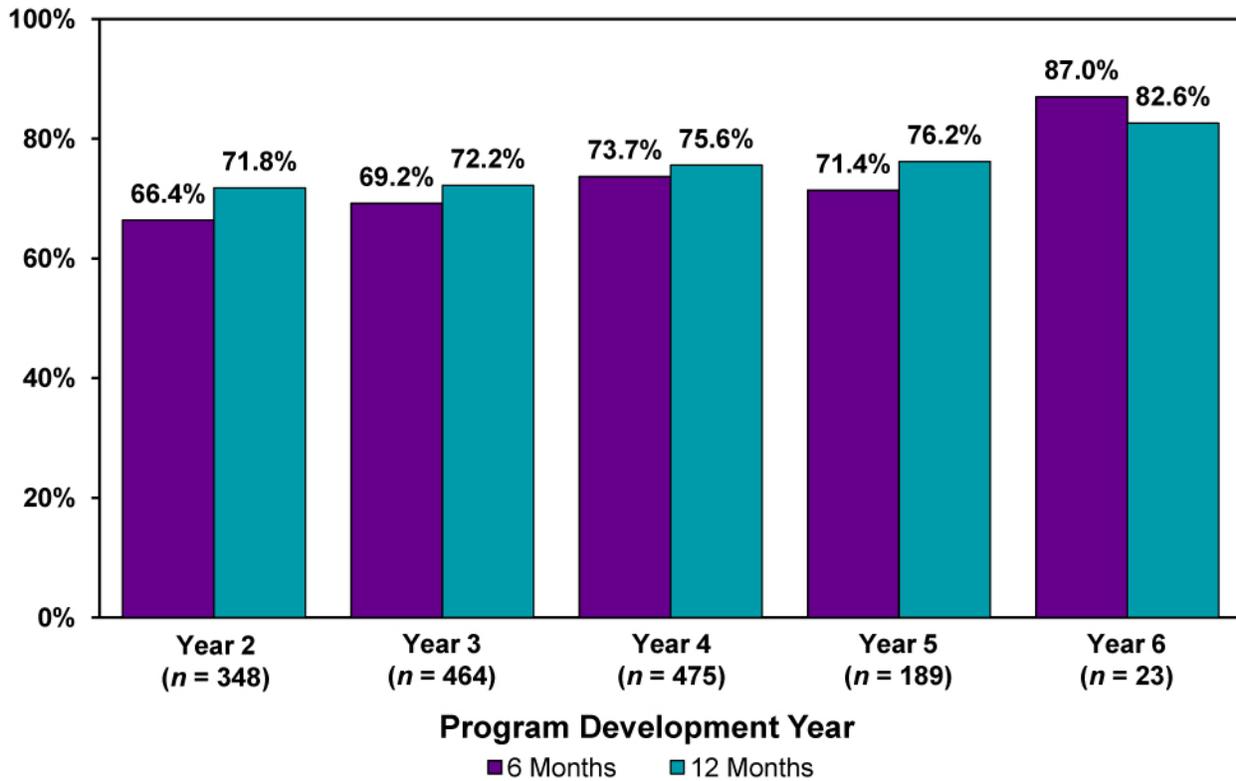
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<sup>47</sup>  $z = 2.45, p < .05$ .

<sup>48</sup>  $z = 2.03, p < .05$ .

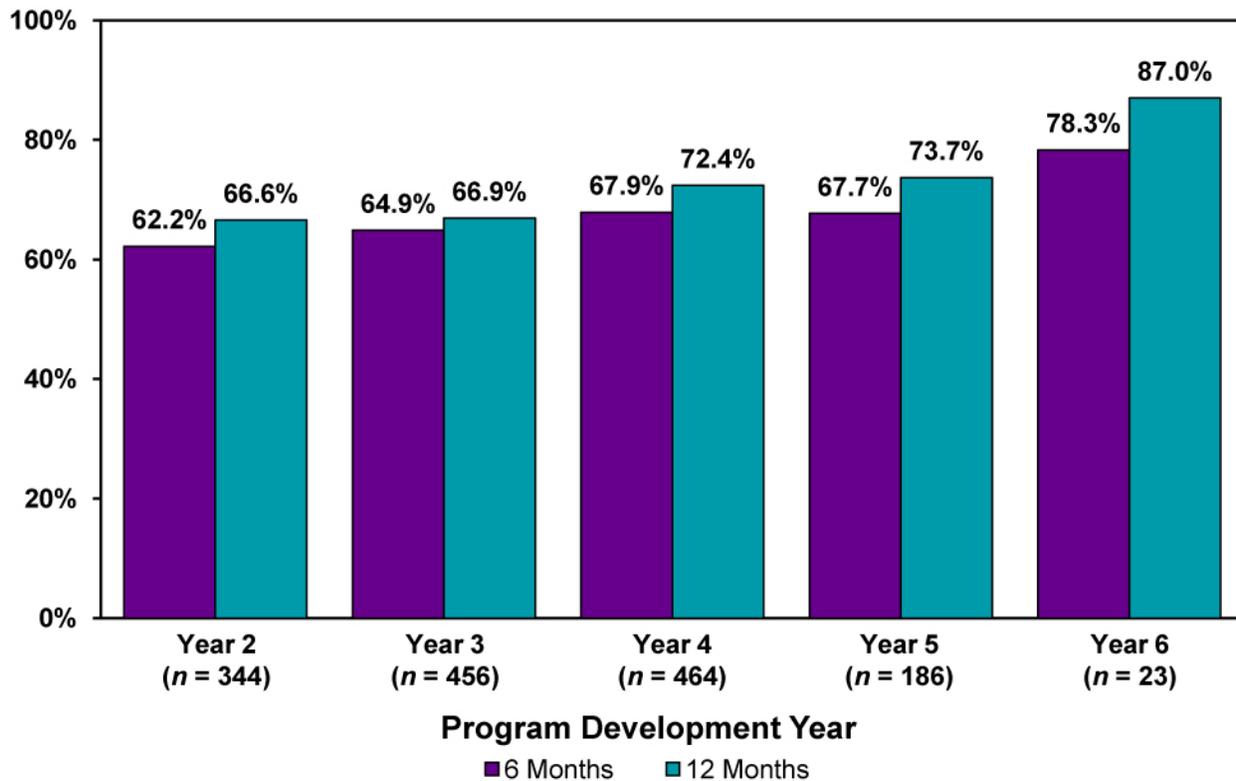
<sup>49</sup>  $n = 1,498$ ; 6-month–12-month:  $z = .09, p > .05$ ; Year:  $z = .93, p > .05$ ; (6-month–12-month) x Year:  $z = .23, p > .05$ .

**Figure 11**  
**Percentage of Youth Reporting Overall Satisfaction with Services**  
**at 6 and 12 Months Following Intake into Services by Program Development Year**



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 12**  
**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:  $z = 0.58, p > .05$ .

Attaining and maintaining this high level of youth consumer satisfaction was a remarkable achievement for system of care communities. Such achievement indicates that local communities were successful in accurately assessing strengths and needs of incoming youth and in arranging for or providing an effective set of services for youth during the first year of services. In addition, communities improved with each passing year. This level of achievement is even more remarkable when considering that both the caseload size and the level of clinical and functional severity of children and youth coming into the program increased through the middle years of the grant-funding cycle (see the section on children’s descriptive characteristics). These phenomena required increased effort on the part of program administrators, care coordinators, and service providers to meet the increasingly complicated needs of these children and youth. There continues to be room for system of care communities to improve, however, as the remaining one-fourth to one-third of youth did not report overall satisfaction with their services, their progress, or their involvement in planning their services.

### Caregivers Were Satisfied with Services

Caregivers also reported overall satisfaction with services their children and families received from system of care communities initially funded in 1997, 1998, 1999, and 2000, the progress their children made, and their own involvement in planning the services for their children and families. Caregiver report of overall satisfaction with services was consistently at or above 75 percent, with no significant differences between 6 months and 12 months after service intake or across development years.<sup>50</sup> Similarly, caregiver satisfaction with their involvement in service planning was consistently at or above 80 percent, with no significant differences at 6 months and 12 months after service intake or across development years.<sup>51</sup> Thus, caregivers were consistently as satisfied in these areas after 12 months of services as they were after 6 months after services across program development years.

Inspection of Figure 13 indicates that while caregiver satisfaction with their child's progress did not differ significantly between 6 months and 12 months after service intake, there was a significant increase in the percentage of caregivers satisfied with their child's progress from year to year.<sup>52</sup> This suggests that although caregiver satisfaction did not significantly increase during the second 6 months of services across time, the overall percentage of caregivers who were satisfied with the progress of their child increased each year. These findings should be interpreted with caution for development year 6 given the small number of cases.

As indicated earlier regarding youth satisfaction, achieving and maintaining a high level of caregiver satisfaction in these three areas is a remarkable achievement by system of care communities. These high levels of satisfaction indicate that system of care communities initially funded in 1997, 1998, 1999, and 2000, were successful in listening and responding to what parents and other caregivers wanted and needed for their children and families, in developing and arranging for or providing effective services, and in including parents and other caregivers in the process.

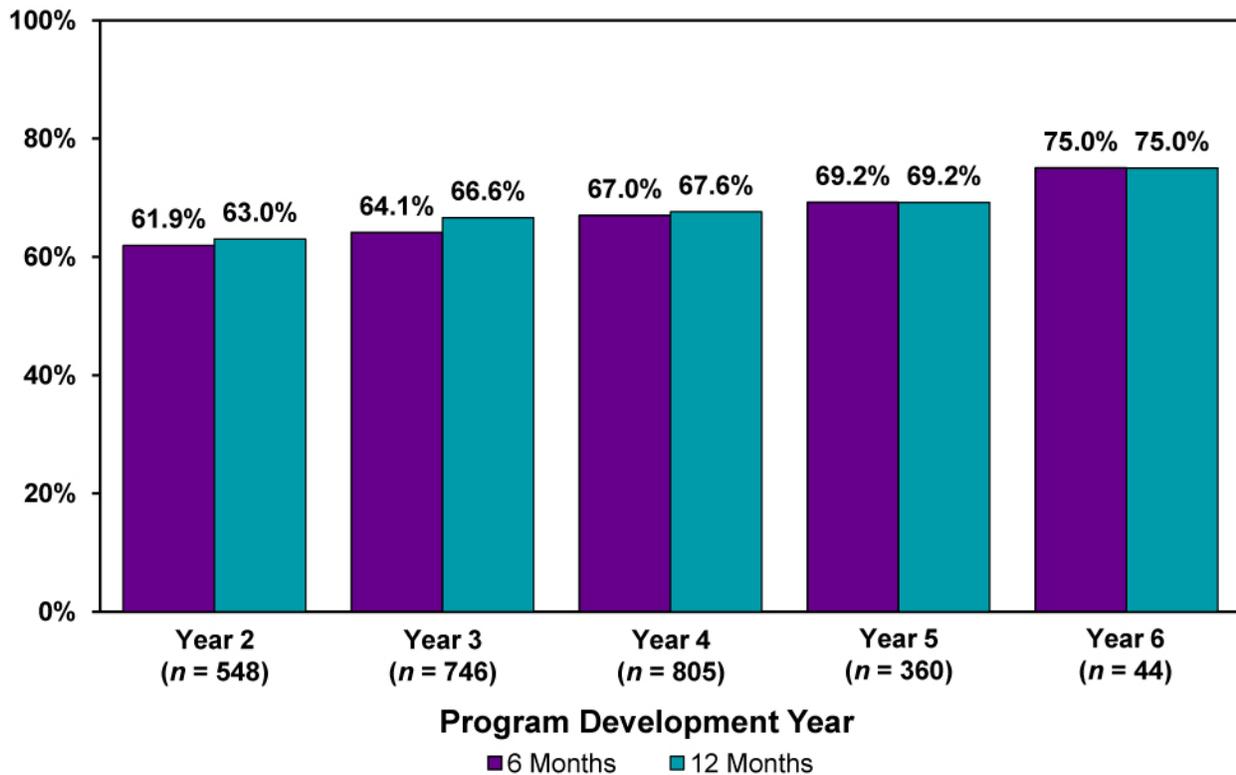
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<sup>50</sup>  $n = 2,502$ ; 6-month–12-month:  $z = .88, p > .05$ ; Year:  $z = 1.31, p > .05$ ; (6-month–12-month) x Year:  $z = -1.06, p > .05$ .

<sup>51</sup>  $n = 2,497$ ; 6-month–12-month:  $z = -.43, p > .05$ ; Year:  $z = .43, p > .05$ ; (6-month–12-month) x Year:  $z = .07, p > .05$ .

<sup>52</sup>  $z = 2.88, p < .05$ .

**Figure 13**  
**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:  $z = -0.38, p > .05$ .

### **Individualized Services**

One of the underlying principles that guide systems of care is that services to children and their families should be individualized according to their own unique strengths and needs. The system of care assessment measures the extent to which communities develop and implement program infrastructure that supports the delivery of individualized services and the extent to which services actually are planned and provided in an individualized manner.

Indicators of achievement at the infrastructure level include the following:

- Staff and service providers are trained on the concept of individualized care.
- A complete wide array of services is created and maintained.
- Flexible funds are available to purchase unique and creative services.
- Local assessment is conducted to assess achievement in providing individualized care across the service system.

Indicators of achievement at the service delivery level include the following:

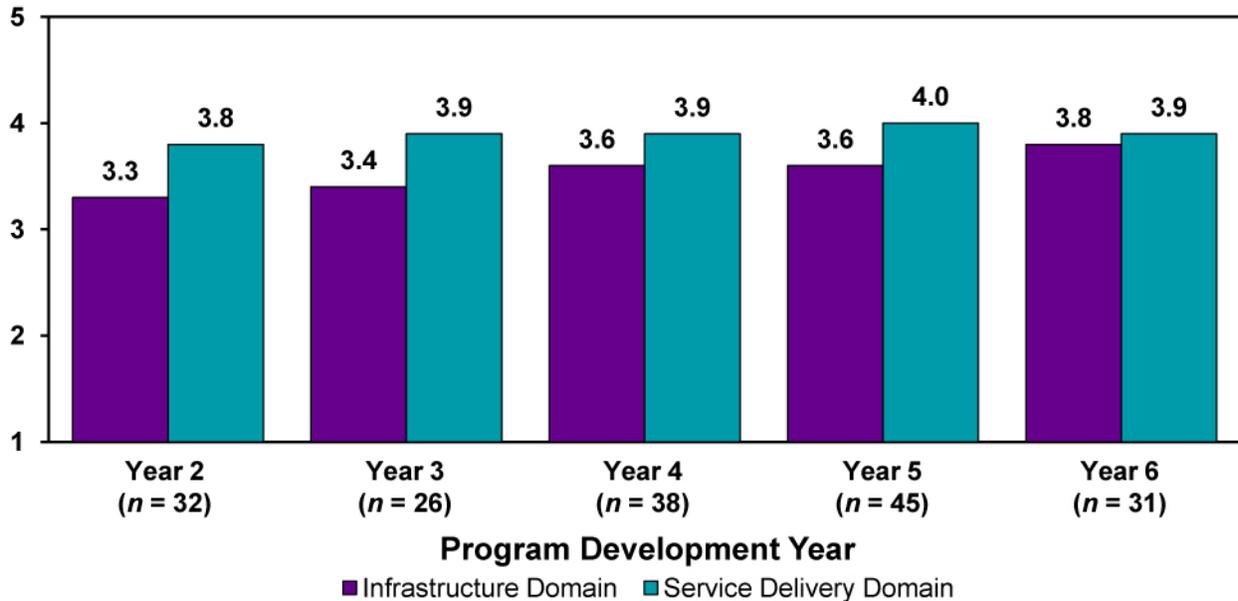
- Individualized service and treatment plans built on child strengths are developed and implemented for all children.
- Planned services match each individual child's needs.
- Planned services are delivered and monitored for continued appropriateness and progress.
- Children and youth are involved in planning their own services and in a case review process when it is needed.

### ***System of Care Communities Were Successful in Developing and Providing Individualized Services***

As shown in Figure 14, system of care communities initially funded in 1997, 1998, 1999, and 2000 were successful and showed improvement in the development and delivery of individualized services over the developmental years in both infrastructure and service delivery, although performance was better at the service delivery level than at the infrastructure level. Generally, communities trained their staff and providers and offered a complete and wide array of services, including flexible funding (see the following section on system development and achievements for more information), but were less successful in tracking the provision of individualized services across their local service systems.

In the service delivery domain, communities were successful in developing and monitoring the implementation of individualized service and treatment plans, but were less successful in describing how identified child strengths were used to develop and guide the planning and provision of services. Communities also were less successful in systematically and routinely involving children and youth in planning their own services and in any necessary care review, although, as noted above, a good majority of youth reported that they were satisfied with their level of involvement in these activities (see the following section for more information regarding youth involvement).

**Figure 14**  
**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 Used Flexible Funds***

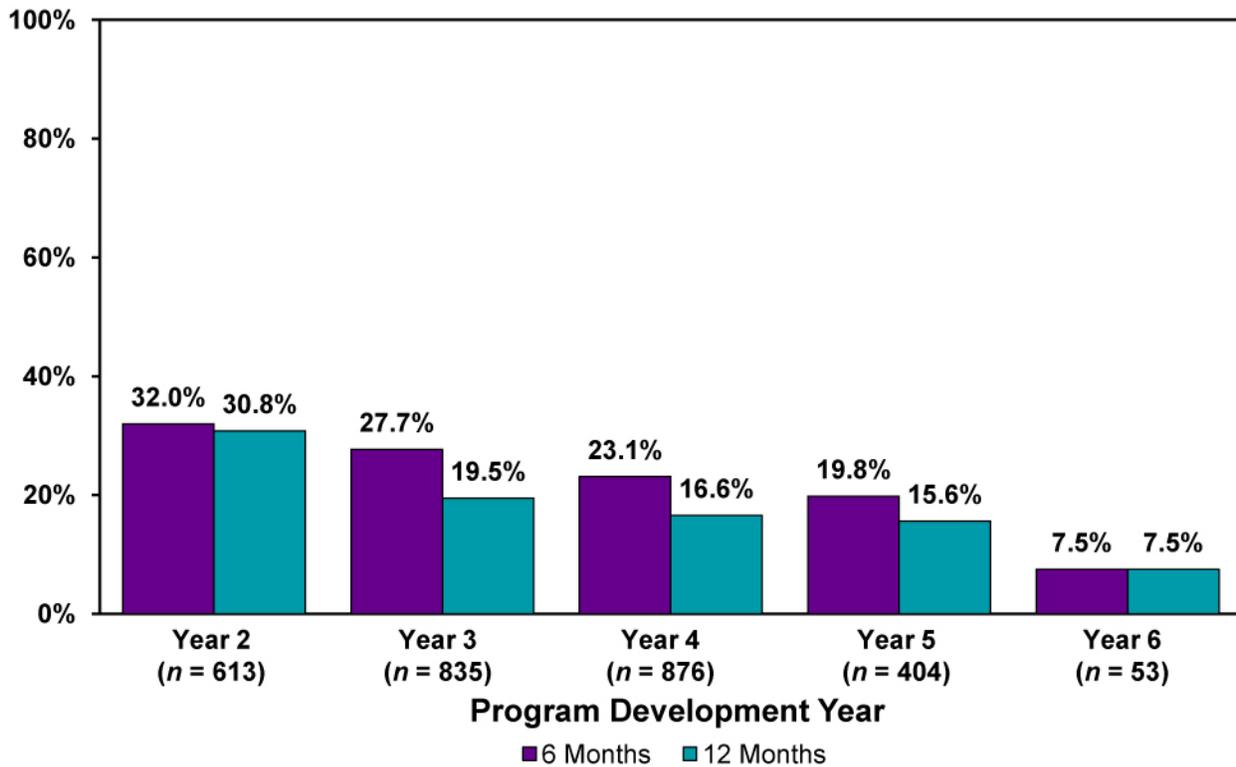
Flexible funds, often supported by CMHI grant dollars, were used by system of care communities initially funded in 1997, 1998, 1999, and 2000 to provide services for families that were not available through other sources. Nearly all communities included the use of flexible funds at some level to provide needed services for children and their families (see the following section on system development and achievements). The extent to which families received services provided through flexible funding was reported by caregivers after 6 months of being enrolled in the program (assessing receipt during the previous 6 months) and again at 12 months.

As shown in Figure 15, almost one-third of caregivers for whom data were available reported receipt of services provided through flexible funds at 6 months and again at 12 months after program enrollment in year 2. The percentage of caregivers reporting the receipt of these services significantly decreased in each succeeding year until the last year, when only 7.5 percent

reported such support,<sup>53</sup> although the small sample of cases in year 6 of program development indicates this finding should be interpreted with caution.

The percentage of caregivers reporting the receipt of services provided through flexible funds decreased 12 months after enrollment in the program compared to 6 months in each development year, although these differences were not significant. Similarly, there were no significant changes in these differences over time. This suggests that families who received services supported by flexible funds in the first 6 months of program participation also received such services in the second 6 months, consistently across program development years; however, significantly fewer families received services through flexible funding each year as the program matured which may reflect the difficulty of sustaining this type of support as grant dollars decrease over years of program development.

**Figure 15**  
**Percentage of Caregivers Reporting Receipt of Services Provided through Flexible Funds at 6 and 12 Months Following Intake into Services by Program Development Year**



6-month–12-month:  $z = -0.92, p > .05$ ; Year:  $z = -5.78, p < .001$ ; (6-month–12-month) x Year:  $z = -1.21, p > .05$ .

<sup>53</sup>  $z = -5.7, p < .001$ .

### ***Case Management Services Were Common to All System of Care Communities***

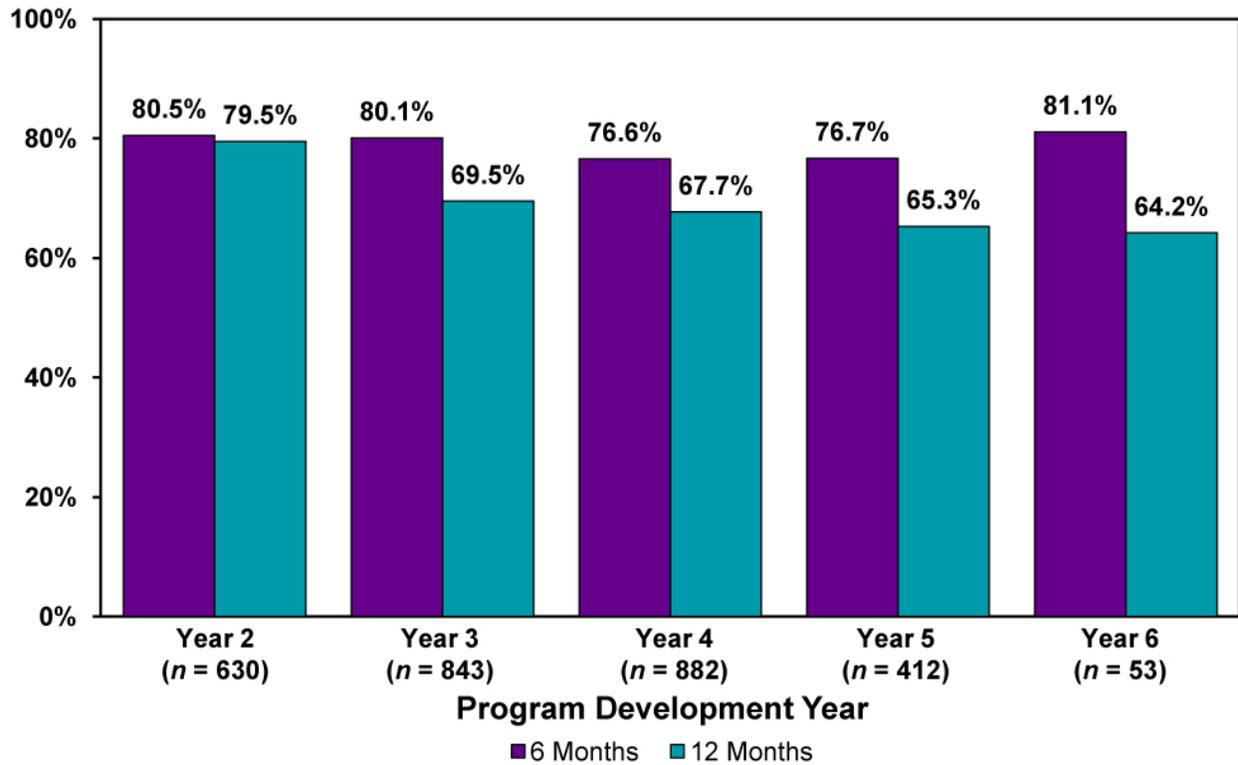
Case management services are a mainstay of systems of care and are included in the set of services required of local communities (see the following section on system development and achievements). While commonly found in system of care communities initially funded in 1997, 1998, 1999, and 2000, there was not always sufficient capacity to meet the need, resulting in wait lists for program entry or less intensive service provision over time. This finding is supported by both the system of care assessment that asks case managers (care coordinators) about the availability and capacity of case management services and by caregiver reports provided through the longitudinal outcome study.

According to caregivers enrolled in the outcome study and for whom data were available, these cohorts of graduated system of care communities were successful in providing case management services to a large majority of children and their families across development years (see Figure 16). Receipt of case management services during the first 6 months of services remained relatively stable with no significant differences across development years. However, the percentage who reported receiving case management services during the second 6 months decreased significantly.<sup>54</sup> This finding is consistent with established practice that more frequent and intense case management services are delivered during the beginning phase of intervention when the service need often is most critical, and then diminishing over time as stability is achieved and service goals are accomplished (Weil & Karls, 1985).

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<sup>54</sup>  $z = -2.20, p < .05$ .

**Figure 16**  
**Percentage of Caregivers Reporting Receipt of Case Management Services at 6 and 12 Months Following Intake into Services by Program Development Year**



6-month–12-month:  $z = -0.68, p > .05$ ; Year:  $z = -1.79, p > .05$ ; (6-month–12-month) x Year:  
 $z = -2.20, p < .05$ .

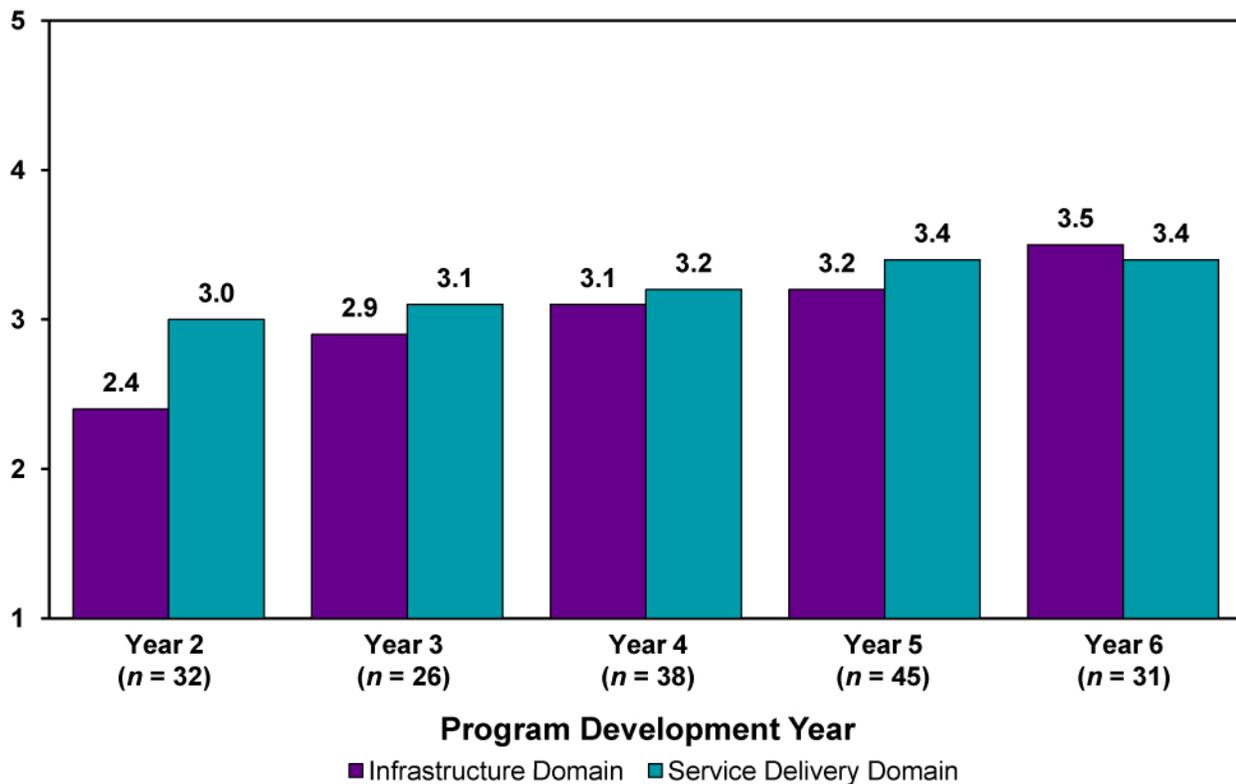
### **Cultural and Linguistic Competence**

Another underlying principle that guides system of care development is that service delivery systems should demonstrate cultural and linguistic competence in both the infrastructure of those systems and in direct service delivery. The system of care assessment evaluated each community's achievement in these two domains by determining the extent to which there was diversity in governance bodies, staff, and service providers; whether there were efforts to reach out to various cultural groups and communities; whether there was systematic assessment and incorporation of cultural traditions, beliefs, and practices into service and treatment plans; and whether efforts were expended to meet the various language needs of the children and families served.

### **System of Care Communities Improved in Cultural and Linguistic Competence**

An overall trend toward improvement in cultural and linguistic competence over time is illustrated in Figure 17.<sup>55</sup> System of care communities initially funded in 1997, 1998, 1999, and 2000 struggled during their early years of program development to implement this system of care principle, particularly in the infrastructure domain, but in later years progress was made toward a higher level of achievement. The same pattern of improvement is seen in the service delivery domain, where these cohorts of communities performed somewhat better. Related to infrastructure, communities made progress over time in recruiting and hiring diverse staff and increasing diversity on governing boards and in developing an array of culturally relevant services. Related to service delivery, these cohorts of communities made progress in planning and providing services in the primary languages as preferred by families served and in taking cultural issues into account when planning and providing services.

**Figure 17**  
**Mean System of Care Assessment Ratings on Cultural Competence**  
**in Infrastructure and Service Delivery Domains by Program Development Year**



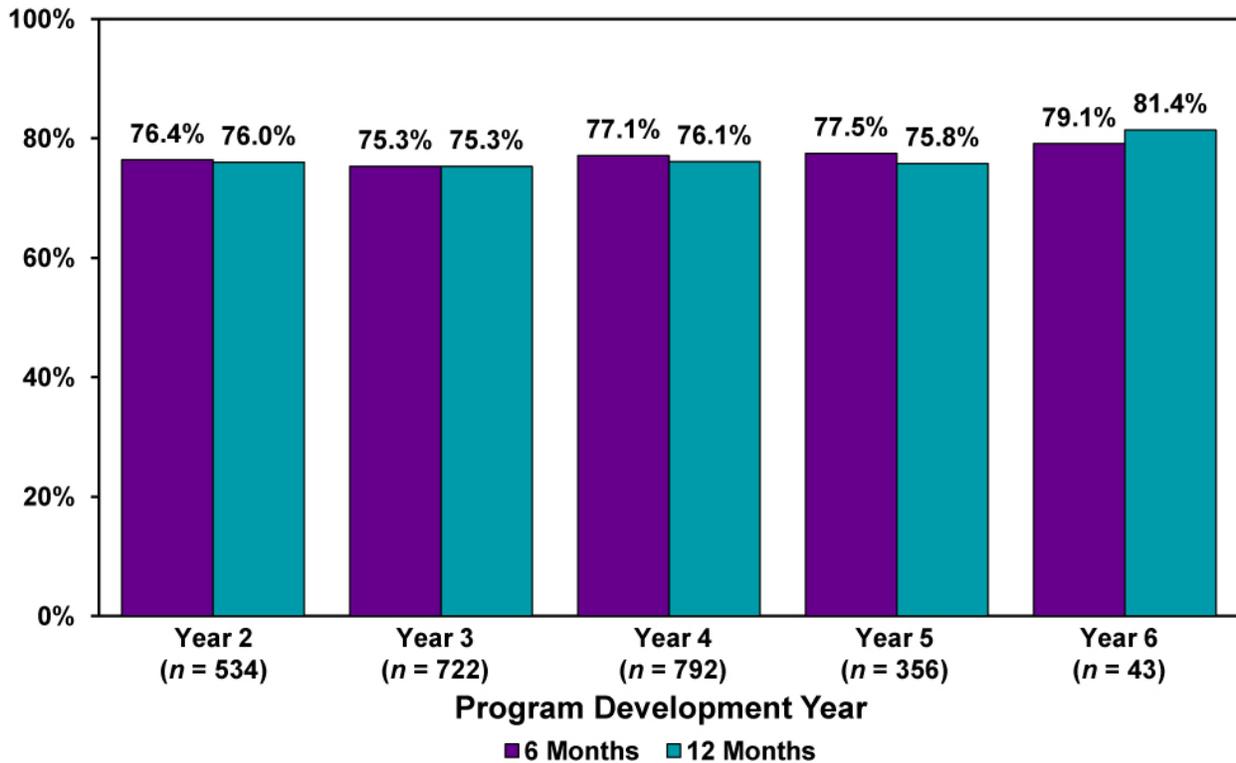
<sup>55</sup> See page 59 for a discussion and interpretation of the ratings.

### Caregivers Were Satisfied with the Cultural Relevance of Services

Caregiver satisfaction provides another vehicle to assess cultural and linguistic competence. Although the system of care assessment demonstrated challenges in reaching the goal of cultural and linguistic competence across communities initially funded in 1997, 1998, 1999, and 2000, caregivers enrolled in the longitudinal outcome study reported a high level of satisfaction both with the acknowledgment and incorporation of their family’s cultural traditions, beliefs, and practices during the service planning process, and with their service providers’ understanding of their cultural issues.

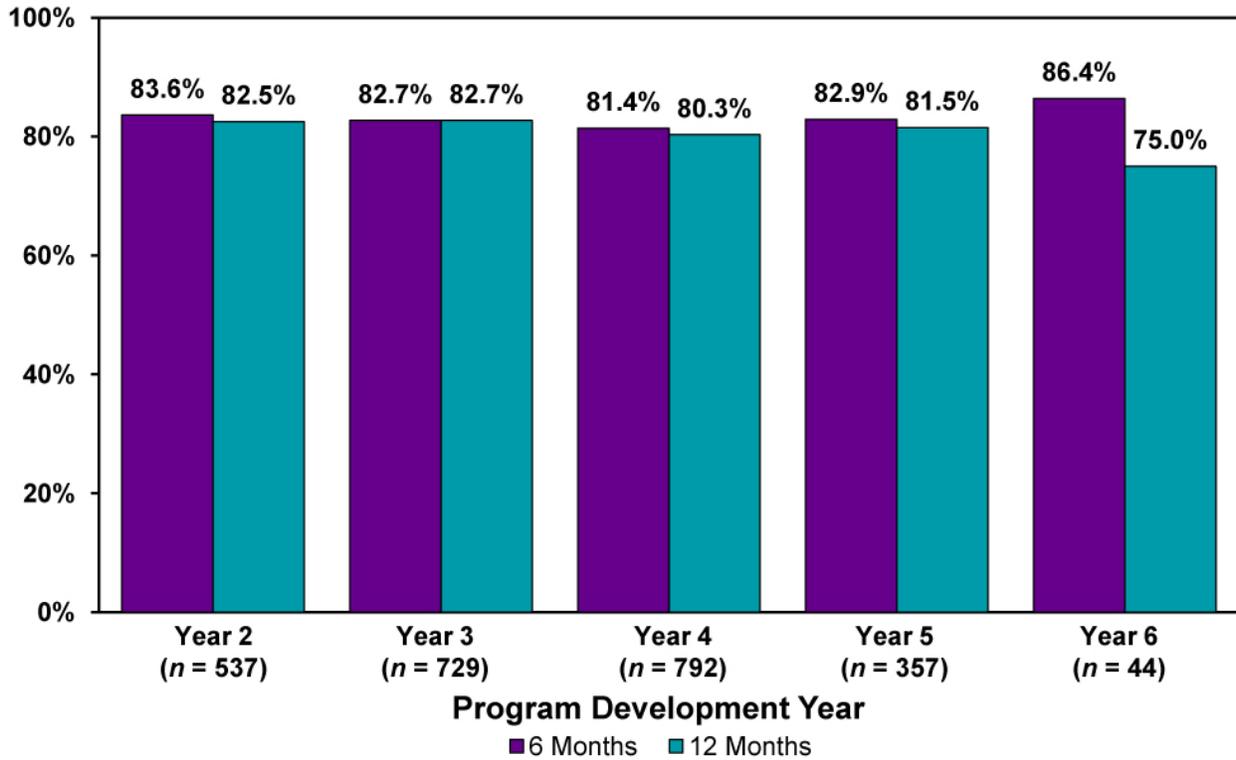
Consistently at 6 months and 12 months after service intake, caregivers’ satisfaction with their care coordinators’ or other providers’ efforts to refer them to culturally relevant services was at or above 75 percent (see Figure 18). Similarly, caregivers consistently rated their satisfaction with the service provider’s cultural understanding above 80 percent (see Figure 19). These high satisfaction rates did not diminish significantly over time. This suggests that after 12 months in services, caregivers were as satisfied with these areas of cultural competence as they were at 6 months in services, and communities were able to maintain these satisfaction rates across development years.

**Figure 18**  
**Percentage of Caregivers Satisfied with Referrals to Culturally Relevant Services at 6 and 12 Months Following Intake into Services by Development Year**



6-month–12-month:  $z = 0.05, p > .05$ ; Year:  $z = 0.72, p > .05$ ; (6-month–12-month) x Year:  $z = -0.27, p > .05$ .

**Figure 19**  
**Percentage of Caregivers Satisfied with Providers' Cultural Understanding**  
**at 6 and 12 Months Following Intake into Services by Development Year**



6-month–12-month:  $z = 0.17, p > .05$ ; Year:  $z = -0.38, p > .05$ ; (6-month–12-month) x Year:  
 $z = -0.57, p > .05$ .

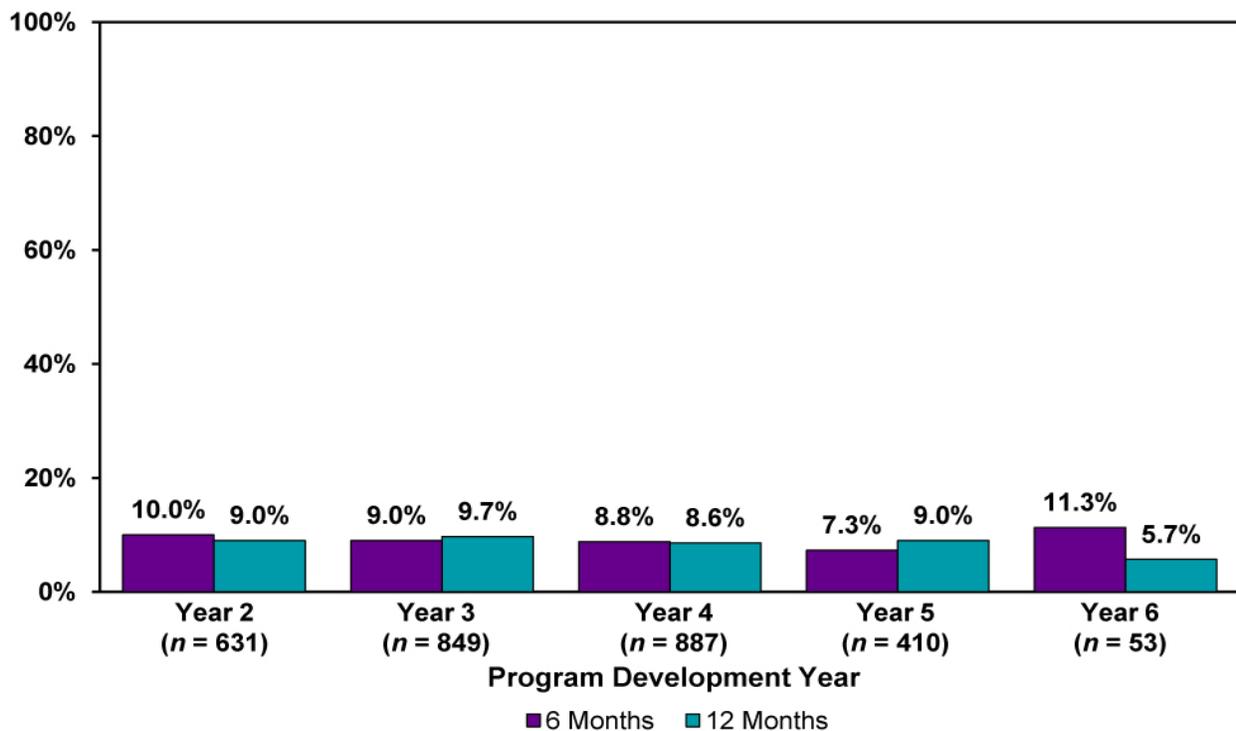
## Service Environments

### *Children Received Services in Least Restrictive Environments*

A third guiding system of care principle is that services should be provided in the least restrictive environment that is therapeutically appropriate. One indicator that measures the extent to which system of care communities initially funded in 1997, 1998, 1999, and 2000 were successful in adhering to this principle is the percent of children who were served in residential treatment facilities. Caregivers enrolled in the longitudinal outcome study were asked to report at 6 months after service intake and again at 12 months after intake whether their children had received services in a residential treatment facility during the previous 6 months.

As shown in Figure 20, the percentage of children who received services in residential treatment facilities was consistently low across program development years among these cohorts of communities. Similarly, the percentage of children who received services at residential treatment facilities in the first 6 months compared to the second 6 months did not differ significantly in any given year or over time. This suggests that communities were able to maintain low levels of placement in residential treatment facilities but were not able to reduce them further over time. The difference between 6 and 12 months in year 6 of program development should be interpreted with caution given the small sample of cases.

**Figure 20**  
**Percentage of Caregivers Who Reported Their Children Received Services**  
**in a Residential Treatment Facility within the Previous 6 Months at 6 and 12 Months**  
**Following Intake into Services by Program Development Year**



6-month–12-month:  $z = -0.38, p > .05$ ; Year:  $z = -1.28, p > .05$ ; (6-month–12-month) x Year:  
 $z = 0.50, p > .05$ .

## Cost Savings

### *Inpatient Care and Associated Costs Decreased*

The cost of inpatient hospital care is sizable compared to the cost of home-based services. According to the Agency for Healthcare Research and Quality (AHRQ), the national estimate of the average daily cost of inpatient hospital care in 2002 was \$1,501 per day (AHRQ, 2004). Caregivers were asked at intake and again after 12 months to report the number of days their child received inpatient hospital care during the previous 6 months. As shown in Table 16, the overall trend in average number of days in inpatient care did not differ significantly across program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000.<sup>56</sup> However, across all development years the average number of days per child spent in inpatient hospital care during the previous 6 months decreased after 12 months of services compared to intake into services, which suggests a significant program impact.<sup>57</sup> Given that communities were faced with similar levels of inpatient care among children entering services across development years, communities were consistently successful in reducing the average number of days in inpatient care after 12 months in services.

The ability to reduce the average number of days spent in inpatient hospital care translates into significant cost savings. As shown in Table 16, cost savings per child in each year of development were substantial and consistent, with no significant differences in cost savings per child from year to year.

**Table 16**  
**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 <sup>a</sup>	# 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 <sup>b</sup>
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:  $z = 0.51, p > .05$ .

<sup>a</sup> Includes cases with complete data at intake and 12 months for communities in development year.

<sup>b</sup> Average cost per day in inpatient hospital care = \$1,501.

**Source:** National estimates of average daily hospitalization charges were obtained from the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (NIS), 2002, Agency for Healthcare Research and Quality (AHRQ). The average daily charges of \$1,501 were based on the information from 120,015 discharges of patients between 1 and 17 years of age with a mental disorder as a chief reason for hospitalization. The NIS 2002 sample contains all discharge data from 995 hospitals located in 35 States (around 90 percent of all hospital discharges in the United States).

<sup>56</sup> Data are not presented for program development year 6 due to the small sample size.

<sup>57</sup>  $z = -2.37, p < .05$ .

## **Law Enforcement and Juvenile Justice Costs Decreased**

In addition to the cost savings associated with a decrease in inpatient hospital care, decreased law enforcement contacts and court appearances also translate into significant cost savings. Cost savings were calculated using information reported by youth on the number of arrests and of court appearances they encountered in the previous 6 months at intake into services and again at 12 months after service intake.

As shown in Table 17, there were fewer average arrests per child in the previous 6 months in each year at 12 months after service intake compared to at intake. Although these differences were not significant, it suggests a positive trend toward reducing the number of arrests. According to data from the Bureau of Justice Statistics, the average cost per juvenile arrest was \$4,149 in 2000 (CASA, 2004). As a result, any reduction in the number of arrests resulted in cost savings. Table 17 indicates that cost savings were realized in each year of program development of system of care communities initially funded in 1997, 1998, 1999, and 2000. There were no significant differences across years.

**Table 17**  
**Costs Savings Associated with Change from Intake to 12 Months**  
**in Number of Arrests within the Previous 6 Months<sup>a</sup>**

Program Development Year <sup>a</sup>	# 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 <sup>b</sup>
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:  $z = -0.61, p > .05$ .

<sup>a</sup> Includes cases with complete data at intake and 12 months for communities in each development year.

<sup>b</sup> 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.

**Source:** CASA (2004) reports the estimates based on the 2000 data from the Bureau of Justice Statistics. In 2000, State and local governments combined spent \$58 billion on law enforcement costs related to arrests. In the same year the total number of arrests was 13,980,297, yielding \$4,149 per arrest.

Court-related expenditures are additional costs that communities must incur when youth are involved in unlawful behavior, and the ability to reduce the number of court appearances is another way to achieve additional cost savings. As shown in Table 18, the overall average number of court appearances per child in the previous 6 months was consistent and did not differ significantly from year to year. However, across program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000, the average number of court appearances in the previous 6 months per child significantly decreased from intake into services

to 12 months after service intake;<sup>58</sup> this difference decreased significantly over time.<sup>59</sup> In each year, with the exception of year 5 of program development, the average number of court appearances decreased at 12 months after services compared to intake. However, the sample of cases in year 5 was somewhat smaller than in earlier years, which may explain this difference.

These findings suggest a significant program impact, and they provide encouraging evidence that providing community-based early intervention services in court-related case situations was successful in diverting youth from further exposure to and involvement with the juvenile justice system where they could possibly not receive medically sound mental health services. Youth entered services with similar levels of court history, but communities successfully reduced those appearances during the first 12 months of services. This finding, however, was not consistent from year to year, with the reduction in court appearances decreasing from year to year. However, as shown in Table 18, any reduction in the number of court appearances resulted in cost savings and communities realized cost savings in each year of program development with the exception of years 5 and 6. Results from years 5 and 6 of program development should be interpreted with caution given the smaller sample of cases in those years.

**Table 18**  
**Costs Savings Associated with Change from Intake to 12 Months**  
**in Number of Court Appearances within the Previous 6 Months**

Program Development Year <sup>a</sup>	# of Court Appearances at Intake	Average # Court Appearances per Child	# of Court Appearances at 12 Months	Average # Court Appearances per Child	Difference in Average # Court Appearances	Cost Savings per Child <sup>b</sup>
Year 2 (n = 509)	344	0.67	248	0.48	-0.19	\$400.03
Year 3 (n = 698)	447	0.64	325	0.46	-0.18	\$370.72
Year 4 (n = 694)	318	0.45	280	0.40	-0.05	\$116.14
Year 5 (n = 287)	172	0.59	214	0.74	0.15	-\$310.39
Year 6 (n = 34)	11	0.32	11	0.32	0.00	\$0

Intake–12-month:  $z = -2.63, p < .01$ ; Year:  $z = -1.90, p > .05$ ; (6-month–12-month) x Year:  $z = 2.02, p < .05$ .

<sup>a</sup> Includes cases with complete data at intake and 12 months for communities in development year.

<sup>b</sup> Average cost per court appearance = \$2,121. Cost savings per child were calculated by multiplying the difference in total number of court appearances between intake and 12 months by \$2,121 and dividing by the total number of cases for each year.

**Source:** CASA (2004) reports the estimates based on the 2000 data from the Bureau of Justice Statistics. In 2000, State and local governments combined spent \$28 billion in court costs. In the same year total number of individuals entering the court system was 13,244,197, yielding \$2,121 per court appearance.

<sup>58</sup>  $z = -2.63, p < .01$ .

<sup>59</sup>  $z = 2.02, p < .05$ .

## **Implementation of Evidence-Based Treatments in Community Settings**

The types and use of evidence-based treatments and interventions are important indicators of the quality of services children and families receive (NFC, 2003; National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment, 2001; SAMHSA, 2005a). According to the Evidence-Based Treatment Survey conducted in 2003–04 among system of care communities initially funded in 1997 and 1998 and two non-funded comparison communities, mental health service providers reported the use of a wide variety of evidence-based treatments and differed in their training and approaches to treatment implementation depending upon the evidence-based treatment they reported using in their work. The current sample was limited to those providers who reported they used at least one specific evidence-based treatment in the course of their work ( $n = 446$ ).

As shown in Table 19, by far the single most commonly reported treatment among this sample of providers was cognitive behavior therapy. Descriptive analyses were conducted on all six of the most frequently reported treatments listed below to identify the source of initial training and the extent to which providers implement the treatment protocol. Of those who reported using cognitive behavior therapy, 69 percent received initial training in graduate school and only 4.9 percent through in-service training. For wraparound users, 54 percent were trained through in-service training and only 7 percent in graduate school. Similarly, most providers who reported using case management indicated initial training through in-service (40 percent) rather than graduate school (18 percent).

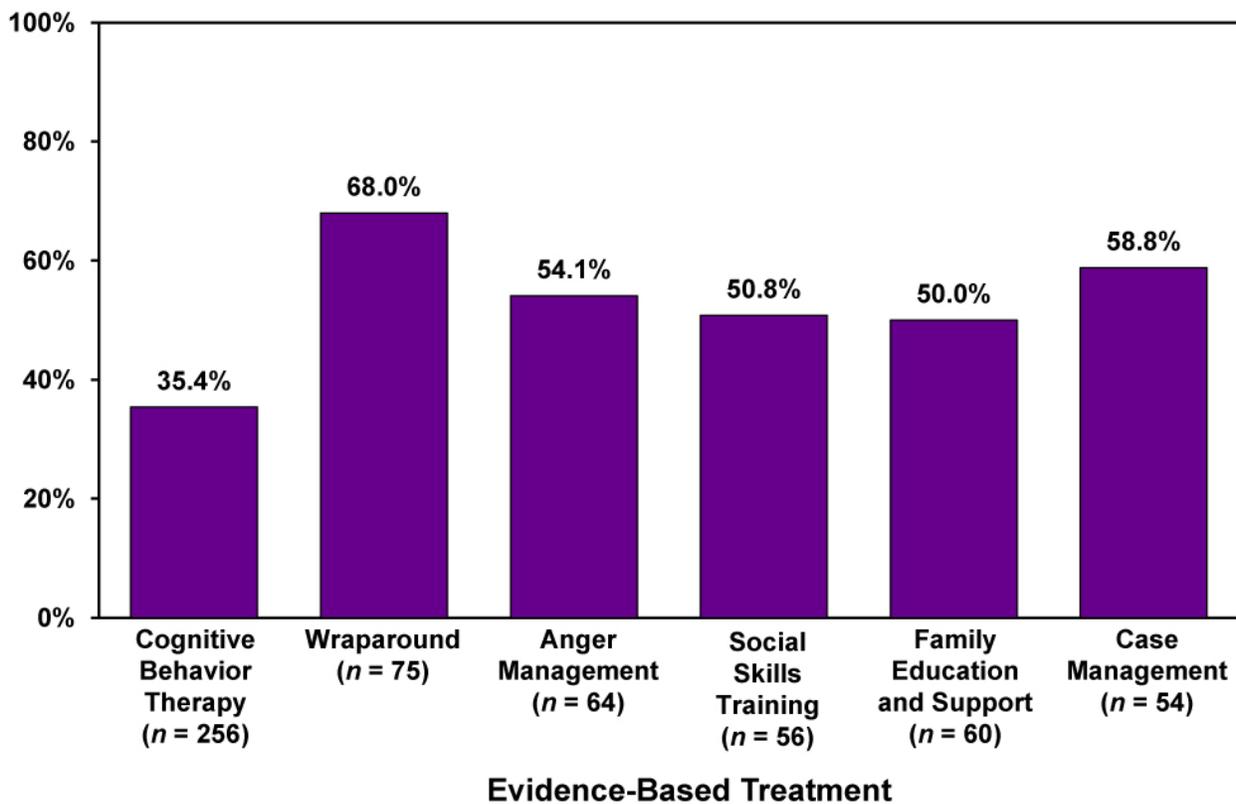
This suggests that agencies are called upon to provide training in service plan development and case management techniques whereas graduate schools more often prepare clinicians for developing and delivering therapeutic interventions such as cognitive behavior therapy. Training experiences for providers of anger management, social skills training, and family education and support were evenly split across both in-service and graduate school training opportunities.

**Table 19**  
**Most Commonly Reported Evidence-Based Treatments Used by Providers in the Course of Work**

<b>Evidence-Based Treatment</b>	<b>Percent of Providers Reporting Use of EBT (<math>n = 446</math>)</b>
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%

Providers also were asked to what extent they implemented the full treatment protocol for the evidence-based treatments they reported using (see Figure 21). Full or near full implementation occurred most frequently for wraparound services (68 percent) and least frequently for cognitive behavior therapy (about 35 percent).

**Figure 21**  
**Percentage of Providers Indicating They Always or Almost Always Implement the Full Treatment Protocol**



### **Summary**

The findings presented in this section are indicators of the extent to which system of care principles and values were integrated into practices and interventions and children and families received coordinated, clinically useful, and cost effective services among system of care communities initially funded in 1997, 1998, 1999, and 2000. Indicators of program success included increasing trends across program development years for youth satisfaction with services, youth involvement in treatment planning, and caregiver satisfaction with their child’s progress. Other indicators of program successes included significant cost savings associated with fewer overall days spent in inpatient hospital care (in the previous 6 months) for youth after 12 months of receiving services compared to intake, and significant cost savings associated with fewer court appearances (in the previous 6 months) after 12 months of receiving services compared to intake. Although not statistically significant, a positive trend also was found for cost savings related to the number of arrests for children receiving services. The average number of arrests per child (in the previous 6 months) decreased after 12 months of receiving services in

each program development year compared to intake into services, resulting in significant cost savings.

Other positive program impacts were found in the areas of cultural competence and individualized services. Significant program efforts focused on increasing the cultural competence of program services, which were illustrated by the positive trends in this area. System of care assessment ratings related to cultural competence in infrastructure and service delivery increased each year, demonstrating positive improvements in this area. In addition, the percentage of caregivers who were satisfied with referrals to culturally relevant services was consistently above 75 percent at both 6 and 12 months after intake into services, trending slightly upward across program development years. Similarly, caregiver satisfaction with the service provider's cultural understanding was consistently above 80 percent at both 6 and 12 months after intake, trending slightly upward across development years. In the area of individualized services, system of care assessment ratings showed positive trends in the ability of programs to provide individualized services.

Even though significant positive program impact was found in many areas, improvement still was needed at the end of grant funding in the use of flexible funding and the receipt of case management services among system of care communities initially funded in 1997, 1998, 1999, and 2000. Although one-third of caregivers reported receipt of services supported by flexible funds during program year 2, the proportion decreased slightly in each subsequent year. Similarly, although reported receipt of case management services was relatively high across all program development years, the overall trend was slightly downward over time.

Given the positive trends that were found in many program areas, including those that continued to show the need for improvement at the end of grant funding, it is important to understand the types of treatment interventions being used in community settings that further supported program efforts. Researchers have promoted the importance of an evidence base to inform effective treatment of children with mental health disorders in community settings (Burns, Hoagwood, & Mrazek, 1999). The results of the Evidence-based Treatment Survey demonstrated that those providing direct services to children with severe emotional or behavioral problems in systems of care used evidence-based treatments. However, provider training experiences and the provider's full implementation of the treatment protocol varied according to the evidence-based treatment being used. Efforts to improve the training experiences of direct mental health providers and support for the full implementation of evidence-based treatment protocols is one way to support continued quality improvement in the system of care service setting.

## **SYSTEM ACHIEVEMENTS IN INFRASTRUCTURE AND SERVICE DELIVERY**

System development in mental health care is a multifaceted process involving collaboration at the Federal, State, and local levels. Changes made at the system level can affect the ease with which children and families navigate through the service delivery system and ultimately affect the outcomes achieved. Based on key principles, the system of care program model delineates program activities that are necessary to achieve desired goals at the system, practice, and child and family levels. Information for this section of the report is drawn from system of care assessments that were conducted in system of care communities initially funded in 1997, 1998, 1999, and 2000 across their respective funding cycles. Discussion focuses on local program achievements at the system level, particularly in the context of family and youth participation, interagency relationships, service availability and capacity, and program sustainability.

The quantitative findings presented from system of care assessment data are derived from qualitative data that have been assigned ratings using ordinal ratings that range from 1 to 5, with 5 being the highest response category. An average rating is calculated from multiple respondents within each system of care community. Aggregate statistical analyses of the data have not been conducted for this report because the data are ordinal and because assessments are conducted according to a schedule related to the grant-funding cycle that results in an inconsistent configuration of communities for which data are available in any given development year. However, the data do yield trends that illustrate program achievements.

### **Family Involvement**

One underlying principle that guides systems of care, which also is expressed as one of the goals of the CMHI, is that families should be involved in all aspects of the system of care. Effective systems include families as partners in policy development and decision-making, program management and operations, service planning and provision, and quality monitoring, and provide families with the necessary supports to successfully engage in these activities.

Table 20 highlights some of the activities in which families typically were involved in system of care communities initially funded in 1997, 1998, 1999, and 2000 that supported program infrastructure, including policy development and program oversight, program management and operations, and quality monitoring. Challenges encountered by communities in increasing family involvement in system infrastructure activities included starting or establishing a firm relationship with a family support and advocacy organization and having an adequate number of family members available to serve on governing boards or to provide direct services to other families.

**Table 20**  
**Infrastructure Activities That Include Family Participation**

Level	Involvement
Policy and Program Oversight	<ul style="list-style-type: none"> <li>• Governance activities               <ul style="list-style-type: none"> <li>▪ Participate in strategic planning</li> <li>▪ Participate in budgetary decision-making</li> <li>▪ Assist in developing the service array</li> <li>▪ Sit on subcommittees (e.g., communications, cultural competence, evaluation, finance, intake)</li> <li>▪ Participate in establishing formal arrangements among agencies and partner organizations</li> </ul> </li> </ul>
Management and Operations	<ul style="list-style-type: none"> <li>• Training activities               <ul style="list-style-type: none"> <li>▪ Participate in conferences</li> <li>▪ Train staff on providing family-friendly services</li> <li>▪ Participate in staff training events (e.g., skills building, wraparound, respite care)</li> </ul> </li> <li>• Attend management meetings               <ul style="list-style-type: none"> <li>▪ Participate in program decisions</li> </ul> </li> <li>• Recruit staff               <ul style="list-style-type: none"> <li>▪ Interview potential candidates</li> <li>▪ Sit on hiring panels</li> </ul> </li> <li>• Serve as staff</li> <li>• Provide respite care, family support, mentoring, advocacy, care coordination, transportation services</li> </ul>
Quality Monitoring	<ul style="list-style-type: none"> <li>• Quality monitoring activities               <ul style="list-style-type: none"> <li>▪ Collect data (e.g., interview other families)</li> </ul> </li> <li>• Participate in evaluation committees (e.g., review surveys, present findings)</li> </ul>

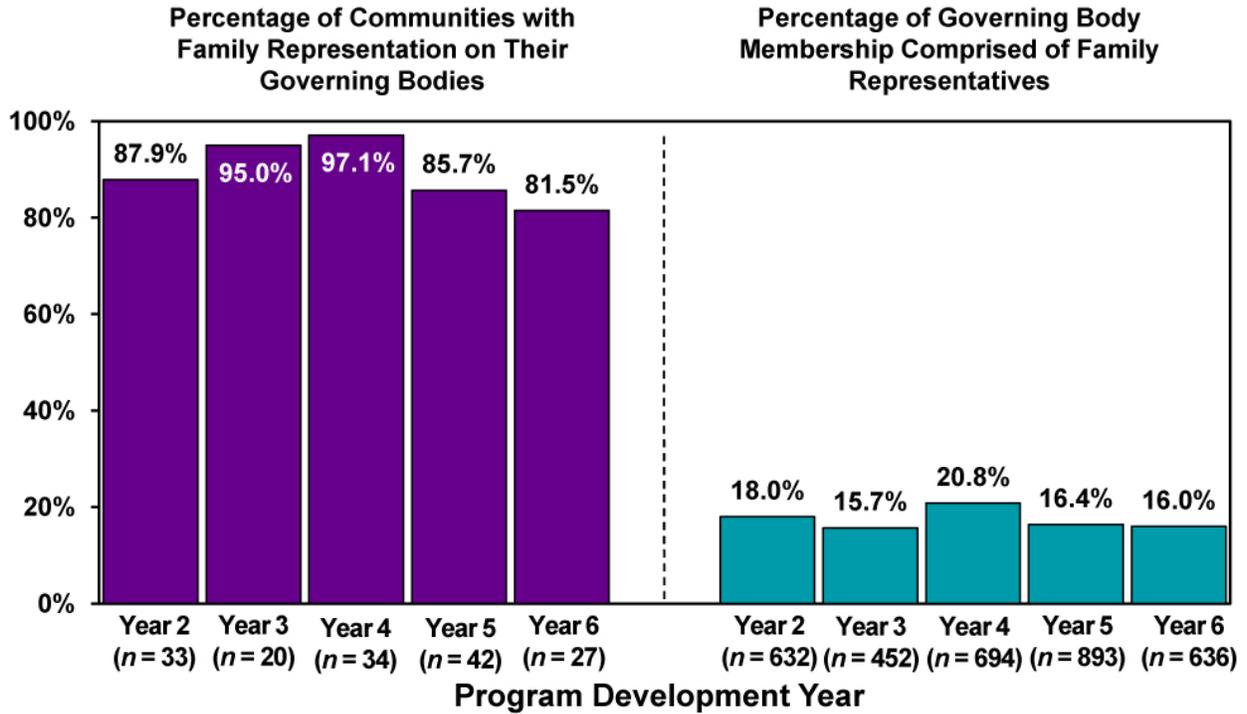
***Family Involvement in Governance Improved  
across Program Development Years***

Figure 22 shows the percentage of system of care communities initially funded in 1997, 1998, 1999, and 2000 that had family representation on their governing bodies and the percentage of governing body membership that was comprised of family members across development years. The findings indicate that almost all communities had family member participants on their system of care governing boards. Analyses from the qualitative data reveal that systems of care in American Indian and Alaska Native communities are governed by tribal councils or boards of directors comprised of elected members from their communities, which may or may not include consumer families. This group of system of care communities, in addition to one other community that used a parent consumer staff person to serve on the governing board, accounts for all communities that did not have family representation on their governing boards.

The size of governing bodies varies from community to community, ranging from as few as 10 to as many as 30 or more. While some governing bodies have bylaws that specify the proportion of family member participants to be as much as 51 percent, it is more usual for family voice to be represented by a few key persons such as the director of the family advocacy organization or a lead parent who serves as staff in the program. It is rare for family consumers to be active participants on governing bodies even when the system of care provides facilitating mechanisms such as evening meetings, child care, meals, or transportation. One explanation commonly offered is that due to the often demanding needs of caring for a child with serious emotional

disturbance and other family considerations, it is difficult for parents and caregivers to assume additional duties and obligations related to governing a system of care. The relatively small percentage of family membership on the governing bodies across development years is illustrated below.

**Figure 22**  
**Family Representation on Governing Bodies by Program Development Year**

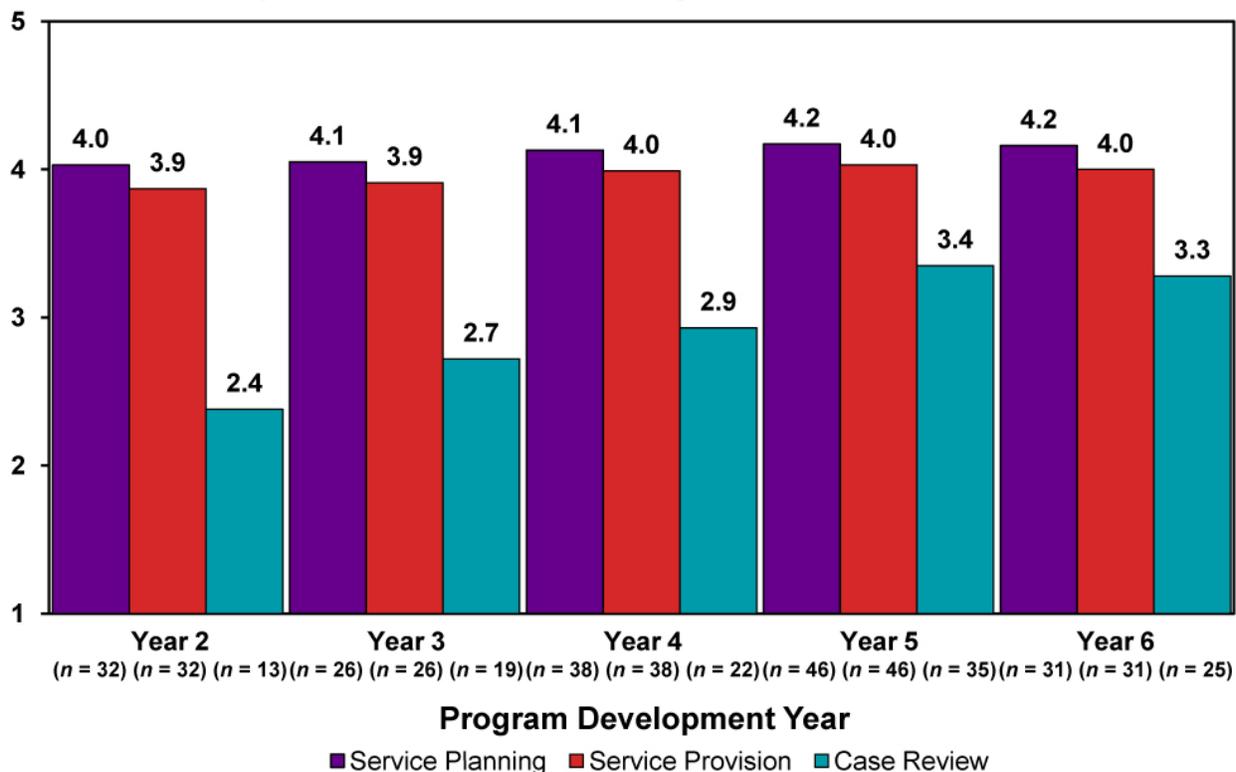


### **Family Involvement in Service Delivery Improved across Program Development Years**

System of care communities initially funded in 1997, 1998, 1999, and 2000 involved families in service delivery by engaging them as full partners in developing the service plans for their children and their families, by including them in the service delivery process, and by including them as participants when their child’s care was being reviewed to meet special service needs. Figure 23<sup>60</sup> indicates that communities

- were most successful in involving families in the service planning process and least successful in involving families in the case review process,
- improved over time in involving families in the service planning process and in including them in service provision activities, and
- 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.

**Figure 23  
Level of Family Involvement in Service Planning, Service Provision, and Case Review**



<sup>60</sup> See page 59 for a discussion and interpretation of the ratings.

## **Youth Involvement**

Involving youth in decision-making has become increasingly important in systems of care. The national evaluation began collecting information about youth involvement during a pilot study conducted in 2005 as part of the system of care assessment that examined youth involvement in all aspects of their local systems of care. Five focus groups were conducted with a total of 22 youth and 11 youth coordinators, and additional youth and youth coordinators were interviewed individually in five selected communities. Information about the youth involvement pilot study can be found in Appendix B. Preliminary findings from this pilot study indicated that in some system of care communities

- infrastructure was being developed to support the development and implementation of youth groups as a mechanism to provide peer and staff support,
- mechanisms were being developed for youth to participate in and organize activities with other youth,
- youth were involved in decision-making activities at the governance level and in conducting training or providing direct services, and
- youth were involved in the development and implementation of their own service plans and treatment.

Youth interviewed in the local communities ranged in age from 14 to 21 and included both males and females; all reported they were attending school or graduate school when interviewed. All reported they were respected and listened to by program staff, were included in developing their service plans and determining their treatment, and were given opportunities to help other young people in a variety of ways. Further, they reported that their involvement in system of care programs had provided them with opportunities for growth. Comments from some of the youth respondents on how the program has benefited them are included in the text box.

### ***Comments from Youth Respondents***

- This program has helped me to see myself as a helpful and caring person
- It has helped me to grow up and not give up because I can do whatever I want
- I have gotten a new job because of my experience in this program
- I do better in school
- I might have been in jail if it hadn't been for this program
- I used to think I was ugly and useless; now I don't
- I have more self confidence
- Last year I almost failed all my classes. This year I have A's in almost every class
- When I was in foster care, everything about me was perceived as negative, now I and others see the same things as strengths.

### ***Youth Involvement in Service Delivery Activities Improved across Program Development Years***

As noted earlier in this report, youth reported a high level of satisfaction with their involvement in service planning across all program development years of system of care communities initially funded in 1997, 1998, 1999, and 2000. The system of care assessment examined the extent to which youth were involved in service delivery activities from the perspective of their parents or other caregivers, care coordinators, and members of case review structures. According to these groups of respondents, system of care communities made improvements as indicated below (see Table 21).

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

The system of care assessment asked care coordinators, caregivers, and members of case review committees how children and youth were involved in their own service planning processes. Involvement ranged from giving input prior to actual team meetings to attending the meetings to various levels of engagement and decision-making roles during the meetings. The relatively high ratings given for responses obtained from care coordinators and caregivers indicate that children and youth almost always at least gave input prior to service planning team meetings. In addition, those of appropriate age and ability actually attended the meetings and participate in developing their goals and choosing their service options, although they were limited in final decision-making by parental concerns or permission and/or by mandated or court-ordered services over which they had no control.

The relatively low ratings given for responses obtained from members of case review committees indicate that children and youth rarely were involved in the case review process in any capacity. Explanations offered by respondents include (a) the committee meeting was not an appropriate forum in which children and youth should participate as it often dealt with various agencies negotiating payment arrangements for services, etc.; (b) the crisis situation that called for the committee to meet and resolve the issues at hand precluded the child or youth from attending; (c) the case review process was an internal agency quality monitoring process that had more to do with clinical review of practitioners' work than with active service planning and review; or (d) most review and decision-making took place at the regular child and family team level rather than at the official case review committee level, which may have put its efforts toward other activities not directly involving the case situations of individual children, youth, and families.

**Table 21**  
**Average Ratings of Youth Involvement in Service Planning and Case Review**  
**by Program Development Year as Reported by Case Review Committee Members, Caregivers, and**  
**Care Coordinators**

	Year 2	Year 3	Year 4	Year 5	Year 6
Average Ratings of Youth Involvement as Reported by Case Review Committee Members	1.60 [1.23] (n = 20)	2.05 [1.43] (n = 31)	2.37 [1.55] (n = 42)	2.38 [1.66] (n = 63)	2.46 [1.55] (n = 34)
Average Ratings of Youth Involvement as Reported by Caregivers	3.36 [1.40] (n = 77)	4.02 [1.16] (n = 44)	3.76 [1.47] (n = 82)	3.82 [1.37] (n = 83)	3.90 [1.25] (n = 53)
Average Ratings of Youth Involvement as Reported by Care Coordinators	3.95 [.86] (n = 86)	4.11 [.96] (n = 65)	4.07 [1.09] (n = 112)	4.20 [1.02] (n = 126)	4.19 [1.13] (n = 67)

**Note:** Average ratings presented with standard deviations in brackets. Average ratings range from 1 to 5, with 5 indicating that efforts made are effective and sufficient.

## **Interagency Involvement**

Another underlying principle that guides systems of care is that the core publicly funded child-serving agencies (i.e., child welfare, health, juvenile justice, education, mental health) should be involved as full partners in both infrastructure and service delivery activities. The system of care assessment measures the extent to which partner agencies are involved in local program governance, management and operations, development of the service array, and quality monitoring (infrastructure level). It also measures the extent to which partner agencies participate in intake to system of care services, service planning, service provision, and case review activities (service delivery level).

### ***System of Care Communities Improved in Interagency Involvement in Both Infrastructure and Service Delivery Activities across Program Development Years***

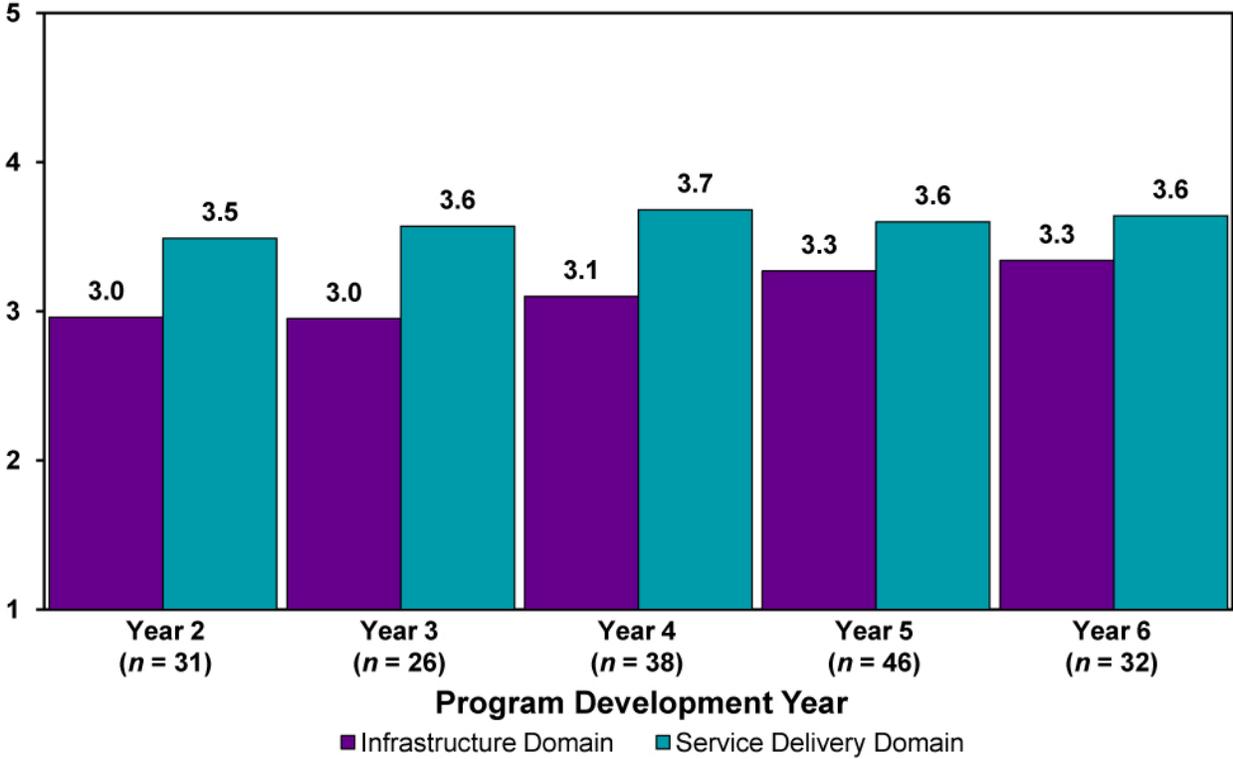
Figure 24<sup>61</sup> indicates that, overall, system of care communities initially funded in 1997, 1998, 1999, and 2000 improved in establishing partnerships among child-serving agencies to develop and implement infrastructure that supported their systems of care and in providing direct services to the children and families served by the program. Communities were most 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. These cohorts of communities were less successful in achieving cross-agency governance, program management and operations, service provision, or quality monitoring partnerships (infrastructure level).

One example of how these cohorts of communities created cross-agency intake opportunities include the outstationing of mental health clinicians or care coordinators in schools, child welfare offices, or juvenile court or detention centers. This permitted ready access to children and youth in their natural environments and facilitated the provision of information and support to the personnel of those agencies. Other examples include developing a single, unified intake and referral form and process that could be implemented by all child-serving agencies and establishing a “no wrong door” intake process that facilitated children and their families receiving appropriate mental health services regardless of which service portal they entered.

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<sup>61</sup> See page 59 for a discussion and interpretation of the ratings.

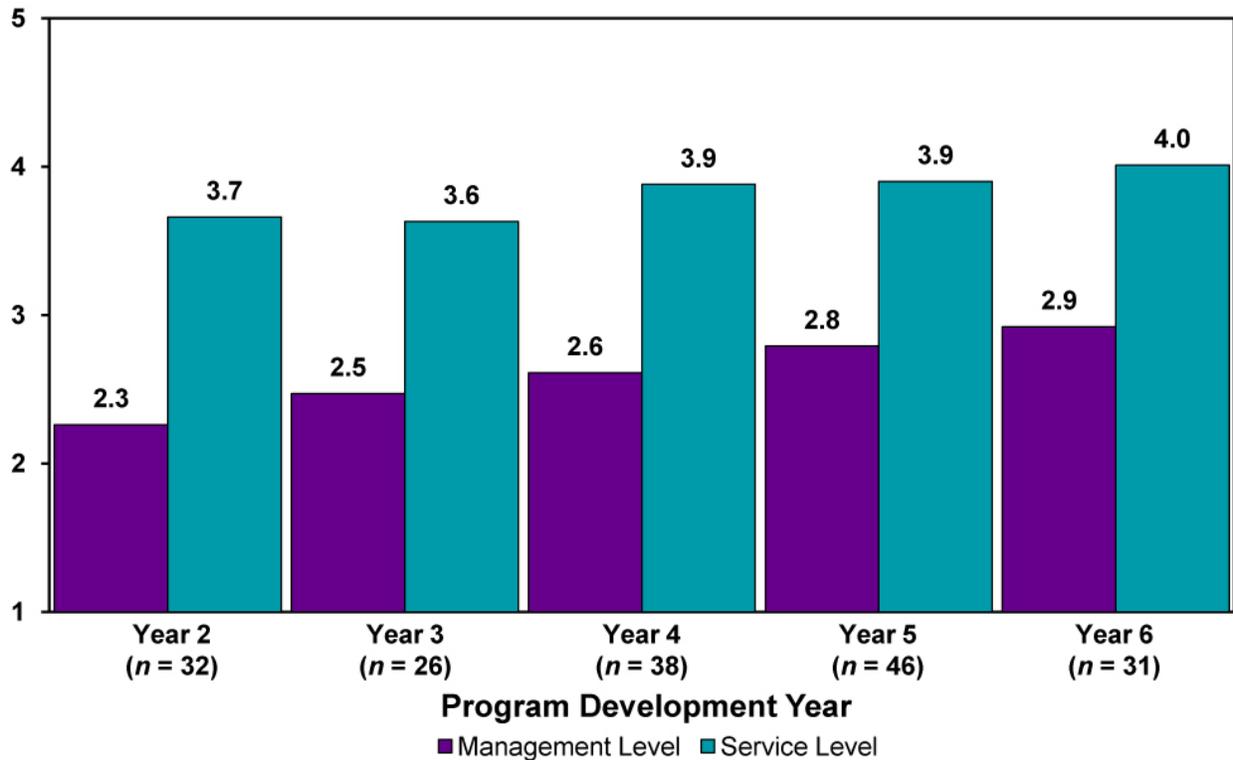
**Figure 24**  
**Interagency Involvement at the Infrastructure and Service Delivery Levels**  
**by Program Development Year**



***System of Care Communities Improved in Interagency Involvement  
in Program Management and Operations and in Service Planning  
across Development Years***

A closer examination of specific elements of the infrastructure and service delivery domains reveals that system of care communities initially funded in 1997, 1998, 1999, and 2000 successfully involved multiple agencies in jointly developing individualized service plans, and that they improved in this area across development years. Efforts to involve partner agencies in program management and operations activities such as having shared administrative processes (e.g., having unified case records, hiring and recruiting staff together, developing cross-training materials, using integrated management information systems) and having shared or blended funding also improved steadily across development years, although communities continued to struggle in achieving these system-change outcomes (see Figure 25).<sup>62</sup>

**Figure 25**  
**Interagency Involvement in Program Management and Service Planning  
by Program Development Year**



<sup>62</sup> See page 59 for a discussion and interpretation of the ratings.

## **Service Array**

As indicated earlier in this report, a primary goal of the CMHI is to provide or arrange for a broad array of effective services, treatments, and supports that include traditional, nontraditional, clinical, and support services that have enough capacity to meet the need, are accessible, and are community based and provided in the least restrictive environments possible. Services that local systems of care are required to provide, either by law or regulation, are listed in the text box to the right.

### ***Grant-Required Services***

- Diagnosis and evaluation
- Case management
- Outpatient individual, family, and group therapy
- Medication management
- Professional consultation
- 24-hour emergency
- Intensive home-based
- Intensive day treatment
- Respite
- Therapeutic foster care
- Transition to adult

Examples of additional services that are available to children, youth, and families served by some grant communities include

- advocacy,
- mentoring,
- parent support and education,
- special programs such as suicide prevention and victim services, and
- transportation.

Nearly all system of care communities initially funded in 1997, 1998, 1999, and 2000 reported using flexible funds to pay for unique services. Examples of services purchased with flexible funds included summer or sports camps, art programs, lessons for children (e.g., martial arts, music, swimming, horseback riding), basic family needs (e.g., utility and rent payments, clothing, automobile repairs, furniture), family outings, parenting classes, and independent living services for transition-aged youth (e.g., apprenticeships, employment support).

***The Percentage of System of Care Communities That Provided a Complete Array of Grant-Required Services Increased across Development Years***

As shown in Table 22 the percentage of system of care communities initially funded in 1997, 1998, 1999, and 2000 that provided a complete array of services as 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. A review of the qualitative data shows that of the required services, system of care communities experienced greater difficulty with continuously providing intensive day treatment, therapeutic foster care and transition to adult services in their service arrays across all program development years.

**Table 22**  
**Percentage of Communities That Provided a Broad Array of Services**  
**by Program Development Year**

	<b>Year 2 (%)</b>	<b>Year 3 (%)</b>	<b>Year 4 (%)</b>	<b>Year 5 (%)</b>	<b>Year 6 (%)</b>
Percentage of Communities That Provided All Required Services	48.6 (n = 35)	68.0 (n = 25)	71.1 (n = 38)	76.6 (n = 47)	93.1 (n = 29)
Percentage of Communities That Provided Additional Services	72.2 (n = 36)	80.0 (n = 25)	60.5 (n = 38)	74.5 (n = 47)	82.8 (n = 29)

### ***Service Capacity Improved for Some Services and Remained Stable for Others***

System of care communities initially funded in 1997, 1998, 1999, and 2000 reported their efforts to establish and maintain adequate service capacity within their service arrays to meet the needs presented to them by the children and families they serve. Those efforts included expanding service hours and locations, filling vacancies as soon as possible, increasing the number of staff, and increasing the number of contract providers.

The system of care assessment examined the extent to which communities were successful in providing grant-required services with sufficient capacity to meet the need, according to reports from care coordinators, across program development years. As shown in Table 23,<sup>63</sup> approximately 80 percent or more 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 in every development year of their programs. Two-thirds to three-fourths of care coordinators reported that there was sufficient capacity to meet child and family needs in three other required services, but only half or fewer reported enough capacity to meet the need for the remaining two required services. Specifically,

- 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.

The capacity to provide specific services to all who needed them varied from year to year, in no particular pattern across services or according to program maturity other than in the three broad categories outlined above and except for case management services which increased steadily each year. This may reflect the difficulty system of care communities faced in

- anticipating the service needs of children and families prior to service entry or changing needs during their course of treatment,
- successfully recruiting mental health and other providers to serve a difficult population in difficult environments,
- not having control over the availability or administration of some services such as intensive home-based or therapeutic foster care which often were provided through child welfare agencies, or
- purchasing needed services when State, local, or program resources were limited.

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<sup>63</sup> The variation in sample size from year to year is due to the differential number of site assessments conducted each year. Sites are assessed based on year of initial funding. As a result, the number of sites and associated respondents will vary each year. The number of respondents reporting on individual, group, and family therapy were grouped together.

**Table 23**  
**Percentage of Care Coordinators Reporting Services**  
**That Had Sufficient Capacity by Program Development Year**

<b>Service</b>	<b>Year 2 (%)</b>	<b>Year 3 (%)</b>	<b>Year 4 (%)</b>	<b>Year 5 (%)</b>	<b>Year 6 (%)</b>
<b>Most Successful</b>					
Professional Consultation	90.4 (n = 73)	90.0 (n = 60)	89.7 (n = 97)	92.4 (n = 118)	92.1 (n = 63)
Emergency Services	88.3 (n = 77)	84.4 (n = 64)	85.6 (n = 104)	92.0 (n = 125)	96.9 (n = 64)
Medication Management	89.7 (n = 78)	82.8 (n = 64)	89.4 (n = 104)	82.7 (n = 127)	73.4 (n = 64)
Case Management	81.8 (n = 77)	81.5 (n = 65)	84.5 (n = 110)	89.8 (n = 127)	88.2 (n = 68)
Diagnostic and Evaluation	85.9 (n = 78)	81.5 (n = 65)	85.2 (n = 108)	81.7 (n = 126)	77.3 (n = 66)
Individual, Group, and Family Therapy	84.1 (n = 227)	79.0 (n = 154)	76.1 (n = 248)	86.6 (n = 317)	78.5 (n = 153)
<b>Less Successful</b>					
Intensive Home-based	69.0 (n = 71)	78.7 (n = 61)	73.8 (n = 103)	74.1 (n = 116)	82.0 (n = 61)
Transition to Adult	71.4 (n = 56)	60.0 (n = 45)	74.1 (n = 81)	63.5 (n = 96)	82.6 (n = 48)
Intensive Day Treatment	67.2 (n = 64)	65.3 (n = 49)	63.7 (n = 91)	66.7 (n = 102)	59.6 (n = 57)
<b>Least Successful</b>					
Respite Services	54.4 (n = 68)	61.7 (n = 60)	46.0 (n = 100)	59.6 (n = 117)	44.4 (n = 63)
Therapeutic Foster Care	47.9 (n = 73)	57.9 (n = 57)	57.6 (n = 92)	57.4 (n = 108)	59.6 (n = 52)

### ***Service Accessibility Improved in Some Measures and Remained Stable in Others***

The system of care assessment examined the extent to which services were accessible to children and families who received services from system of care communities initially funded in 1997, 1998, 1999, and 2000. Specifically, the assessment determined whether services were financially affordable, whether services were provided in convenient locations and at flexible or extended hours in the home communities of the children and families served by the program, and whether transportation was available (see Table 24). Ratings assigned to responses obtained from care coordinators indicate that these cohorts of communities:

- were most successful in providing financially affordable services (e.g., at no or reduced cost to families), providing services in convenient locations (e.g., homes or community settings in addition to agency offices), and providing transportation assistance through various mechanisms (e.g., bus tokens, cab fare, gas money, staff vehicles);
- improved over the course of their program development in providing services within the home communities of the children and families they served, and in conducting service planning meetings in convenient locations (e.g., homes or community settings in addition to agency offices) although there was some decrease in year 6; and
- were least successful in establishing flexible or extended work hours outside of the traditional business hours and week-days during which to provide services or conduct service planning meetings for the convenience of children and families.

**Table 24**  
**Measures of Service Accessibility by Program Development Year**

Service	Year 2	Year 3	Year 4	Year 5	Year 6
<b>Most Successful</b>					
Financially Affordable Services	4.83 [.46] (n = 84)	4.79 [.54] (n = 66)	4.78 [.54] (n = 114)	4.82 [.50] (n = 127)	4.81 [.51] (n = 70)
Convenient Locations for Service Provision	4.46 [.70] (n = 85)	4.64 [.53] (n = 69)	4.71 [.52] (n = 114)	4.73 [.51] (n = 131)	4.66 [.62] (n = 70)
Transportation Assistance	4.31 [.99] (n = 82)	4.46 [.82] (n = 66)	4.50 [.94] (n = 114)	4.44 [.95] (n = 126)	4.44 [1.11] (n = 70)
<b>Improved</b>					
Services Available in Home Communities	4.24 [.70] (n = 83)	4.22 [.73] (n = 68)	4.26 [.81] (n = 111)	4.31 [.73] (n = 127)	4.42 [.61] (n = 66)
Convenient Locations for Service Planning Meetings	4.07 [1.00] (n = 84)	4.20 [1.07] (n = 68)	4.26 [.94] (n = 114)	4.29 [.89] (n = 131)	4.12 [.95] (n = 70)
<b>Least Successful</b>					
Flexible or Extended Hours for Service Provision	3.60 [1.00] (n = 85)	3.79 [1.00] (n = 69)	3.73 [1.01] (n = 114)	3.68 [1.13] (n = 131)	3.74 [1.11] (n = 70)
Flexible or Extended Hours for Service Planning Meetings	3.46 [1.08] (n = 84)	3.54 [1.19] (n = 68)	3.47 [1.14] (n = 114)	3.53 [1.10] (n = 131)	3.59 [.96] (n = 70)

**Note:** Average ratings presented with standard deviations in brackets. Average ratings range from 1 to 5, with 5 indicating that efforts made are effective and sufficient.

***Communities Improved in Providing Services in Least Restrictive Environments, and Remained Stable in Providing Community-Based Services***

Figure 26<sup>64</sup> displays how well system of care communities initially funded in 1997, 1998, 1999, and 2000 developed mechanisms for and provided services in least restrictive environments and within the home communities of the children and families served by their programs across program development years. The findings indicate that:

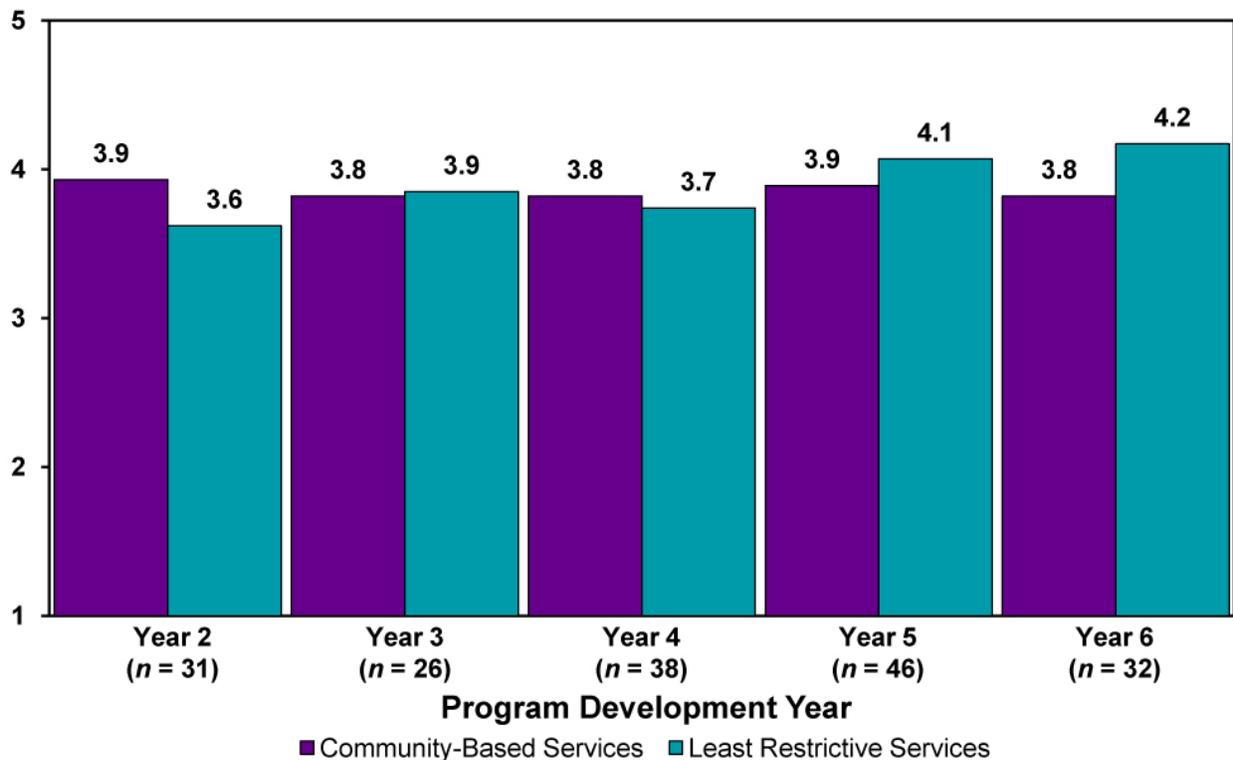
- system of care communities improved in providing services in least restrictive environments across each program development year, but particularly in years 5 and 6, and
- some programs were already providing services to some extent within the home communities of the children and families served when they received their grant funds, a practice that continued across program development years.

<sup>64</sup> See page 59 for a discussion and interpretation of the ratings.

Some approaches used by system of care communities to provide services within home communities and to reduce the use of restrictive service settings include

- home-based case management, therapeutic, and support services;
- outstationed school-based teams;
- one-on-one services with family advocates or mentors;
- development of a juvenile wellness center that included outpatient rehabilitation and treatment services; and
- establishment of mobile crisis response and stabilization services.

**Figure 26**  
**Service Provision of Community-Based and Least Restrictive Services**  
**by Program Development Year**



## **Sustainability Strategies and Lessons Learned**

All aspects of the system of care program will be sustained because . . .

“Those of us working in it see that it works, so we will carry those values with us wherever we may go, even 10 years from now.”

“Awareness is here in all areas. It is up to us to promote them (the principles).”

Sustaining the system of care can be a challenge for communities. They must commit to the system of care philosophy and its principles, while also adhering to broader State or local policy initiatives. Communities also are expected to obtain fiscal support to replace the time-limited Federal grant funds in order to sustain their system of care. To achieve a sustained program, communities must establish strong agency partnerships and garner support from other funding sources such as foundations, local businesses, or charity and community organizations.

Analysis of qualitative data from the final system of care assessments conducted for communities who were in their final year of CMHS funding in 2005 (initially funded in 1999 and 2000) reveals that all of them anticipated that their programs would be sustained, at least to some extent. It was commonly reported that the principles of family-focused, individualized, culturally competent, interagency coordination and collaboration, and community-based services in least restrictive environments were solidly in place among most child-serving agencies and that agency practices had changed as a result of the system of care program. As some respondents put it: “It is clear that the system of care works and that working together is better.” “The program has helped our agency focus on the needs of the family as a whole, instead of just ‘fixing kids’ and putting them back into the home.” “This program is a way to unify the family.” The positive results discussed in this report underscore the importance of communities developing strategies that will continue to sustain financially accessible system of care services so families are able to receive community-based integrated services without risk of having to relinquish legal custody of their children to the State in order to access appropriate services.

Strategies used by communities to sustain the system of care philosophy, values, and approaches include

- continuously monitoring the service array;
- creating a sustainability workgroup or committee;
- enhancing existing partnerships as an ongoing effort;
- hiring diverse staff for family and community buy-in;
- teaching the system of care philosophy and values to child-serving agencies;
- training staff, families, and agency partners early and continuously throughout the life of the grant; and
- using program data to highlight program successes.

A common theme among respondents from many communities was that sustained service capacity and access to a broad service array after CMHS funding was terminated was dependent upon continued financial support and that the magnitude, extent, and sources for that support were not always clear. Some of the more common fiscal strategies reported by communities to maintain their systems of care include

- increasing the use of Medicaid,
- integrating third-party billing into other child-serving systems,
- securing increased or dedicated funds through tax initiatives,
- using State and local agencies to match funds, and
- accessing private foundation grant monies.

This concludes the presentation of findings from the retrospective analyses of system of care communities initially funded in 1997, 1998, 1999, and 2000 conducted for this report. The early findings from current and ongoing data collection from system of care communities initially funded in 2002 and 2003 follow.

## **PROGRAM RESULTS PART II: EARLY FINDINGS FROM SYSTEM OF CARE COMMUNITIES INITIALLY FUNDED IN 2002 AND 2003**

In response to the requirement that an annual report be presented to Congress for all funded system of care communities, this part of the report contains early findings from data collected to date across two cohorts of system of care communities that were initially funded in 2002 and 2003 and began serving children in fall 2003 and fall 2004, respectively, each in their second year of grant funding. The data for this section were collected after Office of Management and Budget approval was obtained for the national evaluation in April 2004 and are current to date. Retrospective analyses could not be conducted because grant funding and data collection are ongoing.

Some changes were made in the design of the descriptive and child and family longitudinal outcomes portions of the evaluation protocol for this phase of the evaluation. These revisions included the deletion of some measures, addition of others, and updating of others with more recent versions. These changes were made following expert review and suggestions to improve relevance and to reduce burden on children, youth, and families receiving services who participate in the evaluation, and on local community program staff who collect the data. Specifically, the Descriptive Information Questionnaire (DIQ) was divided into two components: the Caregiver Information Questionnaire (CIQ) and a record extraction tool called the Enrollment and Demographics Form (EDIF). Items moved to the EDIF included the child's demographic information, problems leading to referral and the referring agencies, the child's ZIP Code, and types of insurance the child has received in the last 6 months. The CIQ added new questions about acculturation and coercion, and questions that addressed suicidality and the role of primary care physicians. In addition, questions were added to the CIQ pertaining to availability of money and time necessary to meet families' basic financial, emotional, and social needs.

Other measures that were revised include the Multi-Sector Service Contacts Questionnaire (MSSC), the Delinquency Survey (DS), the Education Questionnaire (EQ), and the Substance Use Survey–A (SUS–A). Revised versions of the Child Behavior Checklist (CBCL) and Behavioral and Emotional Rating Scale (BERS) were substituted for earlier versions. For the CBCL, a young child version (for ages 1½–5 years; Achenbach & Rescorla, 2000) and an older child version (for ages 6–18 years; Achenbach & Rescorla, 2001) replaced the older version. For the BERS (Epstein, 2004), both the revised caregiver version and the new youth version were included. The Restrictiveness of Living Environments and Placement Stability Scale (ROLES) was revised and re-named the Living Situations Questionnaire (LSQ).

Measures that were dropped from the protocol included the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), the Consequences of Substance Use Scale (SUS–B), the Youth Self-Report (YSR; Achenbach, 1991b), the Family Resources Scale (FRS; Dunst & Leet, 1985), the Family Assessment Device (FAD; Epstein et al., 1983), and the Youth Satisfaction Questionnaire/Family Satisfaction Questionnaire (YSQ/FSQ). New measures added to the protocol included the Global Appraisal of Individual Needs Quick–Substance Related

Issues (GAIN Quick-R), the Family Life Questionnaire (FLQ), the Revised Children's Manifest Anxiety Scales (RCMAS; Reynolds & Richmond, 1978), the Reynolds Adolescent Depression Scale (RADS-2; Reynolds, 1986), the Youth Information Questionnaire (YIQ), the Cultural Competence and Service Provision Questionnaire (CSSP), and the Vineland Screener (VS; Sparrow et al., 1983).

The early findings presented here from the 25 communities initially funded in 2002 and 2003 include descriptive characteristics of the 3,577 children and youth for whom data were available at the time of this report and early clinical and functional outcomes of a subset of those children and youth who voluntarily agreed to participate in the longitudinal outcome study. As in other sections of the report, the specific number of children for whom data were available for each measure is included in the figures and tables presented below. Results should be interpreted with caution due to the preliminary nature of the data and the small sample sizes on which they were collected.

## **DESCRIPTIVE CHARACTERISTICS OF CHILDREN AND FAMILIES AT INTAKE**

### **Child Demographics and History**

#### ***The Majority of Children and Youth Entering Services in System of Care Communities Initially Funded in 2002 and 2003 Were Male, White or African American, and between the Ages of 7 and 18***

The demographic characteristics of children entering services in system of care communities initially funded in 2002 and 2003 are quite similar to the characteristics of children from earlier funding phases (see the previous section on children's descriptive characteristics). The majority of these children were male, either White or African American, and between the ages of 7 and 18.

In these funding cohorts, however, there are considerably more children of multi-racial and Hispanic descent (see Table 25). While earlier funding cohorts of system of care communities tended to increase the recruitment of children of Hispanic origin as they matured, the large increase found in communities initially funded in 2002 and 2003 over those initially funded in 1997, 1998, 1999, and 2000 noted below is likely due to the specific sites that were funded in the 2002 and 2003 cohorts. For example, there are multiple sites in California and Texas that serve largely Hispanic populations. Also, it is anticipated that the percentage will increase further when descriptive data from Puerto Rico, initially funded in 2002, become available.

**Table 25**  
**Demographic Characteristics of Children Served by**  
**System of Care Communities Initially Funded in 2002 and 2003**

	<b>(%)</b>
<b>Gender</b>	<b>(n = 3,577)</b>
Male	64.8
Female	35.2
<b>Age</b>	<b>(n = 3,554)</b>
Mean	12.3 years
Birth–3 years	3.0
4–6 years	7.0
7–11 years	26.8
12–14 years	27.5
15–18 years	23.6
19 to 21 years	2.0
<b>Race and Ethnicity<sup>a</sup></b>	<b>(n = 3,520)</b>
African American or Black	30.7
American Indian or Alaska Native	8.0
Asian	1.3
Of Hispanic origin	23.0
Native Hawaiian or Other Pacific Islander	4.7
White	42.2
Other	0.7
Multi-racial	22.4

<sup>d</sup> Because individuals may claim more than one racial background, the race variable may add to more than 100%.

**Mood Disorders, Attention-Deficit/Hyperactivity Disorders, and  
Oppositional Defiant Disorder Were the Three Most Frequently Assigned  
DSM-IV Diagnoses for Children and Youth Entering Services in System of  
Care Communities Initially Funded in 2002 and 2003**

Diagnostic information is collected from the child's record(s) at intake into services. For children receiving services from system of care communities initially funded in 2002 and 2003 and who were assigned a *DSM-IV* diagnosis, the five most frequent diagnoses were mood disorders, attention-deficit/hyperactivity disorders, oppositional defiant disorder, adjustment disorder, and post-traumatic stress and acute stress disorder (see Table 26). These results are similar to those of children in communities funded earlier; however, the percentage of children with mood disorders was greater than the percentage diagnosed with attention-deficit/hyperactivity disorders. The opposite was true for children who received services from system of care communities initially funded in 1997, 1998, 1999, and 2000. Also, post-traumatic stress and acute stress disorder (combined) were the fifth most frequent *DSM-IV* diagnoses for these children, whereas conduct disorders were the fifth most frequently reported *DSM-IV* diagnoses for children from system of care communities funded earlier.

**Table 26  
Clinical Diagnosis on Any Axis at Intake**

<i>DSM-IV</i> Diagnosis <sup>a</sup>	% (n = 2,719)
No diagnosis or diagnosis deferred on Axis I or II	57.6%
Mood Disorders	33.3%
Attention-Deficit/Hyperactivity Disorders	27.4%
Oppositional Defiant Disorder	21.1%
Adjustment Disorders	13.0%
PTSD and Acute Stress Disorder	8.4%
Other	7.8%
V Code <sup>b</sup>	7.8%
Substance Use Disorders <sup>c</sup>	6.1%
Anxiety Disorders	5.6%
Disruptive Behavior Disorder	5.6%
Learning, Motor Skills, and Communication Disorders	4.9%
Conduct Disorders	4.6%
Impulse Control Disorders	3.3%
Pervasive Developmental Disorders	2.5%
Mental Retardation	2.1%
Schizophrenia and Other Psychotic Disorders	2.0%
Personality Disorders	1.3%
Substance-Induced Disorders	0.3%

<sup>a</sup> Because children may have more than one *DSM-IV* diagnosis, diagnoses may sum to greater than 100%.

<sup>b</sup> V Code refers to relational problems, problems related to abuse or neglect, and additional conditions that may be a focus of clinical attention. Percentage does not include V71.09 (no diagnosis or condition Axis I or II).

<sup>c</sup> Substance use disorders include caffeine intoxication.

**Youth Served by System of Care Communities  
Initially Funded in 2002 and 2003 Reported High Levels of  
Cigarette, Alcohol, and Marijuana Use Prior to Intake**

At intake into services in system of care communities initially funded in 2002 and 2003, youth 11 years and older participating in the longitudinal child and family outcome study were asked whether they had ever used any of 18 different substances. The percentage who responded “yes” is reported for each substance in Table 27.

As seen below, cigarettes, alcohol, and marijuana/hashish had been used most frequently by youth prior to intake into services. Rates of other substance use, however, were relatively low for these youth. With the exception of the three drugs noted above, no other substance had been used by more than 10 percent of youth. A similar pattern was noted for youth who received services from system of care communities initially funded in 1997, 1998, 1999, and 2000.

**Table 27  
Substance Use History at Intake<sup>a</sup>**

Substance Used	Ever Used (%)
Cigarettes	47.1 (n = 544)
Alcohol	44.9 (n = 544)
Marijuana/Hashish	36.9 (n = 542)
Pain killers (e.g., Darvocet, Vicodin)	9.6 (n = 540)
Cocaine (all forms)	9.0 (n = 543)
Inhalants	8.1 (n = 542)
Chewing tobacco/Snuff	7.7 (n = 544)
Ritalin, Adderall, Desoxyn	7.2 (n = 539)
Tranquilizers (e.g., Valium, Xanax)	6.5 (n = 540)
Hallucinogenics (e.g., LSD, 'shrooms)	6.3 (n = 542)
Nonprescription/OTC (e.g., diet pills, No-Doz)	6.1 (n = 541)
Amphetamines/Stimulants	4.8 (n = 541)
MDMA (Ecstasy, X)	4.6 (n = 541)
PCP	2.0 (n = 542)
Barbituates/Sedatives (e.g., Seonol, Nembutal)	1.9 (n = 540)
Heroin	1.7 (n = 541)
Ketamine (Special K)	0.9 (n = 541)
GHB	0.4 (n = 540)

<sup>a</sup> Substance use information was based on self-reports from youth 11 years and older.

**More Than One-Third of Youth Entering Services in System of Care Communities Initially Funded in 2002 and 2003 Had Been Arrested by the Police Prior to Intake**

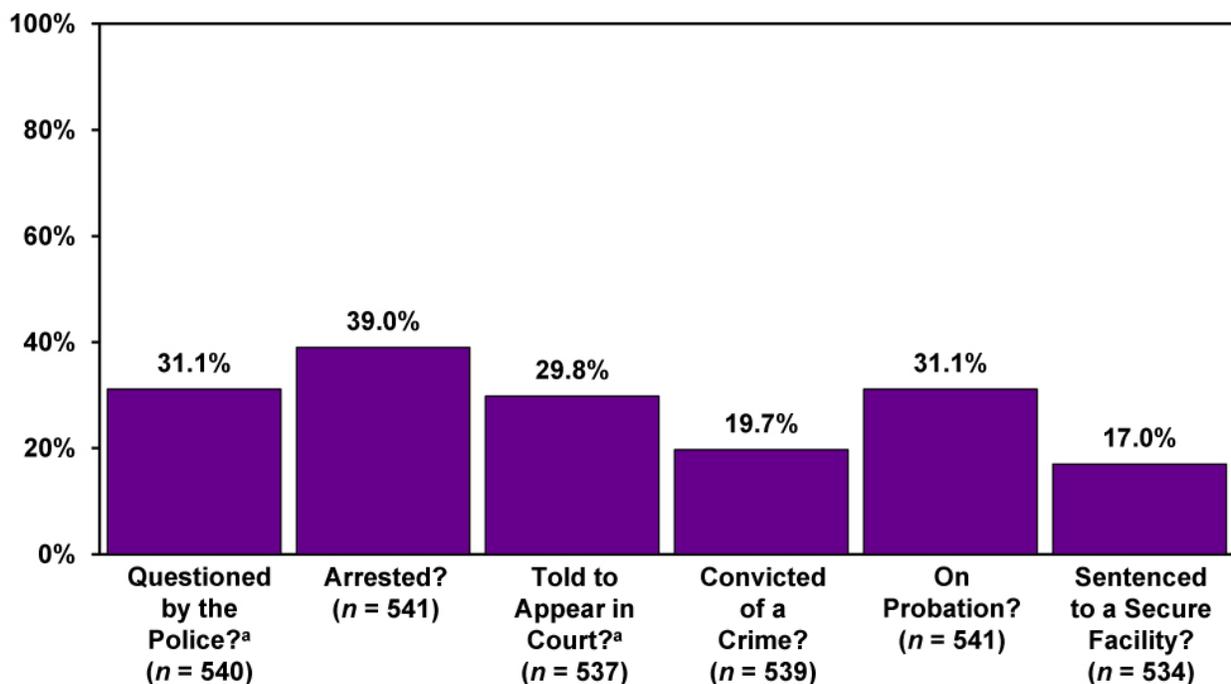
For youth receiving services in system of care communities initially funded in 2002 and 2003, law enforcement encounters, delinquency, and juvenile justice outcomes were measured by the Delinquency Survey–Revised. The survey was administered to youth 11 years and older participating in the longitudinal child and family outcome study. Figure 27 summarizes self-report data from these youth regarding law enforcement encounters and juvenile justice outcomes.

The self-report data indicated that a relatively large percentage of youth had had law enforcement encounters prior to intake. Roughly two-fifths of the youth had been arrested prior to entering systems of care. This rate is roughly equivalent to the rates for youth from earlier phases of the national evaluation. In addition, approximately 30 percent had been questioned by police or summoned to court because they had been suspected of committing a crime.

Regarding judicial outcomes, 20 percent of youth reported having been convicted of a crime prior to intake. Furthermore, 31 percent of youth reported having been on probation sometime before intake and 17 percent reported having been sentenced to a secure facility. While substantial, these percentages are lower than those reported by youth who received services from system of care communities initially funded in 1997, 1998, 1999, and 2000.

**Figure 27  
Criminal Justice History at Intake**

**Have you ever been . . . ?**

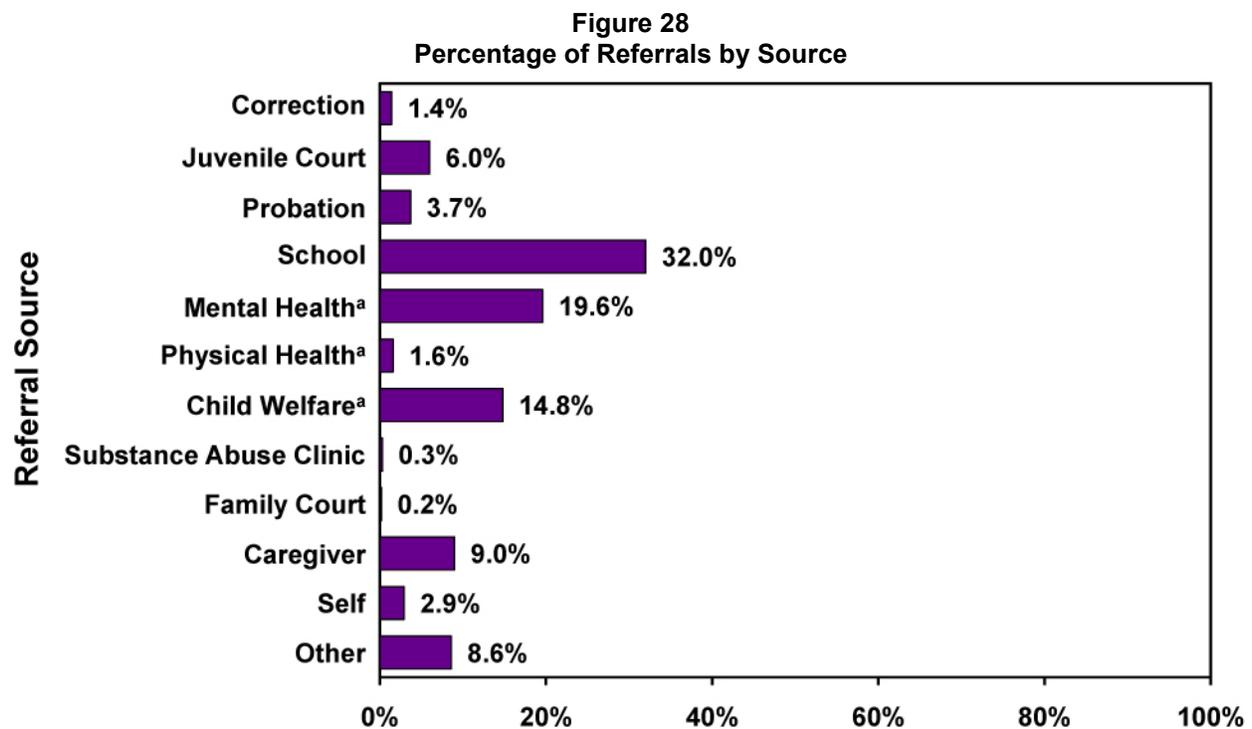


<sup>a</sup> Because you were suspected of committing a crime.

**Schools Were the Most Frequently Used Portal of Entry  
into Services in System of Care Communities Initially Funded in 2002 and 2003**

Examination of referral source information from the Enrollment and Demographic Information Form can be used to assess which portals of entry children are using to access systems of care. As illustrated in Figure 28, most children entering services in system of care communities initially funded in 2002 and 2003 were referred from schools. Mental health agencies or private providers were the second largest source of referrals, accounting for nearly 20 percent, while child welfare agencies accounted for nearly 15 percent of referrals. The large percentage of children referred from schools is consistent with the average age of children at intake. Also, the large percentage of children referred from mental health agencies or providers is not surprising given that the program is targeted toward public mental health agencies.

The referral pattern is similar to that in system of care communities initially funded in 1997, 1998, 1999, and 2000. Mental health agencies or providers, schools, and child welfare organizations also were the three most frequent referral sources, although for those communities funded earlier mental health agencies or providers was the largest source of referrals, followed successively by schools and child welfare agencies.



Number of children = 3,577.

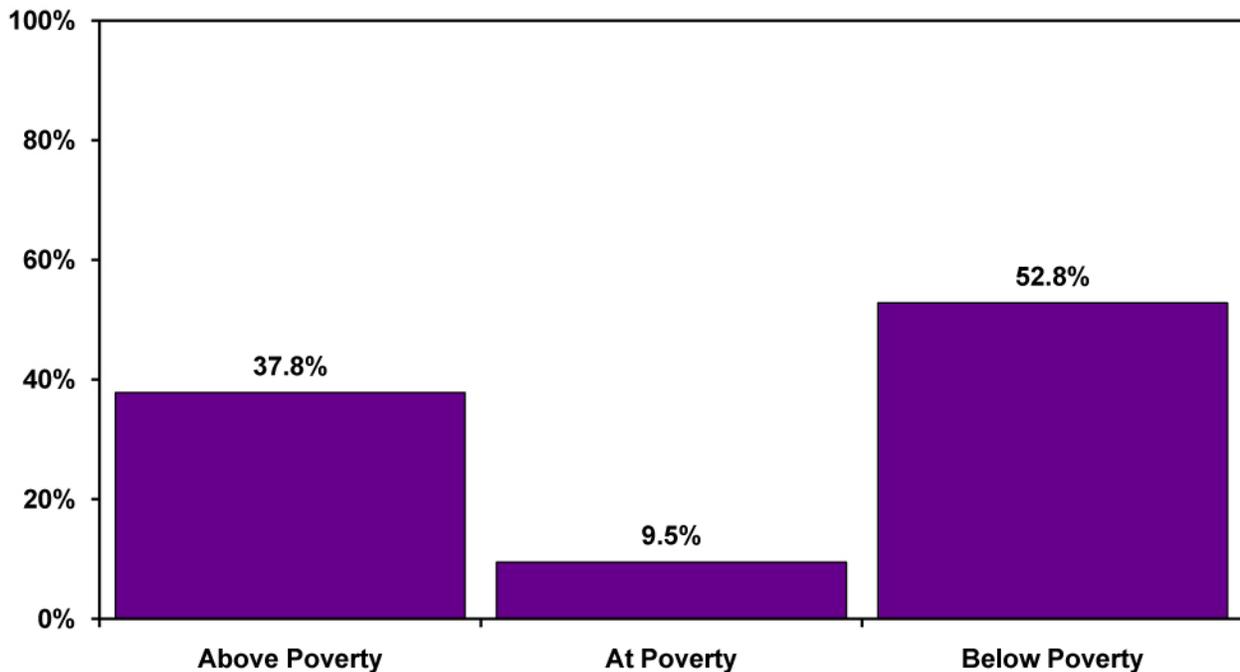
<sup>a</sup> Mental health = Mental health agency, clinic, or provider; Physical health = Physical health care agency, clinic, or provider; Child welfare = Child welfare agency or child protective services.

## **Family Demographics and History**

### ***The Majority of Children and Youth Served In System of Care Communities Initially Funded in 2002 and 2003 Were from Households with Annual Incomes below the Federal Poverty Level***

Almost 53 percent of children entering services in system of care communities initially funded in 2002 and 2003 for whom data were available were from households where the annual income was below poverty levels at the time of intake into services. Another 10 percent of children were from households where the annual income was at the poverty level (see Figure 29).

**Figure 29**  
**Poverty Level at Intake<sup>a</sup>**



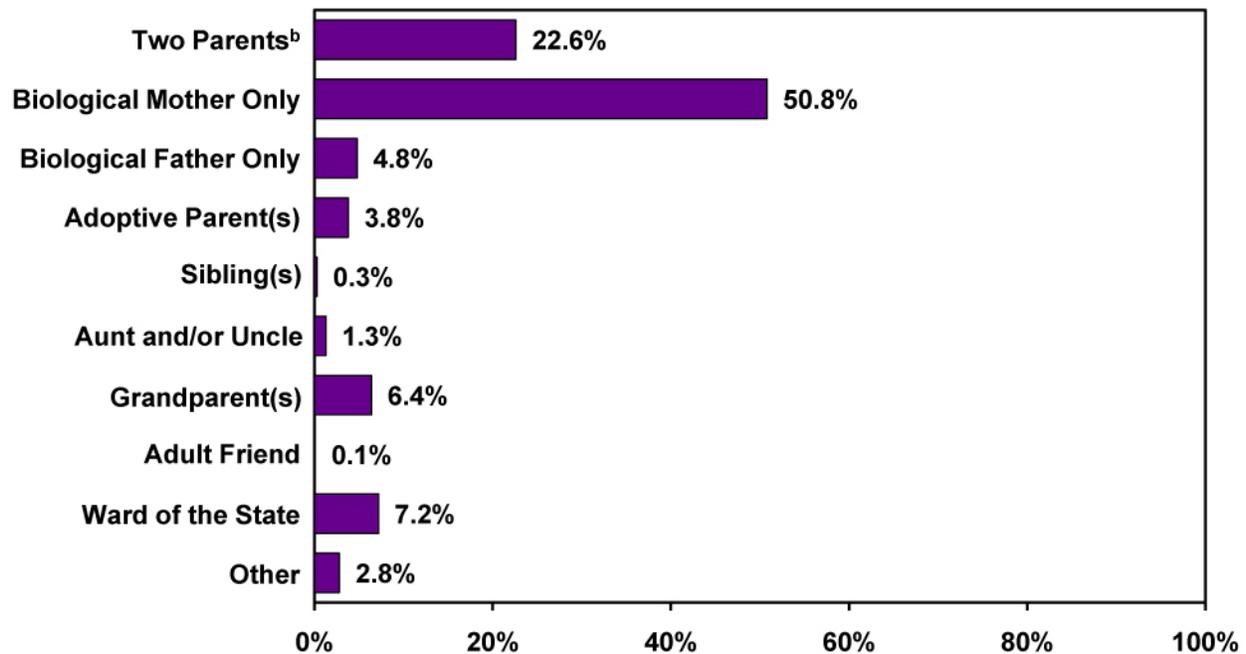
Number of children = 887.

<sup>a</sup> Poverty categories are based on the U.S. Department of Health and Human Services poverty guidelines. Federal poverty guidelines are only available for the 50 States. The categories take into account calendar year, State, family income, and household size. For example, according to these guidelines, in 2004 a family of four residing in the contiguous 48 States was living in poverty if their income was below \$18,850.

***The Majority of Children and Youth Served in System of Care Communities  
Initially Funded in 2002 and 2003  
Were in the Sole Custody of Their Biological Mothers***

Figure 30 summarizes information on children’s legal custody status at intake into services among system of care communities initially funded in 2002 and 2003. The person or agency with legal custody of the child may differ from where and with whom the child lives (e.g., foster parents). At intake, the majority of children were in the sole custody of their biological mothers. The next largest group of children was in the custody of two parents. The State was the third most frequent custodial agent, accounting for over 7 percent of children, followed by grandparent(s), who had legal custody of 6.4 percent of participating children. This pattern is consistent with custody information from system of care communities initially funded in 1997, 1998, 1999, and 2000.

**Figure 30  
Percentage of Children According to Their Legal Custody Status at Intake<sup>a</sup>**



Number of children = 1,010.

<sup>a</sup> Custody status is collected on the Caregiver Information Questionnaire and refers to legal custody. This may not reflect living arrangement, which is collected on the Living Situations Questionnaire.

<sup>b</sup> Includes two biological parents, or one biological parent and a step or adoptive parent.

**Many Children Entering Services in System of Care  
Communities Initially Funded in 2002 and 2003  
Had Experienced Situations That Put Them at Risk**

Historical information on the child and family is gathered at intake on the Caregiver Information Questionnaire. As seen in Table 28, many children entering services in system of care communities initially funded in 2002 and 2003 had experienced situations that put them at risk for behavioral and emotional problems, out-of-home placement, and multi-agency involvement. For example, caregivers reported that two-thirds of children entering systems of care had lived in a household where one household member suffered from depression. Nearly half of these children had witnessed domestic violence or lived in a household where someone had a substance abuse problem.

As far as the child's personal history is concerned, one fourth had been physically abused prior to intake and 18 percent had been sexually abused. An even larger percentage of children (29.2 percent) had run away. Fewer children (15 to 16 percent) were reported to have had a substance abuse problem or to have attempted suicide, but this proportion is still of concern.

**Table 28  
Child and Family History at Intake**

Has the child ever . . . ?	%
Witnessed domestic violence?	46.6 (n = 987)
Lived with someone who was depressed?	65.9 (n = 960)
Lived with someone who had a mental illness?	31.3 (n = 949)
Lived with someone who was convicted of a crime?	35.8 (n = 981)
Lived with someone who had a substance abuse problem?	48.7 (n = 970)
Been physically abused?	24.5 (n = 992)
Been sexually abused?	18.2 (n = 955)
Run away?	29.2 (n = 1,002)
Had substance abuse problems?	15.9 (n = 993)
Attempted suicide?	15.4 (n = 997)

**Summary**

Overall, children entering services in system of care in communities initially funded in 2002 and 2003 were quite similar to children who received services from communities in earlier phases of the program. They tended to be White or Black or African American, male, and between the ages of 7 and 18. The most frequently assigned *DSM-IV* diagnoses were mood disorders and attention-deficit/hyperactivity disorder. The majority were referred into systems of care through schools or mental health agencies or providers. The majority was in the sole custody of their biological mothers or two parents and lived in householders where the annual income was below Federal poverty guidelines. Many had been exposed to experiences that put them at risk for emotional and behavioral problems and out-of-home placement. These experiences included being physically or sexually abused, witnessing domestic violence, being involved with juvenile justice, and abusing substances.

## CHILD CLINICAL AND FUNCTIONAL OUTCOMES AT 6 MONTHS

Preliminary results based on data from children and families participating in the longitudinal outcome study in system of care communities initially funded in 2002 and 2003 are presented below. Given their preliminary nature, these results should be interpreted with caution as they may change as the number of longitudinal outcome study participants increases. In addition, some system of care communities initially funded in 2002 and 2003 are not represented in these preliminary findings because they had not collected sufficient amounts of data at the 6-month time period to allow their inclusion. Thus, the results may not be representative of the final longitudinal outcome study sample.

### **Behavioral and Emotional Strengths**

#### ***Caregiver and Youth Ratings of Behavioral and Emotional Strengths Showed Significant Improvements after 6 Months of Services in System of Care Communities Initially Funded in 2002 and 2003***

Because caregivers and youth often provide discrepant perspectives on the youth's behavioral and emotional outcomes, the introduction of the youth report version of the BERS (BERS-2Y; Epstein, 2004) provides an important opportunity to explore whether similar discrepancies exist for ratings of children's strengths for children and families served in system of care communities initially funded in 2002 and 2003. Figure 31 reports RCIs for caregiver and youth ratings of behavioral and emotional strengths at intake and the 6-month followup period.<sup>65</sup> Caregiver and youth ratings of behavioral and emotional strengths indicated similar numbers of children show 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.<sup>66</sup> Caregivers' average rating of children's behavioral and emotional strengths increased from 77.3 at intake to 80.8 after 6 months of treatment,<sup>67</sup> 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.<sup>68</sup> BERS scores below 90 indicate below average strengths.

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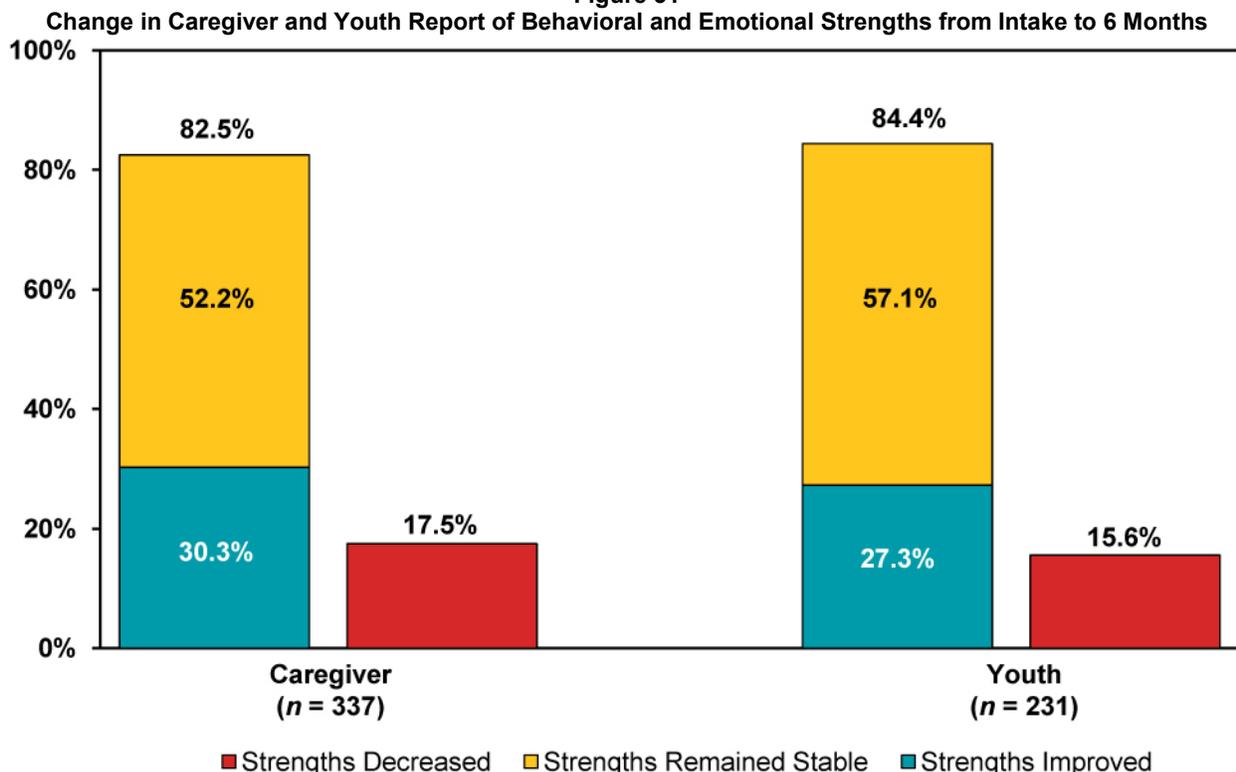
<sup>65</sup> For more information on the reliable change index, see page 42.

<sup>66</sup> Caregiver ratings of child behavior and emotional strengths were measured by the Behavioral and Emotional Rating Scale-Second Edition, Parent Rating Scale (BERS-2C; Epstein, 2004). Youth ratings of child behavior and emotional strengths were measured by the Behavioral and Emotional Rating Scale-Second Edition, Youth Rating Scale (BERS-2Y; Epstein 2004). Standard scores for the strength subscales range from 1 to 16. The strength index is based on the sum of the subscale scores, excluding career strength, and ranges from 38 to 131.

<sup>67</sup>  $t(336) = -4.34, p < .001$ .

<sup>68</sup>  $t(230) = -2.80, p = .006$ .

Figure 31



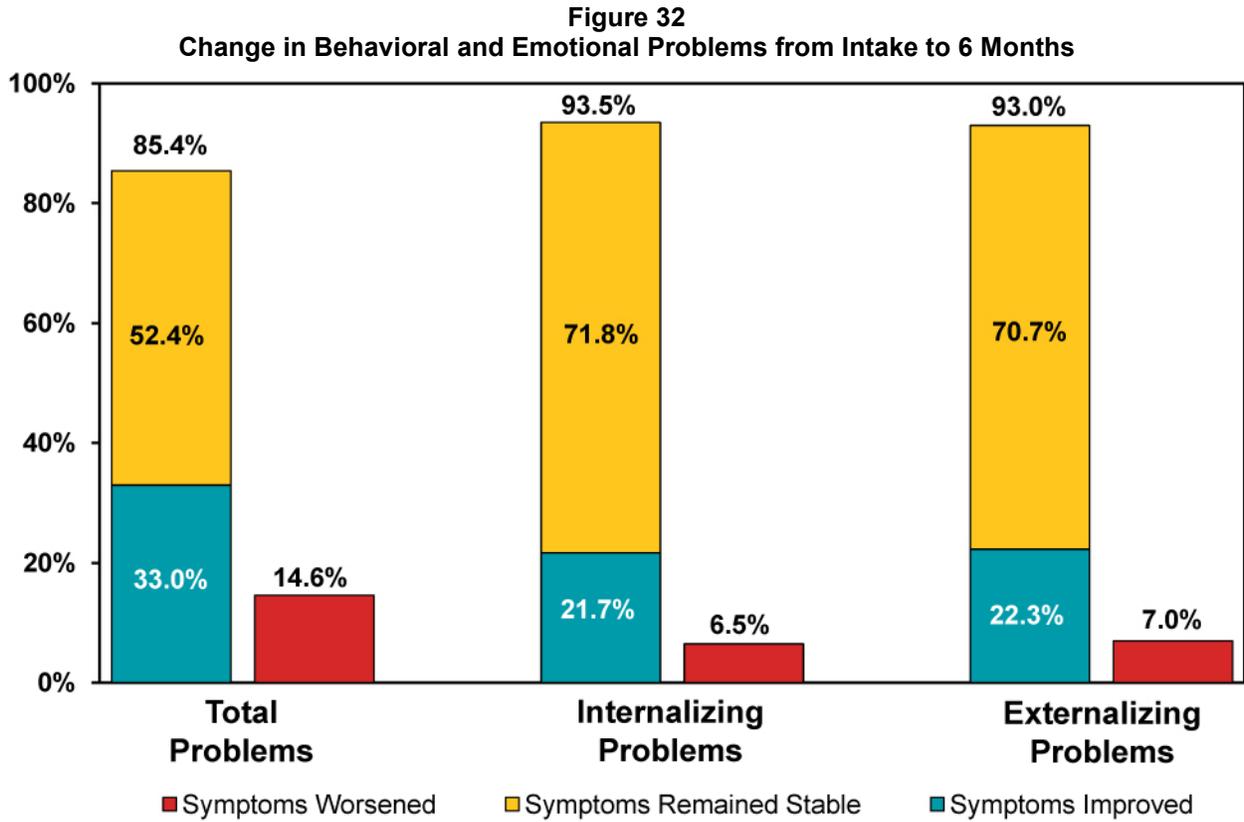
**Caregiver Ratings of Behavioral and Emotional Problems Showed Significant Improvement after 6 Months of Services in System of Care Communities Initially Funded in 2002 and 2003**

Changes in child emotional and behavioral problems after 6 months of receiving services in system of care communities initially funded in 2002 and 2003 are summarized using RCIs for Child Behavior Checklist 6–18 (CBCL; Achenbach & Rescorla, 2001) total problems, internalizing problems, and externalizing problems (see Figure 32).<sup>69,70</sup> 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

<sup>69</sup> The CBCL 6–18 is a revised version of the CBCL 4–18 administered to caregivers and measures behavioral and emotional problems in children aged 6 to 18. The CBCL 6–18 produces two broadband syndrome scores: internalizing and externalizing, and a total problems score. T-scores between 60 and 63 on the Internalizing, Externalizing, and Total Problems Scales are in the borderline clinical range. T-scores of 64 or above are in the clinical range. The CBCL 6–18 has been widely used in children’s mental health services research and for clinical purposes.

<sup>70</sup> For more information on the reliable change index, see page 42.

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.<sup>71</sup>



Number of children = 355.

<sup>71</sup>  $t(354) = 6.43, p < .001$ .

**Child Functional Impairment and Anxiety and Adolescent Depression  
Decreased Significantly after 6 Months of Services in System of Care  
Communities Initially Funded in 2002 and 2003**

Average overall and total scores on the Columbia Impairment Scale (CIS; Bird, et al., 1993),<sup>72</sup> Revised Children’s Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978);<sup>73</sup> and Reynolds Adolescent Depression Scale–2nd Edition (RADS–2; Reynolds, 1986)<sup>74</sup> at intake and 6 months appear in Table 29 below. Scores on the CIS showed that 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.

**Table 29**  
**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 <sup>a</sup> (n = 392)	25.9 (SD = 10.2)	22.9 (SD = 10.8)
Revised Children’s Manifest Anxiety Scale Total Anxiety Score <sup>b</sup> (n = 246)	54.8 (SD = 11.8)	52.8 (SD = 11.6)
Reynold’s Adolescent Depression Scale–2 Total Depression Score <sup>c</sup> (n = 257)	53.9 (SD = 10.2)	51.5 (SD = 10.0)

<sup>a</sup>  $t = 6.24, df = 391, p < .001.$

<sup>b</sup>  $t = 3.14, df = 245, p = .002.$

<sup>c</sup>  $t = 4.10, df = 256, p < .001.$

<sup>72</sup> Child functional impairment was measured by the Columbia Impairment Scale (CIS). CIS scores range from 0 to 52. Higher scores indicate a greater level of impairment. A score of 15 or higher is considered clinically impaired.

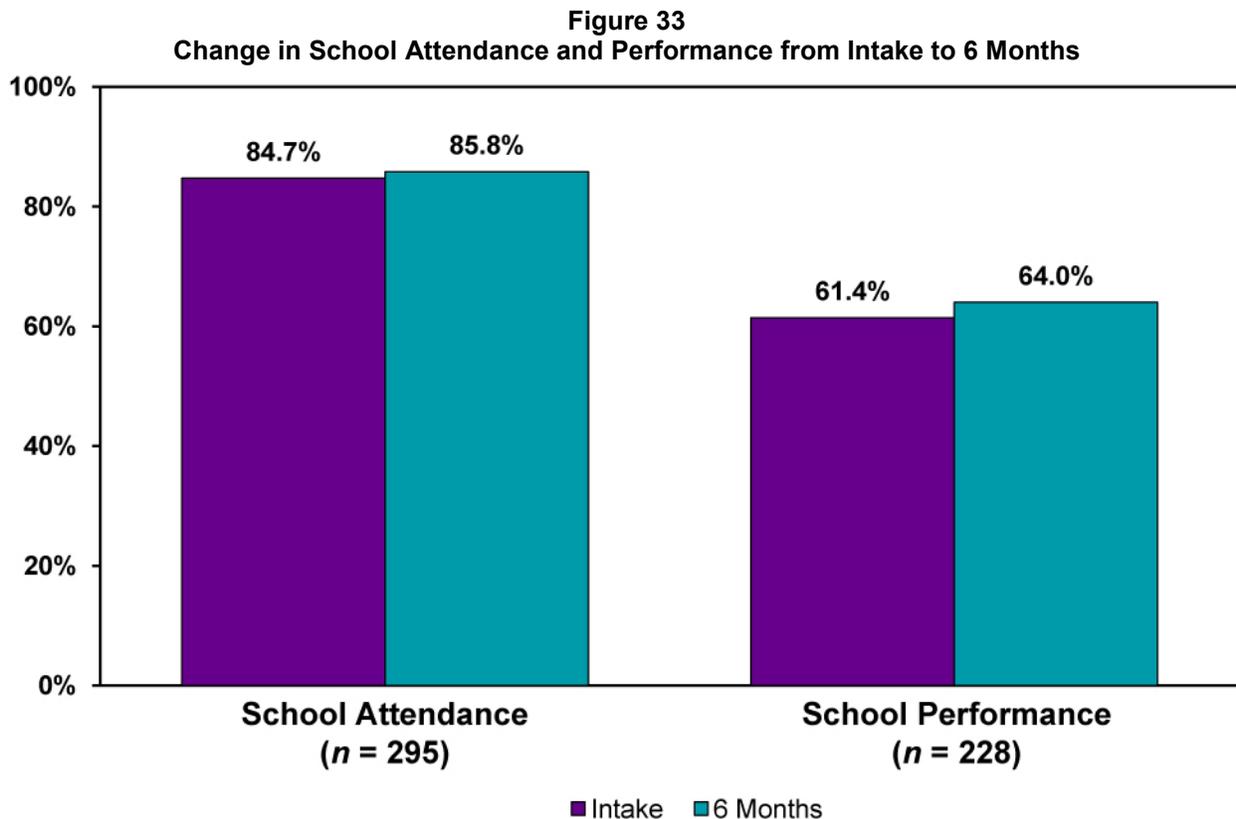
<sup>73</sup> Child anxiety was measured by the Revised Children’s Manifest Anxiety Scale (RCMAS). RCMAS Total Anxiety T-scores range from 18 to 92. T-scores greater than or equal to 60 indicate levels of anxiety in the range of clinical interest.

<sup>74</sup> Adolescent depression was measured by the Reynolds Adolescent Depression Scale–2nd Edition (RADS–2). Total Depression T-scores of less than 61 represent Normal range, 61 to 64 represent Mild clinical depression range, 65 to 69 represent Moderate clinical depression range, and greater than or equal to 70 represent Severe clinical depression range.

***School Attendance and Academic Performance Improved for More Than One-Third of Children after Receiving Services for 6 Months in System of Care Communities Initially Funded in 2002 and 2003***

Educational improvement was measured by changes in school attendance and grade performance from intake to 6 months. As illustrated in Figure 33, 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.

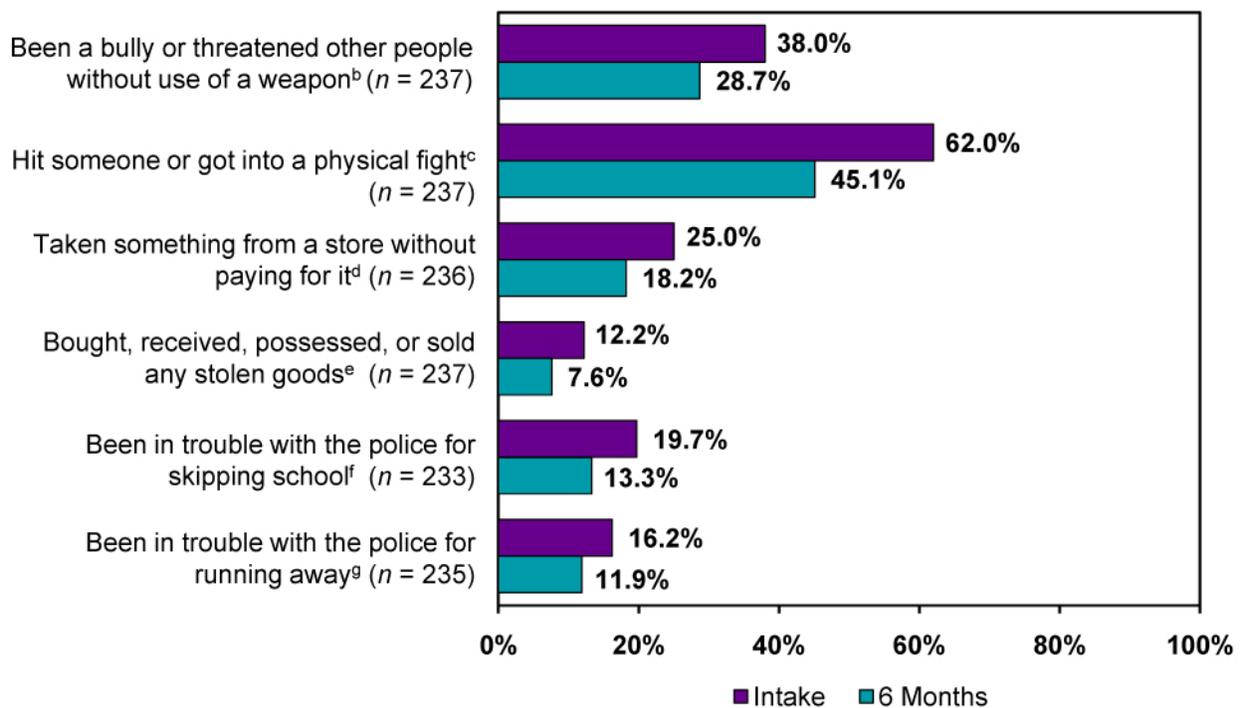
School performance was assessed by children's receipt of passing grades (defined as a caregiver-reported grade average of C or better). As seen below, the percentage of children with passing school performance increased from 61.4 percent at intake to 64 percent after 6 months of services. This increase was not statistically significant.



**Youth Reported Significant Decreases in Juvenile Delinquency and Involvement with Law Enforcement after Receiving Services for 6 Months in System of Care Communities Initially Funded in 2002 and 2003**

The two most frequent violent crimes, property crimes, and other delinquent acts reported at intake were examined again after receiving services for 6 months in system of care communities initially funded in 2002 and 2003. The percentage of youth 11 years old and older who reported each act at intake and at 6 months is presented in Figure 34. 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 34  
Delinquent Behavior at Intake and 6 Months<sup>a</sup>**



<sup>a</sup> Categories represent the two most frequently reported violent crimes, property crimes, and other behaviors reported at intake.

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

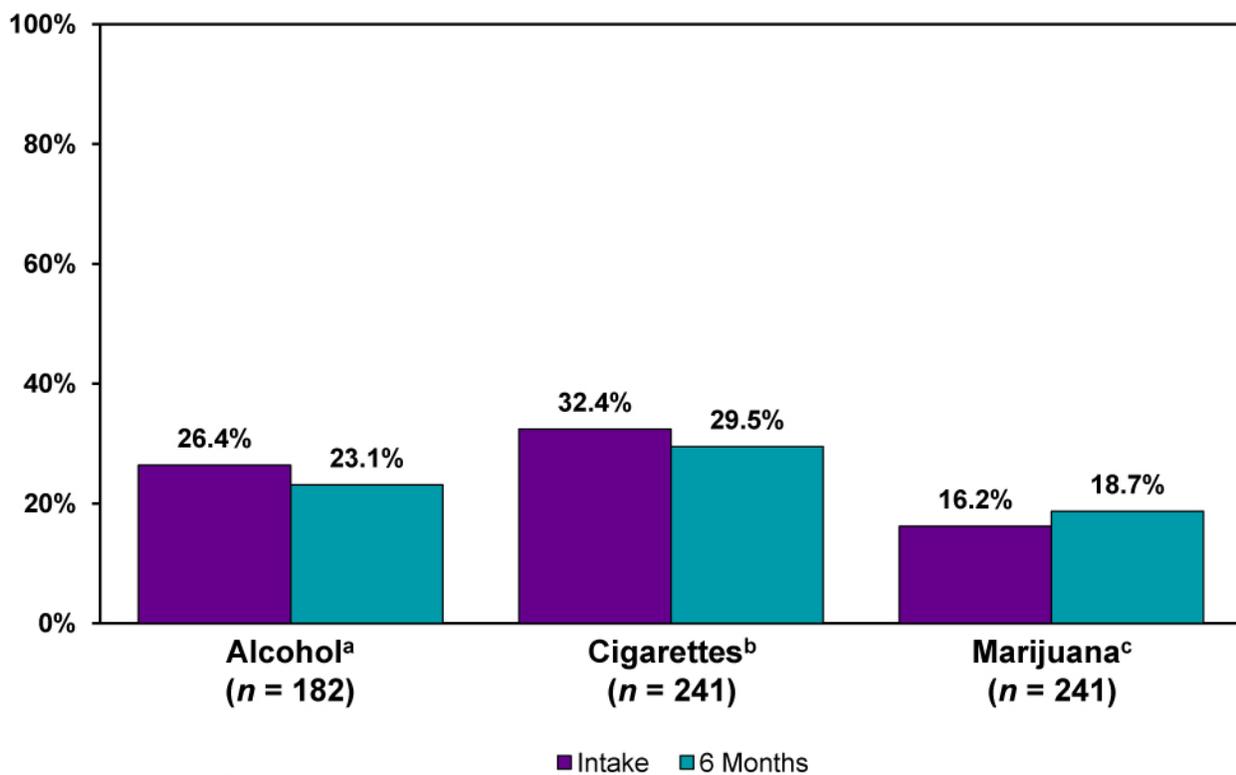
<sup>c</sup>  $\chi^2 = 43.89, df = 1, p < .001.$       <sup>f</sup>  $\chi^2 = 38.96, df = 1, p < .001.$

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

**Youth Reported Significant Decreases in Tobacco and Alcohol Use after Receiving Services for 6 Months in System of Care Communities Initially Funded in 2002 and 2003**

Change over time in substance use between intake and 6 months of service in system of care communities initially funded in 2002 and 2003 was examined for the three most frequently used substances at intake. The percentage of youth 11 years old and older who used alcohol, cigarettes, and marijuana/hashish at intake and 6 months is reported in Figure 35. Although marijuana use increased significantly, there were significant reductions in alcohol and cigarette use by youth after being in system of care services for 6 months.

**Figure 35  
Substance Use at Intake and 6 Months**



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

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

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

## **Summary**

These early outcome data for children and youth enrolled in the longitudinal outcome study in system of care communities initially funded in 2002 and 2003 are quite promising, although they should be interpreted with caution due to preliminary nature of the data and the small sample size. There was a significant improvement in child functioning, as measured by the CIS, and the vast majority of children showed clinically significant improvement or stability in internalizing and externalizing problems as measured by the CBCL 6–18. The majority of caregivers and youth also indicated that behavioral and emotional strengths showed clinically significant improvement or stability.

These preliminary data indicated stable levels of school functioning as evidenced by findings for school attendance and performance. Further, there was a significant reduction in illegal and delinquent behavior between intake into services and 6 months. Alcohol and cigarette use decreased during the same period although marijuana/hashish use increased.

## GPRA PROGRAM INDICATORS FOR FY 2005

GPRA Program Indicators	Actual Performance
(1) Increase in number of children receiving services	
• FY 2005 Target:9,120	9,200
(2) Increase in percentage of children attending school 75% or more of time after 12 months	
• FY 2005 Target:83%	80.2%
(3) Increase in percentage of children with no law enforcement contacts at 6 months	
• FY 2005 Target:53%	68.3%
(4) Decrease in utilization of inpatient facilities at 6 months	
• FY 2005 Target:Establish new baseline	-1.75 days
(5) Decrease inpatient costs	
• FY 2005 Target:Establish new baseline	-\$5,016,930

# SUMMARY AND RECOMMENDATIONS

## SUMMARY

The CMHI is largely successful in serving its intended population. The majority of children and youth were below age 22, with larger percentages of younger children entering systems of care in the later program development years. The program served children and youth with a variety of *DSM-IV* diagnoses, including ADHD, mood disorders, oppositional defiant disorder, adjustment disorders, and conduct disorder, and the majority were assigned more than one *DSM-IV* diagnosis.

In general, children and youth displayed marked impairment across a variety of domains upon their entry into local system of care programs and presented with below average strengths and competence and with levels of behavioral and emotional problems that indicated a need for intervention. In addition, the data reveal that children and youth were involved with more than one child-serving agency prior to intake into system of care services.

### **Child and Family Gains**

Positive clinical changes were accompanied by increased stability in living arrangements, improved school performance, and decreased law enforcement contacts. Most families experienced improvement or stability in resources, and reduced strain. In addition, youth and caregivers reported high levels of satisfaction with the services they received and the progress they made toward the achievement of their goals while participating in their systems of care.

### **Clinical Improvements**

Participation in systems of care resulted in meaningful outcomes related to recovery and quality of life for the children, youth, and families served. Children and youth generally experienced meaningful improvement in important clinical and functional indicators. Their strengths, behavioral and emotional symptoms, and functional impairments were improved significantly at 12 months following intake into services in systems of care.

### **System Change**

System of care communities 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. System of care communities showed improvement over their years of development 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.

## **Cost Savings**

System of care communities realized significant cost savings associated with fewer overall days spent in inpatient hospital care (in the previous 6 months) for youth after 12 months of receiving services compared to intake, and with fewer court appearances (in the previous 6 months) after 12 months of receiving services compared to intake. A positive trend also was found for cost savings related to the number of arrests for children receiving services as the average number of arrests per child (in the previous 6 months) decreased after 12 months of receiving services in each program development year compared to intake into services.

## **RECOMMENDATIONS**

The CMHI offers an example of a community-level model of care that has successfully and effectively provided a coordinated approach to service delivery for children and youth with serious emotional disturbance and their families. The program evaluation findings presented in this Report indicate that it clearly has resulted in positive outcomes for the children, youth, and families served, and it also has contributed to the transformation of mental health services as described in the *Federal Action Agenda*. The CMHI has operated for the 12 years of its existence according to a set of principles that are described in the *Agenda* as indicators of a transformed mental health system, and, as shown in this Report, local system of care communities have demonstrated continued growth and improvement in implementing programs that adhere to those principles and result in improved outcomes for the children, youth, and families served by them.

To build upon the historic success of the CMHI, it is recommended that it be allowed to expand into local communities within States, tribes, and territories not yet participating in the program. The success of the CMHI is determined, in part, according to the extent to which mental health service providers are well trained in the model; are sensitive and prepared to offer services to culturally and linguistically diverse populations of children, youth, and families; and are willing and available to provide services in remote, rural, or otherwise difficult geographic environments or locations. Therefore, it is recommended that incentives be created and implemented that would support an expanded and well-trained workforce to meet the particular goals of the CMHI.

A third recommendation is that traditional sources of reimbursement for mental health services, such as State Medicaid programs and private insurances, continue to explore and create mechanisms that allow for reimbursement for a broader array of nontraditional services that have been found to be effective and supportive to families with children with serious emotional disturbance.

A final recommendation is that continued leadership be offered at the Federal level to encourage and enhance the collaboration of child-serving agencies at all levels of government and jurisdiction to meet the holistic needs of children and youth with serious emotional disturbance and their families. A useful approach would be the development and implementation of mechanisms to blend or braid funding across various service or program categories or agency boundaries. Sustained interagency involvement and cross-agency collaboration in the development and implementation of unified and comprehensive service plans will be successful to the extent that various funding sources and mechanisms are flexible and available.

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# **A P P E N D I C E S**

## APPENDIX A

# SYSTEM OF CARE COMMUNITIES FUNDED THROUGH THE COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM (1993–2006)

Phase I (Grants Awarded in 1993 and 1994)		
Cycle I (Grants Awarded in October 1993)		
Grant Community	Location	State
East Baltimore Mental Health Partnership	East Baltimore, Maryland	Maryland
Stark County Family Council and Southern Consortium	Stark County and 10 southeastern counties	Ohio
The Village Project	Charleston and Dorchester counties	South Carolina
ACCESS	Statewide	Vermont
Cycle II (Grants Awarded in February 1994)		
Grant Community	Location	State
Children's Systems of Care/California 5	Riverside, San Mateo, Santa Cruz, Solano, and Ventura counties	California
COMCARE	Sedgwick County	Kansas
Wings for Children and Families	Piscataquis, Hancock, Penobscot, and Washington counties	Maine
Olympia (formerly Doña Ana County Child and Adolescent Collaborative)	Doña Ana County	New Mexico
Pitt-Edgecombe-Nash Public-Academic-Liaison Project (PEN-PAL)	Pitt, Edgecombe, and Nash counties	North Carolina
Project REACH Rhode Island	Statewide	Rhode Island
Wraparound Milwaukee	Milwaukee County	Wisconsin

Phase I (Grants Awarded in 1993 and 1994)		
Cycle III (Grants Awarded in September and November 1994)		
Grant Community	Location	State
Multiagency Integrated System of Care (MISC)	Santa Barbara County	California
Sonoma-Napa Comprehensive System of Care	Sonoma and Napa counties	California
Hawai'i 'Ohana Project	Wai'anae Coast and Leeward Oahu	Hawai'i
Community Wraparound Initiative	Lyons, Riverside, and Proviso townships	Illinois
KanFocus	13 southeastern counties	Kansas
K'é Project	Navajo Nation <sup>a</sup>	Arizona, New Mexico, Utah
Families Reaching in Ever New Directions (FRIENDS)	Mott Haven	New York
Partnerships Project	Minot, Bismarck, and Fargo regions	North Dakota
New Opportunities	Lane County	Oregon
South Philadelphia Family Partnership Project	South Philadelphia	Pennsylvania
City of Alexandria System of Care	City of Alexandria	Virginia

Phase II (Grants Awarded in 1997 and 1998)		
Cycle IV (Grants Awarded in October 1997)		
Grant Community	Location	State
The Jefferson County Community Partnership	Jefferson County	Alabama
Children's Mental Health Services Initiative	San Diego County	California
Kmihqitahasultipon ("We Remember") Project	Passamaquoddy Tribe Indian Township <sup>a</sup>	Maine
Southwest Community Partnership	Detroit	Michigan
Nebraska Family Central	22 central counties	Nebraska
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 <sup>a</sup>	North Dakota
Children's Upstream Services	Statewide	Vermont
Northwoods Alliance for Children and Families	Forest, Langlade, Lincoln, Marathon, Oneida, and Vilas counties	Wisconsin

Phase II (Grants Awarded in 1997 and 1998)		
Cycle V (Grants Awarded in October and November 1998)		
Grant Community	Location	State
Tampa-Hillsborough Integrated Network for Kids (THINK) System	Hillsborough County	Florida
Kentucky Bridges Project	3 Appalachian regions	Kentucky
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 <sup>a</sup>	Michigan
Partnership With Families	St. Charles County	Missouri
Families First and Foremost	Lancaster County	Nebraska
Neighborhood Care Centers	Clark County	Nevada
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
Clark County Children's Mental Health Initiative	Clark County	Washington
Children and Families in Common	King County	Washington
With Eagle's Wings	Wind River Indian Reservation <sup>a</sup>	Wyoming

Phase III (Grants Awarded in 1999 and 2000)		
Cycle VI (Grants Awarded in October 1999)		
Grant Community	Location	State
Yuut Calilriit Ikaiyuquulluteng (“People Working Together”) Project	Delta region of southwest Alaska <sup>a</sup>	Alaska
Project MATCH (Multi-Agency Team for CHildren)	Pima County	Arizona
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
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 <sup>a</sup>	South Dakota
Nashville Connection	Nashville	Tennessee
Mountain State Family Alliance	12 counties	West Virginia

<b>Phase III (Grants Awarded in 1999 and 2000)</b>		
<b>Cycle VII (Grants Awarded in May and July 2000)</b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
A-KO-NES Wraparound System of Care	Humboldt and Del Norte counties <sup>a</sup>	California
Kidsnet Rockdale	Rockdale and Gwinnett counties	Georgia
<b>Phase IV (Grants Awarded in 2002, 2003, and 2004)</b>		
<b>Cycle VIII (Grants Awarded in October 2002)</b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
Ch'eghutsen' A System of Care	Fairbanks Native Association <sup>a</sup>	Alaska
Glenn County Children's System of Care	Glenn County	California
OASIS (Obtaining and Sustaining Independent Success)	Sacramento County	California
San Francisco Children's System of Care	San Francisco	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
I Famagu'on-ta (Our Children)	Territorywide	Guam
Building on Each Other's Strengths	Statewide	Idaho
System of Care Chicago	Chicago	Illinois
Show Me Kids	Barry, Christian, Green, Lawrence, Stone, and Taney counties	Missouri
Coordinated Children's Services Initiative (CCSI)/The Family Network	New York City	New York
Choctaw Nation CARES	Choctaw Nation of Oklahoma <sup>a</sup>	Oklahoma
Great Plains Systems of Care	Beckham, Canadian, Kay, Oklahoma, and Tulsa counties	Oklahoma
Puerto Rico Mental Health Initiative for Children	Llorens Torres Housing Project in San Juan and Municipality of Gurabo	Puerto Rico
Border Children's Mental Health Collaborative	El Paso County	Texas
Community Solutions	Fort Worth	Texas

<b>Phase IV (Grants Awarded in 2002, 2003, and 2004)</b>		
<b><i>Cycle IX (Grants Awarded in September 2003)</i></b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
La Familia Sana	Monterey County	California
Urban Trails	Oakland <sup>a</sup>	California
Louisiana Youth Enhanced Services for Children's Mental Health (LA-YES)	Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany parishes	Louisiana
Transitions	St. Louis County and City	Missouri
Tapestry	Cuyahoga County	Ohio
Columbia River Wraparound	Gilliam, Hood River, Sherman, and Wasco counties	Oregon
YouthNet	Chester, Lancaster, and York counties and Catawba Indian Nation <sup>b</sup>	South Carolina
<b><i>Cycle X (Grants Awarded in September 2004)</i></b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
Kentuckians Encouraging Youth to Succeed (KEYS)	Boone, Campbell, Carroll, Gallatin Grant, Kenton, Owen, and Pendleton counties	Kentucky
Missoula Kids Integrated Delivery System Management Authority (KMA)	Statewide and Crow Indian Nation <sup>b</sup>	Montana
Families Together in Albany County	Albany County	New York
Family Voices Network	Erie County	New York

Phase V (Grants Awarded in 2005)		
Cycle XI (Grants Awarded in September 2005)		
Grant Community	Location	State
ACTION for Kids (Arkansas Collaborating to Improve Our Network)	Craighead, Lee, Mississippi and Phillips counties	Arkansas
Connecting Circles of Care	Butte County	California
Seven Generations System of Care	Los Angeles County <sup>a</sup>	California
Project ABC	Los Angeles County	California
Transforming Children's Mental Health Through Community and Parent Partnerships	Placer County	California
Building Blocks	New London County	Connecticut
Early Childhood Mental Health Partnership	Sarasota County	Florida
Project Ho'omohala (Transition to Adulthood)	Honolulu City and County	Hawai'i
McHenry County Family CARE (Child/Adolescent Recovery Experience)	McHenry County	Illinois
THRIVE	Androscoggin, Franklin, and Oxford counties	Maine
Central Massachusetts Communities of Care	Worcester County	Massachusetts
Impact	Ingham County	Michigan
Kalamazoo Wraps	Kalamazoo County	Michigan
STARS for Children's Mental Health (System Transformation of Area Resources and Services)	Benton, Sherburne, Stearns, and Wright counties	Minnesota
The Po'Ka Project (Blackfeet Children System of Care)	Blackfeet Reservation <sup>a</sup>	Montana
Monroe County Achieving Culturally Competent and Effective Services and Supports (Monroe County ACCESS)	Monroe County	New York
Mecklenburg CARES	Mecklenburg County	North Carolina
Wraparound Oregon: Early Childhood	Multnomah County	Oregon
Starting Early Together (SET)	Allegheny County and City of Pittsburgh	Pennsylvania
Beaver County System of Care: Optimizing Resources, Education and Supports (BC-SCORES)	Beaver County	Pennsylvania

<b>Phase V (Grants Awarded in 2005)</b>		
<b><i>Cycle XI (Grants Awarded in September 2005) continued</i></b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
Positive Educational Partnership (PEP)	Statewide	Rhode Island
Tiwahe Wakan (Families as Sacred)	Yankton Sioux Tribe <sup>a</sup>	South Dakota
Mule Town Family Network	Maury County	Tennessee
Systems of Hope	Harris County	Texas
The SAGE Initiative	Statewide	Wyoming
<b><i>Cycle XII (Grants Awarded in September 2006)</i></b>		
<b>Grant Community</b>	<b>Location</b>	<b>State</b>
Sewa Uusim Systems of Care	Pascua Yaqui Tribe of Arizona <sup>a</sup>	Arizona
Community Circle of Care	10 northeastern counties	Iowa
Our Children Succeed Initiative	Kittson, Mahnomon, Marshall, Norman, Polk, and Red Lake counties	Minnesota
commUNITY cares	Forrest, Lamar, and Marion counties	Mississippi
Circle of H.O.P.E. (Home, Opportunities, Parents & Providers, Empowerment)	Andrew and Buchanan counties	Missouri

<sup>a</sup>American Indian/Alaska Native tribe.

<sup>b</sup>State–Tribal partnership.

## **APPENDIX B**

### **DESCRIPTION OF STUDY COMPONENTS**

#### **CULTURALLY COMPETENT PRACTICES STUDY**

The culturally competent practices study is designed to investigate several key components of cultural competence. It will (a) assess system of care service providers' level of competence across several domains of cultural competence (i.e., attitudes, knowledge, and practice), (b) increase understanding of the role that organizations and agencies play in hindering or facilitating culturally competent service provision, (c) investigate the relationship between child and family outcomes and culturally competent services, and (d) help identify areas in which training, resources, and research need to be directed in order to increase the pervasiveness of cultural competence in services (i.e., to move beyond cultural awareness and assessment).

Data collection strategies used in this study include

- a Web-based Culturally Competent Practices Survey that will be completed by service providers in all system of care communities funded in 2002 and 2003, and
- focus groups with service providers, caregivers, youth, administrators, and program staff in communities with high and low levels of culturally competent services.

Data from the longitudinal child and family outcome study also will be used to assess the relationship between outcomes and cultural competence.

#### **DESCRIPTIVE AND OUTCOME STUDIES OF CHILDREN AND FAMILIES SERVED**

##### **DESCRIPTIVE STUDY**

The primary purpose of the descriptive study is to provide information on the children and families served by the systems of care across grant communities. Data for the descriptive study were obtained at intake into services and included demographic characteristics, custody status, living arrangements, child and family risk factors, presenting problems, clinical diagnoses, functional status, and mental health service history. Descriptive information about the child's history of chronic illness; medications for physical, emotional, or behavioral problems; and status as a Medicaid recipient was collected, as was information about family socioeconomic status, composition, and available resources. This type of information about child and family characteristics contributes to our understanding of the similarities and differences among the children served as well as the extent to which these factors may be related to family service experiences, changes in children's emotional and behavioral problems and social functioning, and changes in caregiver strain and family functioning over time. Descriptive information was collected on every child who was enrolled in system of care programs. Please refer to Appendix C for a list of descriptive data collected in the study.

## **LONGITUDINAL CHILD AND FAMILY OUTCOME STUDY**

The primary purpose of the longitudinal outcome study is to assess changes over time among children and families participating in system of care services. Outcome data collected from caregivers included the child's clinical and social functioning, behavioral and emotional strengths, restrictiveness of living situation, educational performance, and satisfaction with services. Assessments of family functioning, family resources, and caregiver strain also were obtained from caregivers. In addition, youth 11 years or older reported on their own delinquent behaviors, behavioral and emotional problems, history of substance use, perceptions of family functioning, and service satisfaction. Standardized and nonstandardized instruments typical in the field of children's mental health services were used to collect these data. Please see Appendix C for detailed descriptions of these instruments. In addition to meeting the eligibility for enrollment, children enrolled in system of care programs must meet all the following criteria to be enrolled in the longitudinal outcome study:

- Enter the grant-funded system of care (child has completed intake, descriptive information has been collected, and caregiver has consented to treatment).
- Be receiving or on the verge of receiving services in the community by the time of the baseline outcome study interview. Services can be considered to include clinical assessment, contact with a service coordinator (case manager), and initial efforts to plan additional services.
- Have a caregiver who legally can grant consent to participate in the evaluation (can grant consent for treatment), or a legal custodian who will grant consent for the child and the child's primary caregiver to participate in the outcome study.
- Have a caregiver who can provide the information requested and is capable of completing a data collection interview (e.g., no severe cognitive impairment).
- Be no younger than 5 years old and no older than 17.5 years old at the time of intake (baseline).
- Not be the sibling of a child already enrolled in the outcome study.
- If applicable, be selected through the sampling method used at the community.

## **EVIDENCE-BASED TREATMENT SURVEY**

The Evidence-based Treatment (EBT) Survey is a 65-item survey (completion time approximately 20 minutes) administered to direct mental health service providers to children with serious emotional disturbance and their families. The EBT Survey contains questions related to the mental health clinician's knowledge, training, and use of evidence-based treatments in their practice. The EBT Survey was designed as a Web-based survey; however, hard copies of the survey were available upon request.

A two-stage process was used to identify a comprehensive list of mental health clinicians from each targeted community. Target communities included the 23 system of care communities funded in 1997 and 1998 and the two non-funded communities selected for the Phase II Comparison Study. The first stage of the participant identification process involved a structured telephone call to the community contact (i.e., project director in funded communities and field

office staff in comparison communities) during which they were asked to identify all agencies and organizations that provide mental health services to children eligible for, or enrolled in, system of care services. There were 28 first-stage contacts; one contact each from 26 sites in 23 system of care funded communities and two non-funded comparison study communities. Five hundred and seventy-one appropriate agencies were identified at stage one (range 1–129 agencies per stage one contact, average number of agencies per stage one contact = 19.7).

The second stage of the participant identification process involved contact with each agency/organization identified at stage one, and a request for a list (including names and addresses) of their mental health clinicians (1,669 appropriate respondents identified; range 1–90 per agency; average number of appropriate respondents per stage two contact = 5.5). In addition, the second stage contacts were also asked to identify other local agencies/organizations that provide services to these same children. Any agency/organization not previously identified at stage one was added to the stage two contact lists. A proportional sample (using an average of 50 respondents per community for a total of 1,402 respondents as the target) was drawn from the list of identified potential respondents. Sampling was performed within any system of care community where 80 or more potential respondents were identified. No sampling was performed for system of care communities with fewer than 80 identified potential respondents or comparison communities.

A five-stage mailing process was used to recruit selected potential respondents for the cross-sectional EBT Survey (Dillman, 2000). Data collection for the EBT Survey began in late August 2003 continued through January 2004. Survey responses were received from 615 individuals from the 26 sites who were identified via 23 system of care funded sites and two comparison sites. The response rate for the EBT Survey was 44 percent, consistent with published Web-based response rates (Dillman et al., 2001; Frazee, Hardin, Brashears, Smith, & Lockaby, 2002; Ladner, Wingenbach, & Raven, n.d.). Twenty-seven percent of respondents completed the survey via hard copy and 73 percent via the Web.

## **FAMILY-DRIVEN STUDY**

The family-driven study is being conducted by a field-based team of family members and youth who have experience with communities funded by the CMHS grant. This study is being conducted under the leadership of the Federation of Families for Children's Mental Health and the Georgia Parent Support Network in collaboration with ORC Macro. The perspectives and interests of families raising children with serious emotional disturbance who are enrolled in system of care grant communities govern all aspects of this special study. The Federation of Families for Children's Mental Health serves as the lead agency for the study, and was charged with establishing a study team. The study team includes staff members of the national evaluation team.

The broad goal of the family-driven study is to examine how families experience systems of care. Which aspect of that experience would be studied was left up to study team members to determine. So, from its inception, the study was to be driven, in concept, methods, and delivery, by family members. This study endeavors to determine what is important to families and how best to obtain information from them. The intention is to use the results of this study to make service systems more responsive to families.

Family members and experts in the field were engaged to assist in the development of a research question. Study team members used the results of this process to generate the broad study question: Does family engagement in systems of care impact child and family outcomes? The team defined engagement as “the act of doing something for your child, yourself, or your family that determines or derives from a care plan or supports the delivery of services and supports.” Engagement can also be associated with “participation of families and youth with the intention of improving or enhancing service planning and delivery of treatment, services, family supports, or care.”

Following this process, four focus groups were conducted (three with caregivers and one with youth) to obtain final consensus regarding the study question, to explore viability of terminology, and to obtain feedback on study methods. Results indicated that all agreed that the question developed by the team was an important one. However, there was also agreement that the term *engagement* was confusing. In its place they recommended the use of *involvement* or *participation*. Results regarding data collection approaches differed across focus groups. All four of the proposed methods (i.e., in-person interview, mailout survey, mailout survey followed by telephone call, and focus group) were supported by at least one group.

The study team fully used all results of the focus groups to inform decisions regarding study design. The study design involves the use of a mixed-methods approach. A mailout survey has been developed. The survey has both closed- and open-ended items that assess the extent of family involvement in the system of care. A subsample of the survey respondents will be asked to participate in these focus groups. In addition, the survey distribution and data collection process were pilot-tested with nine family members whose children were receiving services in funded system of care communities.

Three of the 22 communities funded in 1999 and 2000 will participate in the study. In each community, 60 caregivers who have children participating in the longitudinal outcome study of the CMHI will receive a mailed copy of the questionnaire. Two focus groups of nine people or less designed to last 1 hour 30 minutes each also will be conducted in the three communities. The participants in the focus groups will be recruited from the pool of individuals who returned their questionnaire to the research team. Participants will be asked to sign a consent form giving the study team permission to obtain their longitudinal outcome study data from the local evaluator. These data will be linked to the family-driven study data to address the research questions.

## **PRIMARY CARE STUDY**

The purpose of the primary care study is to investigate the role of primary health care providers in systems of care and to further understand the impact of services provided within primary care on child and family outcomes. More specifically, the study is designed to answer four main questions:

- What is the physical health status, health care utilization, and health care financing status of children with serious emotional disturbance participating in the program?
- How do the physical health status, health care utilization, and health care financing status of children with serious emotional disturbance participating vary over time and affect child and family outcomes?

- What are the factors that influence primary care providers' active participation in the care of children with serious emotional disturbance who are being served within systems of care?
- How does the health care provided by primary health care providers influence child and family outcomes?

Stakeholders including youth, caregivers, service providers, project directors, and primary care personnel, will guide this three-part study. Part 1 addresses the questions, "What is the physical health status, health care utilization, and health care financing status of children participating in the program", "How do these factors vary over time," and finally, "How do these factors affect child and family outcomes?" This part of the study involves collecting descriptive data on participating children's health status, care, and financing through the Enrollment and Demographic Information Form (EDIF) and Child Information Update Form (CIUF). EDIFs are administered to all children who have received CMHS-supported services. Children enrolled in the longitudinal child and family outcome study also will complete a followup version of the EDIF called the Child Information Update Form every 6 months thereafter for 36 months.

Part 2, conducted during Year 2 of the evaluation, addresses the question, "What are the factors that influence primary health care providers' active participation in the care of children who are being served within systems of care?" Data will be obtained from 10 discussion groups with various stakeholder groups involving nine or fewer participants. Data will be used to develop a model of the factors influencing the role of primary care providers in systems of care and to develop a Primary Care Provider Survey to be administered in Part 3 of this study

Part 3, conducted during Years 3 through 5 of the evaluation, addresses the question, "How does the health care provided by primary care providers influence child and family outcomes?" During Part 3 of the study, primary care providers will be asked to complete the Primary Care Provider Survey. Providers may respond via a Web-based survey or a paper-and-pencil version of the survey. The targeted yearly sample total will be 320 providers.

## **SERVICES & COSTS STUDY (MIS STUDY)**

A Web-based MIS and Technology Survey was designed and conducted in 2004 to assess the degree of data integration across various agencies in system of care communities and the completeness of service and costs data captured in the databases of the grantees. The survey was administered to all system of care communities funded between 1999 and 2003. The survey design was divided into four sections. Part A ascertained whether communities have access to, used, or linked to other agency's databases. Next, communities provided contact information for agencies whose data they can access. All communities indicated whether they can gain access to Medicaid records of children they serve. Also, all communities provided information on whether part of their funding is allocated to integrating data with other child-serving agencies.

If the communities had access to at least one MIS, then they were required to provide up to three successful strategies they used to integrate the data and up to three barriers they encountered when integrating data. If they responded that they did not have access to another agency's data, the communities answered whether they had attempted to integrate data with these other agencies and if so, what barriers they faced when attempting to integrate data. Next, respondents replied whether they stored sources of funding other than CMHS grant dollars electronically and

if so, how often the information was recorded. If the information is not captured electronically, then communities were asked to report whether there are plans to do so.

In addition to cross-agency integration questions covered in Part A, Part B of the MIS and Technology Survey assessed various services available to children in system of care communities and whether the information about these services is captured in the local MIS. If the site offered the listed service and captured the data in the MIS, then respondents indicated what data were captured, such as the unit of service, charge, payment, and adjustment for that service.

In the third section of the survey, Part C, respondents were given an opportunity to list unique services offered in their community that were not listed in the previous section and to describe the information captured by an electronic MIS for these unique services.

Finally, Part D of the survey determined technology use, including use of telemedicine and a Web site. Specifically, communities were asked whether they offered psychiatric assessments, remote therapy sessions, or case conferencing via videoconferencing, or whether they used e-mail to set appointment reminders. Finally, respondents reported which, if any, telehealth technologies were Medicaid reimbursable.

To administer the survey, individual e-mails were sent to project directors, principal investigators, and local site evaluators at each funded community to request that the MIS and Technology Survey be completed. Each e-mail contained a brief description of the survey, a unique user identification and password for each individual to access the survey Web site, and technical support contact information. The Web site was monitored to determine who had completed the survey and to update the completion rate.

For communities that did not complete the survey by the due date, telephone calls were made to determine any problems the user may be having in accessing or completing the survey. Liaisons assigned to each community were updated on their community's progress in completing the survey and assisted in reminding communities to complete the survey. Overall, 36 communities completed the survey in time for the analysis included in this report.

## **SUSTAINABILITY STUDY**

The sustainability study explores the extent to which systems of care are maintained after funding from the CMHI grant program has ended, identifies features of systems of care that are more likely to be sustained, and identifies factors that contribute to or impede the ability to sustain the systems of care developed with grant support. The intent of the study is to learn from the experience of earlier grantees in order to assist current and future grantees to maximize the likelihood that their systems of care will be maintained over time.

The study method includes a Web-based survey completed by key stakeholders in graduated sites and those nearing graduation. Hard copies of the survey are available upon request. Four stakeholders in each grant community complete the Web-based survey: the current or former site project director, a key person responsible for children's mental health in the community, a family member, and a representative from another child-serving agency. The survey protocol explores aspects of systems of care that are likely to be sustained and aspects that are less likely to be

sustained, factors affecting sustainability, and what effects these factors have had in each grant community.

In 2004, the survey was completed by grantees that received funding in 1993 and 1994 and in 1997. After reviewing the survey data, followup telephone interviews were conducted with two of the respondents in each community to obtain additional clarifying and explanatory information related to survey responses and to further explore factors and strategies that affect the maintenance of systems of care. In addition, a telephone interview also will be conducted with the children's mental health director at the State level in each State where local communities are included in the study, in order to obtain a State perspective on maintaining systems of care over time.

The report resulting from this study will be geared to leaders of local systems of care as well as to Federal and State policymakers to enable them to consider sustainability issues at the earliest phases of system development and to learn about strategies and approaches that may enhance their efforts to build enduring systems of care.

## **SYSTEM OF CARE ASSESSMENT**

This study examines whether programs have been implemented in accordance with system of care program theory and documents how systems develop over time to meet the needs of the children and families they serve. Of particular interest is whether services are delivered in an individualized, family-focused, culturally relevant and coordinated manner, and whether the system involves multiple child-serving agencies. Please see Appendix C for a detailed description of this assessment tool. Site visits were conducted every 18 to 24 months. Information was collected through a combination of document reviews, review of randomly selected case records, semistructured interviews, observations made on site, and followup telephone interviews to clarify information. Categories of respondents included project directors, agency representatives, direct service providers, case coordinators, representatives from family organizations, and individual family members.

## **STAKEHOLDER INTERVIEWS**

Thirteen separate semistructured interview guides were used to collect data from key stakeholders at each system of care community, including the project director, representatives from core agencies, family organization representatives, direct service providers, and caregivers whose families are being served. Each respondent was asked questions that they would be most able to answer given their function and perspective. For example, service planning questions were asked of caregivers and case managers and not of the project director. The interviews varied in length, requiring 30 minutes (e.g., intake worker) to 2 hours (e.g., project director) to complete. Some of the items in the interviews were for context or descriptive purposes, while others were linked to indicators on the framework. For items that are rated, interviewers used the response provided by the individual respondent to rate the system on a 5-point scale using the established criteria for that item. That is, the qualitative data collected in the semistructured interviews were used to rate the system of care community on each item. The responses of the various stakeholder informants were rated separately.

## **YOUTH INVOLVEMENT STUDY**

The Youth Involvement Study (YIS) assesses the extent to which youth are active participants at the system and service levels within system of care communities. As a subcomponent of the System of Care Assessment, the YIS provides more detailed descriptions of youth involvement in the mental health service delivery system from the perspectives of youth and youth coordinators. The study examines the barriers and facilitators to youth involvement (including their involvement at the decision-making level, in management and operations of the program, in quality monitoring, in service planning and provision, and in case review), the experience of youth in system of care youth groups, and the support (or lack of support) for youth involvement from administrators and staff in systems of care.

Focus groups were conducted to provide insight into the ways in which youth are involved in systems of care, the benefits from involvement and the challenges of involving youth and developing youth groups. The content of these focus groups was guided by a conference call that was held with youth and youth coordinators, and provided information about the activities and experiences of youth in systems of care. Focus group discussions were analyzed and used to create a standardized youth instrument that captured issues that are relevant to youth. Pilot interviews were conducted subsequently in selected system of care communities. The instruments will be administered through a semistructured on-site interview and interviews are scheduled to begin for communities funded in 2002 and 2004 in spring 2006.

## **TREATMENT EFFECTIVENESS STUDY**

The treatment effectiveness studies (TES) use a randomized, controlled study design (system of care services plus evidence-based practice vs. system of care services only) to evaluate the impact of administering evidence-based treatments in the system of care service setting on child and family outcomes. Three separate studies are being conducted on the following interventions:

- Parent–Child Interaction Therapy (PCIT) in Clackamas County, Oregon, and Eastern Kentucky
- Common Sense Parenting (CSP) in Westchester County, New York, and Marion County (Indianapolis), Indiana
- Brief Strategic Family Therapy (BSFT) in Oklahoma City, Oklahoma, and Cuyahoga County (Cleveland), Ohio

A fourth study will be conducted in a community funded in 2004.

## **STUDY DESIGN**

The study design reflects an integrated process that dovetails with the general child and family outcome study for the national evaluation. This involves initially identifying communities for the study, documenting procedures for the specific intervention to be studied, assessing whether the intervention is implemented as designed, and utilizing a methodology and data collection strategy that builds upon the framework for the child and family outcome study to follow cases across time. In addition to the core data collected on children participating in the child and family outcome study, treatment-specific outcomes related to the evidence-based treatment are

assessed before and after participation in the treatment. Treatment fidelity measures also assess whether the evidence-based treatments are implemented as intended.

All children enrolled into the study must first be enrolled in the local system of care program. The CMHS-funded systems of care are designed to serve children with serious mental health disorders. Thus, the standard severity criteria that are used to enroll children into systems of care also apply to children in the treatment effectiveness study.

In addition to the system of care criteria, children are screened for the disorder most relevant to treatment being examined. For the studies involving communities funded in 1998 and 1999 and also the communities funded in 2002 and 2003, these disorders include attention-deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder identified through the Diagnostic Interview Schedule for Children or the DISC Predictive Scales.

## **PHASE II TREATMENT EFFECTIVENESS STUDY: CLACKAMAS COUNTY, OREGON, AND EASTERN KENTUCKY**

### **Parent–Child Interaction Therapy**

The Phase II TES was implemented in April 2003 in Clackamas County, Oregon, and in southeastern Kentucky. Parent–Child Interaction Therapy (PCIT) is an empirically supported treatment for young children with disruptive behavior disorders such as conduct disorders, attention-deficit/hyperactivity disorder, and oppositional defiant disorders. This therapy emphasizes improving the quality of the parent–child relationship and changing parent–child interaction patterns. Enrollment into the TES has ended in both sites and data collection continued through October 2005.

The TES incorporated a randomized control study design. Preliminary analyses comparing the demographic characteristics of the treatment group versus the control group found no significant differences between the groups on factors of gender, age, race and ethnicity, custodial status, family income, Medicaid eligibility status, and referral source. Given the quality of the design, any differences that are found in outcomes can be attributed to PCIT. Efforts are ongoing to analyze the impact of PCIT on child and family outcomes.

## **PHASE III TREATMENT EFFECTIVENESS STUDY: WESTCHESTER COUNTY, NEW YORK, AND MARION COUNTY, INDIANA**

### **Common Sense Parenting**

The Phase III TES was implemented in April 2004 in Westchester County, New York, and in August 2004 in Marion County, Indiana. Common Sense Parenting (CSP) is a skill-based parenting program developed by Girls and Boys Town (Burke & Herron, 1996) that provides parents with easy-to-learn techniques and strategies aimed at lessening children’s problem behaviors, building parent–child relationships, and working with families from various backgrounds. Enrollment and data collection are ongoing at both sites.

Comparisons of child and family outcomes for the treatment versus control groups and analyses of treatment fidelity will be conducted as part of this study.

## **PHASE IV TREATMENT EFFECTIVENESS STUDY: OKLAHOMA CITY, OKLAHOMA, AND CLEVELAND, OHIO**

### **Brief Strategic Family Therapy**

Two sites funded in 2002 and 2003 were selected to participate in the Phase IV TES: the Oklahoma State Systems of Care Initiative, Oklahoma City, Oklahoma, and Project TAPESTRY, Cuyahoga County (Cleveland), Ohio. Brief Strategic Family Therapy (BSFT) was selected as the intervention in these communities. BSFT is a family-based intervention that recognizes the family as a system. This treatment mode strives to improve family functioning to address the youth's behavioral problems. BSFT was developed at the Spanish Family Guidance Center in the Center for Family Studies at the University of Miami. Providers in Oklahoma City completed BSFT training and study enrollment, and data collection began in October 2005. Providers in Cleveland completed training in October 2005, and study enrollment is expected to begin in 2006.

### **WRAPAROUND FIDELITY STUDY**

In recent years, prominent thinkers in children's mental health have increasingly asserted that improving outcomes for youth with serious mental health problems will require deployment of evidence-based practices combined with methods, such as development of systems of care and the wraparound process, to ensure accessibility and relevance of services and supports for children and families (Tolan & Dodge, 2005). The *wraparound process* is an intensive community-based intervention that has been cited in Surgeon General's Reports on both mental health and youth violence as a promising service delivery option (DHHS, 1999, 2001). This care management process uses a definable, team-based planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes (Bruns et al., 2004; Burchard, Bruns, & Burchard, 2002; Burns & Goldman, 1999). Wraparound is employed in the majority of currently funded Federal grant communities; however, despite its widespread use, the research base on the wraparound process has been slow to develop. The current project aims to advance our understanding of (a) how fully the wraparound process is implemented in typical systems of care for children and families, and (b) what outcomes are associated with greater fidelity to the defined wraparound model.

The Wraparound Comparison Study (WACS) enrolls families who have already consented to be enrolled in the national evaluation of the CMHI, and for whom outcomes measures are being collected as part of the national evaluation. For families who agree to be part of the WACS, study staff administer the Wraparound Fidelity Index, version 3.0 (WFI-3) via telephone to the enrolled children's parents or caregivers, and to wraparound facilitators (service providers employed by the study site). WFI-3 interviews are conducted at 6 and 12 months post-enrollment in services. Results from the WFI will be analyzed to assess fidelity to the wraparound process in study sites. In addition, outcomes data collected via the national evaluation will be analyzed at the site- and individual child and family level to assess the association between wraparound fidelity and outcomes. Specifically, the following research questions will be addressed:

- How does adherence to core principles of the wraparound process vary across CMHS-funded system of care sites?
- How do child and family outcomes vary across CMHS-funded system of care communities that propose to use the wraparound process? What is the association between level of adherence to wraparound and outcomes at the site level?
- Across individual families, what is the relationship between wraparound fidelity and client outcomes? How much variance in outcomes is accounted for by the level of fidelity achieved by individual wraparound facilitators?

In addition to allowing investigation of the above research questions, the study has been facilitating ongoing quality assurance by participating communities. All sites regularly receive individually tailored wraparound fidelity reports (at a site level; no identifying information on families or providers is included) to aid their training, technical assistance, and policy and program planning.

Data collection in all participating study sites is now complete. The study team at the University of Washington is now working with national evaluators at ORC Macro to merge fidelity and outcomes data to conduct analyses that will address the above research questions.

# APPENDIX C

## MEASURES

### INTRODUCTION

Descriptive data were collected primarily from caregivers as their children entered system of care services, and some data such as diagnostic assessments were drawn from intake records. For children enrolled in the outcomes study, caregivers reported on children's strengths (Behavioral and Emotional Rating Scale [BERS]; Epstein & Sharma, 1998), functional impairment (Child and Adolescent Functional Assessment Scale [CAFAS]; Hodges, 1990), behavioral and emotional problems (Child Behavior Checklist [CBCL]; Achenbach, 1991a), caregiver strain (Caregiver Strain Questionnaire [CGSQ]; Brannan Heflinger, & Bickman, 1997), educational history (EQ), family resources (Family Resource Scale [FRS]; Dunst & Leet, 1985), stability of the child's living situation (ROLES-R), and service utilization (MSSC). Children 11 years or older reported on their behavioral and emotional problems (Youth Self-Report [YSR]; Achenbach, 1991b), delinquent behaviors (DS), and history of substance use (SUS-AB). Both caregivers and youth reported on their family's functioning (Family Assessment Device [FAD]; Epstein, Baldwin, & Bishop, 1983) and their satisfaction with services (Family Satisfaction Questionnaire-Abbreviated [FSQ-A] and Youth Satisfaction Questionnaire-Abbreviated [YSQ-A]).

In the comparison study of the national evaluation, in addition to the descriptive and outcomes measures mentioned above, an additional measure was administered, the Experience with Service System Questionnaire (ESSQ).

The following section provides a brief list of the descriptive and outcome data collected. The rest of this appendix provides more detailed information on each of the measures used in the national evaluation. These measures are listed in alphabetical order.

### MEASURES USED IN COMMUNITIES FUNDED IN 1997, 1998, 1999, AND 2000

#### DESCRIPTIVE AND OUTCOME STUDY

- Demographics, medications, chronic illnesses – Descriptive Information Questionnaire (DIQ)
- Caregiver strain – Caregiver Strain Questionnaire (CGSQ)
- Child behavior – Child Behavior Checklist (CBCL) and Youth Self-Report (YSR)
- Child functioning – Child and Adolescent Functional Assessment Scale (CAFAS)
- Child strengths – Behavioral and Emotional Rating Scale (BERS)
- Clinical history – Administrative Record (AR)
- Delinquent behaviors – Delinquency Survey (DS)
- Educational indicators – Education Questionnaire (EQ)
- Family functioning – Family Assessment Device (FAD)

- Family resources – Family Resource Scale (FRS)
- Family satisfaction – Family Satisfaction Questionnaire–Abbreviated (FSQ–A)
- Service use information – Multi-Sector Service Contacts (MSSC)
- Stability of living situations – Restrictiveness of Living Environments and Placement Stability Scale–Revised (ROLES–R)
- Substance abuse – Substance Use Survey (SUS–AB)
- Youth satisfaction – Youth Satisfaction Questionnaire–Abbreviated (YSQ–A)

## **DESCRIPTIONS OF THE DESCRIPTIVE AND OUTCOME STUDY MEASURES**

### **Behavioral and Emotional Rating Scale (BERS)**

The BERS identifies the emotional and behavioral strengths of children. Whereas most existing assessment measures focus on deficits and problems, the BERS focuses on areas of strength and resiliency. The principal uses of the BERS include identifying children with limited strengths, targeting goals for an individual treatment plan, identifying strengths and weaknesses for intervention, documenting progress in a strength area as a consequence of specialized services, and measuring strengths in research and evaluation projects.

The 52-item checklist includes items that identify emotional and behavioral strengths of children across five dimensions of childhood strengths that correspond to the five subscales in the measure. The dimensions and subscales are Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength. Behaviors are rated on a 4-point scale: (0) *not at all like the child*, (1) *not much like the child*, (2) *like the child*, and (3) *very much like the child*.

The BERS has demonstrated test–retest reliability, interrater reliability, and internal consistency (Epstein, Cullinan, Harniss, & Ryser, 1999). Test–retest reliability coefficients for the BERS subscales ranged from .85 to .99 with a 10-day interval between the two ratings. Interrater reliability was tested using a sample of 96 students with emotional and behavioral disorders rated by their special education teachers. Cronbach’s alpha coefficients for the scales were .83 or above. Content validity (Epstein, 1999) and convergent validity (Harniss, Epstein, Ryser, & Pearson, 1999) have been established.

### **Caregiver Strain Questionnaire (CGSQ)**

The CGSQ assesses the extent to which caregivers are affected by the special demands associated with caring for a child with emotional and behavioral problems. It is currently being used in several studies of children’s mental health services. The CGSQ provides a way to assess the impact that participating in system of care services has on the strain caregivers and families may experience (e.g., determining whether strain lessens over time as better services and supports are provided by the system of care).

The CGSQ contains 21 items that assess strain experienced by caregivers in the last 6 months related to the care of a child with emotional and behavioral challenges. It is comprised of three related dimensions of caregiver strain: objective strain, subjective internalizing strain, and

subjective externalizing strain. The CGSQ is a 5-point scale with the following response options: (1) *not at all*, (2) *a little*, (3) *somewhat*, (4) *quite a bit*, and (5) *very much*.

The CGSQ demonstrated good reliability and validity in previous research. Confirmatory factor analysis findings from previous research with the CGSQ have supported the existence of three related dimensions of caregiver strain (Brannan et al., 1997). The three CGSQ subscales demonstrated adequate internal consistency with alpha coefficients ranging from .73 to .91 (Heflinger, Northrup, Sonnichsen, & Brannan, 1998). In addition, the CGSQ subscales were found to correlate with measures of family functioning and caregiver distress in expected ways, providing evidence of construct validity (Brannan et al., 1997). The predictive validity of the CGSQ is supported by findings that the prediction of service utilization pattern by the CGSQ was above that provided by measures of the child's clinical and functional status (Foster, Summerfelt, & Saunders, 1996; Lambert, Brannan, Breda, Heflinger, & Bickman, 1998).

### **Child and Adolescent Functional Assessment Scale (CAFAS)**

The CAFAS is a widely used measure of child functioning. It assesses the degree to which a youth's mental health or substance abuse disorder is disruptive to his or her functioning in everyday life in each of eight psychosocial domains: the community, the school, the home, substance use, moods and emotions, self-harming behavior, behavior towards others, and thinking. The CAFAS is designed to assess the effects of the child's challenges and behaviors on his or her ability to function successfully in various life domains. For instance, a youth with a variety of symptoms as indicated on the CBCL may still function successfully in the community, in school, and in relationships with family and friends.

A score is assigned to each subscale by the CAFAS rater to designate the level of impairment the child is experiencing for that life domain. For each subscale, there is a "menu" of behaviors associated with each level of impairment. The four levels of severity are as follows:

- (30) Severe impairment (severe disruption or incapacitation)
- (20) Moderate impairment (major or persistent disruption)
- (10) Mild impairment (significant problems or distress)
- (0) Minimal or no impairment (no disruption of functioning)

Good interrater reliability has been found among a variety of raters, including mental health intake workers, providers, lay raters, and graduate students. Hodges & Wong (1996) reported that the most behaviorally oriented scales (e.g., community role and home role) had the highest reliability, with correlations for the total CAFAS score ranging from .92 to .96 across four different samples. Intra-class correlations for total scores ranged from .84 to .89. Adequate test-retest reliability has also been reported (Cross & McDonald, 1995). A variety of studies (e.g., Hodges, Lambert, & Summerfelt, 1994) demonstrated the construct, concurrent, and discriminant validity of the CAFAS when used with child clinical samples.

## **Child Behavior Checklist (CBCL)**

The CBCL is designed to provide a standardized measure of symptoms and behavioral and emotional problems among children aged 4 through 18 years. The CBCL has been widely used in children's mental health services research and for clinical purposes to assess social competence, behaviors, and feelings. The CBCL elicits a rich and detailed description of behaviors and symptoms that provides information beyond diagnosis.

Although it does not yield diagnoses, the CBCL assesses children's symptoms along a continuum and provides a total problems score; two broadband syndrome scores; eight narrow-band syndrome scores; and competence scores in activities, social, and school.

Achenbach (1991a) has reported a variety of information regarding internal consistency, test-retest reliability, construct validity, and criterion-related validity. Good internal consistency was found for the Internalizing, Externalizing, and Total Problems scales ( $\alpha \geq .82$ ). The CBCL demonstrated good test-retest reliability after 7 days (Pearson  $r$  at or above .87 for all scales). Moderate to strong correlation with the Connor Parent Questionnaire and the Quay-Peterson scale (Pearson  $r$  coefficients ranged from .59 to .88) suggested the construct validity of the CBCL. The CBCL was, for most items and scales, capable of discriminating between children referred to clinics for needed mental health services and those youth not referred (Achenbach, 1991a). A variety of other studies have also shown good criterion-related or discriminant validity (e.g., Barkley, 1988; McConaughy, 1993).

The instrument has been nationally normed on a proportionally representative sample of children across income and racial and ethnic groups. Racial and ethnic differences in total and subscale scores of the CBCL disappeared when controlling for socioeconomic status, suggesting a lack of instrument bias related to differences in race and ethnicity.

## **Delinquency Survey (DS)**

The Delinquency Survey gathers information reported by youth about their delinquent behaviors such as contact with law enforcement and juvenile justice. The questionnaire consists of 25 items that assess the youth's behaviors toward others in the community, and contact with law enforcement, including criminal offenses, arrests, and probation. Nineteen of the 25 items ask specific questions about the youth's delinquent acts, such as fire setting, stealing, and property damage. These 19 items are coded along a 3-point scale that measures the frequency of these acts: (1) *none*, (2) *one time*, and (3) *two or more times*.

There is no formal reliability and validity information for the DS. However, field testing and review of the measure have been conducted in the comparison study communities funded in 1993 and 1994. Based on reliability analysis of the national evaluation data from grant communities funded in 1997 and 1998, Cronbach's alpha coefficient for the 19 delinquent act items was .83.

### **Descriptive Information Questionnaire (DIQ)**

The DIQ was developed to provide a uniform method of collecting the descriptive data elements required by the CMHI. DIQ information is collected at baseline and followup.

As a method for collecting descriptive information, conventional assessments of reliability and validity are not appropriate for the DIQ baseline version. However, data collected with the DIQ baseline version will be compared to descriptive data provided in the fiscal MISs used in the services and costs study to check for consistency.

### **Education Questionnaire (EQ)**

The EQ was developed to collect information on children's educational status and their experiences in school during the past 6 months. The EQ contains 21 questions, including items about school (1st grade through 12th grade) attendance; grade level; school achievement; type of school setting (e.g., special or alternative school); reasons for placements; special education; overall academic performance; and whether the child has been suspended, detained, or expelled from school. The final items on the questionnaire assess availability and effectiveness of help (from the school) to meet the educational, behavioral, and/or emotional needs of the child.

There is no formal reliability and validity information for the EQ because items included on the questionnaire do not measure a single educational domain. However, the EQ has been reviewed and revised by experts with experience and knowledge in special education and education in general.

### **Family Assessment Device (FAD)**

Based on the multidimensional McMaster model of family functioning, the FAD is a self-report measure of how families interact, communicate, and work together (Epstein et al., 1983). For the national evaluation of grant communities funded in 1997 and 1998, the complete 60-item scale was used. For the national evaluation of grant communities funded in 1999 and 2000, only the General Functioning Scale (GFS), an abbreviated version of the complete measure, was used.

Internal consistency has been good across many studies and samples, with alphas ranging from .71 to .92 across the seven subscales (Byles, Byrne, Boyle, & Offord, 1988; Heflinger et al., 1998; Perosa & Perosa, 1990). Test-retest reliability after 7 days was also found to be good with correlations for most subscales above .70 (Kabacoff, Miller, Bishop, Epstein, & Keitner, 1990; Miller, Epstein, Bishop, & Keitner, 1985). Construct validity has been supported in several studies, with the FAD correlating in the expected directions with other measures of family functioning, family cohesion, marital satisfaction, and other family factors (Byles et al., 1988; Epstein et al., 1983; Fristad, 1989; Heflinger et al., 1998; Miller et al., 1985). The FAD demonstrated good predictive validity, distinguishing between families in clinical treatment and those who were not (e.g., Epstein et al., 1983; Fristad, 1989). In addition, the FAD did not correlate significantly with the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), suggesting that responses to the FAD were not greatly influenced by social desirability.

Validity was further indicated by confirmatory factor analyses that supported the original scale structure; 90 percent of the items loaded on the factors hypothesized by the McMaster model (Kabacoff et al., 1990). This factor structure held across three separate samples.

### **Family Resource Scale (FRS)**

The FRS is used to assess the caregiver's perception of the adequacy of the resources (e.g., food, shelter, money for bills) available to the family in the past 6 months. The FRS was developed for use with families of children with special needs and has been used with families of children with serious emotional disturbance. The FRS is based on the premise that the adequacy of resources necessary to meet individually identified needs will affect both family well-being and caregiver capacity to participate fully in child treatment and care plans.

The scale includes 30 items that assess adequacy of resources for the family. Some items inquire about basic necessities and other items inquire about resources beyond those needed for basic physical survival. Five response options are used to assess the adequacy of each resource: (1) *not at all adequate*, (2) *seldom adequate*, (3) *sometimes adequate*, (4) *usually adequate*, and (5) *almost always adequate*.

The reliability and validity information on the FRS comes from studies of two populations: children who were retarded, handicapped, or developmentally at risk (Dunst & Leet, 1987), and children with emotional and behavioral disturbance (Heflinger et al., 1998). In both samples, good internal consistency among all the items was demonstrated, with alpha coefficients ranging from .92 to .95 (Dunst & Leet, 1987; Heflinger et al., 1998). Test-retest reliability after 2–3 months was .52 (Dunst & Leet, 1987).

Exploratory factor analysis suggested good construct validity yielding eight factors that accounted for 75 percent of the variance (Dunst, Leet, & Trivette, 1988). Construct validity was further supported in correlational analyses that found statistically significant relationships, in the hypothesized directions, between the FRS total score and other family variables such as caregiver strain, family functioning, negative life events, social support, and parental distress (Heflinger et al., 1998). In addition, the FRS demonstrated good criterion validity, with family resources found to be predictive of commitment to carrying out prescribed child treatment plans (Dunst et al., 1988).

### **Family Satisfaction Questionnaire–Abbreviated Version (FSQ–A)**

The FSQ–A assesses the caregiver's satisfaction in the past 6 months. It contains one screening question followed by 14 items divided into two parts. The initial screening question asks whether the caregiver, youth, and/or his or her family have received any services in the past 6 months. If not, the remainder of the questionnaire is skipped.

The first part of the FSQ–A contains seven items that assess the caregiver's satisfaction with services as a whole, the child's progress, and the cultural competence and family-focused nature of services. Respondents report their satisfaction on a 5-point scale: (1) *very dissatisfied*, (2) *dissatisfied*, (3) *neutral*, (4) *satisfied*, and (5) *very satisfied*. The second part of the FSQ–A contains seven items that assess whether the services the family received improved the caregiver's (or other family member's) ability to work for pay, and quantifies the impact in terms of days worked.

The measures from which the satisfaction items were extracted have demonstrated internal consistency in their original forms. The items collected for the abbreviated versions also

demonstrated internal consistency. Based on reliability analysis of the national evaluation data from grant communities funded in 1997 and 1998, Cronbach's alpha coefficient for the seven satisfaction rating items (Item 1 through Item 7) was .88.

### **Multi-Sector Service Contacts (MSSC)**

The MSSC assesses the types and frequencies of services children and families receive across different service settings and child-serving sectors as well as the caregiver's perceptions about whether services met the child and family's needs. The MSSC identifies the services received; service settings; and the location, frequency, and sequence of services for 22 different types of services.

Based on reliability analysis of the national evaluation data from grant communities funded in 1997 and 1998, Cronbach's alpha coefficient was .98 for the 22 items (Items 3, 4, 5, etc.) that asked about whether a child received services or not in the past 6 months.

### **Restrictiveness of Living Environments and Placement Stability Scale—Revised Version (ROLES–R)**

Originally developed to operationalize the concept of restrictiveness, this scale incorporates an adapted version of the Restrictiveness of Living Environments Scale (ROLES) with a Placement Stability Scale. In the original scale, ratings of restrictiveness were associated with each of the living arrangements or placements. In this revised version, the ratings are not calculated but valuable information about the type of placement and length of stay is captured.

Collecting information regarding the nature of children's living environments helps determine how the type and number of living arrangements may affect children's lives. For instance, children with fewer changes in living environments within a 6-month period may experience more stability.

- The ROLES–R documents the settings in which children have lived (starting with the most recent settings) during the past 6 months. There are 27 placement categories, including the following:
- Independent, living by self
- Living independently in community with minimal supervision
- Two parents/caregivers, at least one biological
- Biological mother only, without partner
- Camp
- Supervised independent living
- Foster care

No formal reliability and validity information is available on the original ROLES; however, expected relationships have been found between levels of restrictiveness, as assessed with the original ROLES, and programmatic variables. The original ROLES was used to document changes in the restrictiveness of placements over time as a quality assurance indicator for children in foster care (Thomlison, 1993) and as a process outcome for a therapeutic case

management program for children with severe emotional disturbance (Yoe, Bruns, & Burchard, 1995).

### **Substance Use Survey (SUS–AB)**

The SUS–AB provides important information regarding the self-reported substance abuse of the children and youth in the national evaluation.

The SUS–AB has two parts:

- SUS–A. The SUS–A collects information about the frequency of a youth’s substance use, including use of cigarettes, alcohol, and other drugs.
- SUS–B. The SUS–B focuses on the consequences of substance use that youth have experienced ever and during the past 6 months. The SUS–B is adapted from the Child and Adolescent Functional Assessment Scale (CAFAS) Parent Report with permission of the author and is for use only in the CMHS national evaluation.

*SUS–A.* The first nine items measure a youth’s use of alcohol (including history and frequency of drinking behaviors) and cigarettes. The next 12 items focus on the youth’s use of illegal substances. The remaining items assess the youth’s illicit use of prescription drugs and use of nonprescription or over-the-counter drugs for recreational purposes. Response options for the first nine items include yes/no and multiple choice. Response options for the next 12 items include yes/no (e.g., ever used substance, yes or no), fill-in-the-blank (e.g., age at first usage, number of times used in past 30 days), and multiple choice.

*SUS–B.* Twenty-one items assess the consequences of the youth’s alcohol or drug use. Questions ask about the youth’s lifetime experiences (ever) and the consequences experienced in the past 6 months. Response options for the SUS–B are yes/no (were consequences of usage experienced, yes or no).

Based on reliability analysis of the national evaluation data from grant communities funded in 1997 and 1998, Cronbach’s alpha coefficient for the items on lifetime substance use on the SUS–A (SUS–A Items 1, 6, 10, 11a, 12a, 13a, 14a, 15a, 16a, 17a, 18a, 19a, 20a, and 21a) was .84. Cronbach’s alpha coefficient for the lifetime consequence items on the SUS–B (all the a. items on the SUS–B, e.g., Items 1a, 2a, 3a, etc.) was .89.

### **Youth Satisfaction Questionnaire–Abbreviated Version (YSQ–A)**

The YSQ–A assesses youth satisfaction in the past 6 months. It contains one screening question followed by eight satisfaction-related items. The screening (initial) question asks whether the youth or their family have received any services in the past 6 months. If not, the remainder of the questionnaire is skipped.

The next seven items assess youth satisfaction with services as a whole, the youth’s progress, and the cultural competence and individualization of services received. Respondents report their satisfaction on a 5-point scale: (1) *very dissatisfied*, (2) *dissatisfied*, (3) *neutral*, (4) *satisfied*, and (5) *very satisfied*. The last item asks whether services were helpful, and if so, what was the most helpful thing about the services received.

The measures from which the satisfaction items were extracted have demonstrated internal consistency in their original forms. The items collected for the abbreviated versions also demonstrated internal consistency. Based on reliability analysis of the national evaluation data from grant communities funded in 1997 and 1998, Cronbach's alpha coefficient for the seven satisfaction rating items (Items 1 through 7) was .89.

### **Youth Self-Report (YSR)**

The YSR is the adolescent self-report version of the Child Behavior Checklist (CBCL) and has been widely used in the field of children's mental health services research as well as for clinical purposes. The YSR assesses an adolescent's perceptions of his or her social competence and behavioral and emotional problems. It is necessary to have both reports (caregivers with the CBCL and youth with the YSR) because there is evidence that caregivers are more reliable informants about children's externalizing behaviors (e.g., conduct problems), while adolescents are more reliable informants of their own internalizing symptoms (e.g., sadness, worry).

Like the CBCL, the YSR provides a total problems score; two broadband syndrome scores; eight narrow-band syndrome scores; and competence scores in activities, social, and school.

Achenbach (1991b) reported internal consistency, test-retest reliability, construct validity, and criterion-related validity for the YSR. For the Internalizing, Externalizing, and Total Problems scales, Cronbach's alpha was .89 or higher. Assessment of the test-retest reliability of the YSR found correlation coefficients of .91 for older youth (aged 15–18 years) and .67 to .70 for younger youth (aged 11–14 years). The Internalizing and Externalizing scales of the YSR correlated in expected ways with other adolescent self-report measures (Thurber & Hollingsworth, 1992). For most of its scales, the YSR successfully discriminated between clinical and nonclinical samples (Achenbach, 1991b).

## **SYSTEM OF CARE ASSESSMENT**

The system of care assessment is guided by a conceptual framework that describes generic components of any service delivery system and rates each component on how well system of care principles are manifest. The framework is organized into a table with two domains that each contains four service system components that form the columns of the table. The domains are infrastructure and service delivery. The infrastructure domain is comprised of four components that address governance, management and operations, service array, and evaluation and quality monitoring. The service delivery domain is comprised of four components that address entry into services, service planning, service provision, and case review. Definitions of the components are provided in Table C-1.

**Table C-1  
Definition of Service System Components**

<b>Infrastructure</b>	
Governance	The governing structure responsible for explicating the system's goals, vision, and mission; strategic planning and policy development; and establishing formal arrangements among agencies. Governance structures may be boards of directors, oversight or steering committees, interagency boards, or management teams.
Management and Operations	The administrative functions and activities that support direct service delivery. For this study, this component focuses primarily on staff development, funding approaches, and procedural mechanisms related to the implementation of the system of care service delivery system.
Service Array	The range of service and support options available to children and their families across the system of care.
Quality Monitoring	Quality management conducted by the system that tracks the integration of process assessment and outcome measurement, and the use of continuous feedback loops to improve service delivery.
<b>Service Delivery</b>	
Entry into Service System	The processes and activities associated with children and families' initial contact with the service system, including eligibility determination.
Service Planning	The identification of services for children and families through initial development as well as periodic updating of initial service plans.
Service Provision	The processes and activities related to the ongoing receipt of and participation in services.
Case Review Structure	The process used to review the care of children at risk of out-of-home or out-of-community placement. For those already in such placements, there may be routine monitoring to determine whether that setting is still appropriate, or to plan transition to services in the community or back to the home. This process may also include review of challenging cases to resolve difficult problems that could not be resolved by other means. Key to the case review process is that the persons involved have the authority to make service decisions, including transitions to and from restrictive or out-of-community placements.

The rows of the framework table are comprised of eight system of care principles: family focused, individualized, culturally competent, interagency, collaborative and coordinated, accessible, community based, and least restrictive. Definitions of the system of care principles are provided in Table C-2.

**Table C-2  
Definition of System of Care Principles**

<b>Principle</b>	<b>Definition</b>
Family Focused	The recognition that (a) the ecological context of the family is central to the care of all children; (b) families are important contributors to, and equal partners in, any effort to serve children; and (c) all system and service processes should be planned to maximize family involvement.
Individualized	Provision of care that is expressly child centered, addresses child-specific needs, and recognizes and incorporates child-specific strengths.
Culturally Competent	Sensitivity and responsiveness to, and acknowledgment of, the inherent value of differences related to race, religion, language, national origin, gender, socioeconomic background, and community-specific characteristics.
Interagency	The involvement and partnership of core agencies in multiple child-serving sectors, including child welfare, health, juvenile justice, education, and mental health.
Collaborative/ Coordinated	Professionals working together in a complementary manner to avoid duplication of services, eliminate gaps in care, and facilitate child and family movement through the service system.
Accessible	The minimizing of barriers to services in terms of physical location, convenience of scheduling, and financial constraints.
Community Based	The provision of services within close geographical proximity to the targeted community.
Least Restrictive	The provision of services in settings that maximize freedom of choice and movement, and that present opportunities to interact in normative environments (e.g., school and family).

The intersection of these organizational aspects and system of care principles form the assessment framework. Each component within the two domains (infrastructure and service delivery) is rated on the extent to which it manifests system of care principles. Each cell in the framework contains indicators or measures of system performance that are linked to a series of questions asked of respondents during semistructured interviews described below. The indicators upon which the ratings are based are included in each cell of the framework. For example, for the cell in which governance and family focused intersect, questions are asked about three distinct indicators to address the general question, “To what extent is system governance conducted in a family-focused way?”

## **RELIABILITY AND VALIDITY**

Interrater reliability (i.e., reduce variation across raters) is assured by explicitly defined rating criteria for each item. Site visitors participate in a 3-day training session to learn how to apply the criteria in a standard fashion. Each site visitor is required to achieve 85 percent agreement with accurate ratings for 25 hypothetical scripts. Additionally, reliability testing and refresher training sessions are conducted annually to ensure continued reliability among site visitors.

## **DATA ANALYSIS METHODS**

The quantitative data are determined from items linked to framework indicators. Site visitors rate these items on a 5-point scale, with 1 being the lowest and 5 the highest possible rating. For each

interview, items are rated using only information reported by that specific informant and are based on standard criteria. Mean ratings are derived from ratings of the system of care assessment protocols. This information reveals how systems of care develop or are developing vis-à-vis system of care principles.

The qualitative data are derived from a narrative report that organizes and describes all information obtained from the community. The report includes a summary of service component areas, as well as a brief and preliminary synopsis of observed salient strengths and challenges. The report is entered into the *Atlas.ti* qualitative analysis software that organizes and classifies all information. The data are analyzed according to a set of defined codes that are assigned to segments of the text. The codes are identified a priori, and represent components of the system of care service structure.

## **MEASURES USED IN COMMUNITIES FUNDED IN 2002 AND 2003**

### **DESCRIPTIVE AND OUTCOME STUDY**

- Demographics, medications, chronic illnesses – Caregiver Information Questionnaire (CIQ) and Youth Information Questionnaire (YIQ)
- Caregiver strain – Caregiver Strain Questionnaire (CGSQ)
- Child behavior – Child Behavior Checklist 1½–5 (CBCL 1½–5) and Child Behavior Checklist 6–18 (CBCL 6–18)
- Child development – Vineland Screener 0–Under 3 (VS1), Vineland Screener 3–5, (VS2), and Vineland Screener 6–12 (VS3)
- Child social functioning – Columbia Impairment Scale (CIS)
- Child strengths – Behavioral and Emotional Rating Scale–2: Parent Rating Scale (BERS–2C) and Behavioral and Emotional Rating Scale–2: Youth Rating Scale (BERS–2Y)
- Clinical history – Enrollment and Descriptive Information Form (EDIF) and child Information Update Form (CIUF)
- Cultural competence of services – Cultural Competence and Service Provision Questionnaire (CCSP)
- Delinquent behaviors – Delinquency Survey–Revised (DS–R)
- Educational indicators – Education Questionnaire–Revised (EQ–R)
- Family functioning – Family Life Questionnaire (FLQ)
- Family satisfaction – Youth Services Survey for Families (YSS–F)
- Service use information – Multi-Sector Service Contacts–Revised (MSSC–R)
- Stability of living situations – Living Situations Questionnaire (LSQ)
- Substance abuse – Substance Use Survey–Revised (SUS–R) and GAIN Quick–R Substance Problem Scale (GAIN)
- Youth anxiety – Revised Children’s Manifest Anxiety Scale (RCMAS)
- Youth depression – Reynold’s Adolescent Depression Scale–Second Edition (RADS–2)
- Youth satisfaction – Youth Services Survey (YSS)

## **DESCRIPTIVE AND OUTCOMES STUDY MEASURES**

### **Behavioral and Emotional Rating Scale–Second Edition, Parent Rating Scale (BERS–2C)**

The BERS–2C is administered to caregivers of children participating in the outcome study. The 57-item checklist measures children’s behavioral and emotional strengths in six different areas: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and career strength. Caregivers may respond based on a 4-point scale: (0) not at all like your child, (1) not much like your child, (2) like your child, and (3) very much like your child.

Several analyses reported in the BERS–2 Examiner’s Manual, 2nd Edition indicated that the BERS–2C demonstrates adequate reliability. Coefficient alphas are reported for each BERS–2C subscale across 12 different age intervals in the BERS–2 Examiner’s Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .80 to .93. The average for the strength index across the 12 age intervals was .97.

Two studies reported in the BERS–2 Examiner’s Manual, 2nd Edition examined the test–retest reliability of the BERS–2C. In the first study, test–retest correlation coefficients for the BERS–2C subscales ranged from .80 to .94. The coefficient for the strength index was .90. In the second study, test–retest correlation coefficients for the BERS–2C subscales ranged from .88 to .92, while the coefficient for the strength index was .87. All of these coefficients are in the very large range (Hopkins, 2002). Finally, interrater reliabilities between parent and student ratings on each of the subscales ranged from .50 to .63, while the interrater reliability on the Strength Index was .54.

Several analyses reported in the BERS–2 Examiner’s Manual, 2nd Edition indicate that the BERS–2C demonstrates adequate validity. Concerning construct-identification validity, confirmatory factor analysis supports the factor structure of the five core subscales used in calculating the strength index (Epstein, 2004). In addition, correlations between the BERS–2C standard scores and the Child Behavior Checklist (Achenbach & Rescorla, 2001) total problems score, broadband syndrome scores, narrow-band syndrome scores, competence scores, and total competence score were in the expected direction, demonstrating criterion-prediction validity. Finally, correlations between the BERS–2C standard scores and the Total Social Skills scale of the Social Skills Rating System, Parent Form (Gresham & Elliot, 1990) were positive, while correlations between the BERS–2C standard scores and the Total Problem Behavior scale of the Social Skills Rating System were negative. These correlations were in the hypothesized direction as well, further evidencing criterion-prediction validity.

### **Behavioral and Emotional Rating Scale–Second Edition, Youth Rating Scale (BERS–2Y)**

The BERS–2Y is a youth version of the BERS–2C. It is administered to youth 11 years and older who are participating in the outcome study. As with the caregiver version, the BERS–2Y uses a 57-item checklist to measure children’s emotional and behavioral strengths in six different areas: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and career strength. Youth may respond based on a 4-point scale: (0) *not at all like you*, (1) *not much like you*, (2) *like you*, and (3) *very much like you*.

Several analyses reported in the BERS–2 Examiner’s Manual, 2nd Edition indicated that the BERS–2Y demonstrates adequate reliability. Coefficient alphas are reported for each BERS–2Y subscale across six different age intervals in the BERS–2 Examiner’s Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .79 to .88, while the average for the strength index across the six age intervals was .95. Test–retest correlation coefficients for the BERS–2Y subscales ranged from .84 to .91, while the coefficient for the strength index was .91. Finally, interrater reliabilities between parent and student ratings on each of the subscales ranged from .50 to .63, while the interrater reliability on the strength index was .54.

Several analyses reported in the BERS–2 Examiner’s Manual, 2nd Edition indicated that the BERS–2Y demonstrates adequate validity. Concerning construct-identification validity, confirmatory factor analysis supports the factor structure of the five core subscales used in calculating the Strength Index (Epstein, 2004). In addition, correlations between the BERS–2Y standard scores and the Youth Self-Report (Achenbach, 1991b) total problems score, broadband syndrome scores, narrow-band syndrome scores, competence scores, and total competence score were in the expected direction, demonstrating criterion-prediction validity. Finally, correlations between the BERS–2Y standard scores and the Total Social Skills scale of the Social Skills Rating System, Student Form (Gresham & Elliot, 1990) were in the hypothesized direction (i.e., positive), further evidencing criterion-prediction validity.

### **Caregiver Information Questionnaire (CIQ)**

The CIQ is administered to all caregivers of children participating in the longitudinal child and family outcome study. There are caregiver and staff-as-caregiver versions, as well as an intake version and followup versions that are administered every 6 months for up to 36 months.

The CIQ was developed to capture uniform demographic data about caregivers to whom the national evaluation instruments are being administered. The intake version of the CIQ that caregivers respond to contains 39 items with subparts that describe the child and family. These items gather information on demographic characteristics, child and family risk factors, family composition, legal custody of the child, the child’s mental and physical health service use history, caregiver employment status, attitudes about coercion in receiving services, and the child’s presenting problem(s). The staff-as-caregiver version contains a reduced number of items, since some questions items can or should be posed to staff-as-caregivers. The followup versions of the CIQ contained a reduced number of items because some questions are not repeated at followup.

### **Caregiver Strain Questionnaire (CGSQ)**

The CGSQ assesses the extent to which caregivers are affected by the special demands associated with caring for a child with emotional and behavioral problems. It is currently being used in several studies of children’s mental health services. The CGSQ provides a way to assess the impact that participating in system of care services has on the strain caregivers and families may experience (e.g., determining whether strain lessens over time as better services and supports are provided by the system of care).

The CGSQ contains 21 items that assess strain experienced by caregivers in the last 6 months related to the care of a child with emotional and behavioral challenges. It is comprised of three related dimensions of caregiver strain: objective strain, subjective internalizing strain, and subjective externalizing strain. The CGSQ is a 5-point scale with the following response options: (1) *not at all*, (2) *a little*, (3) *somewhat*, (4) *quite a bit*, and (5) *very much*.

The CGSQ demonstrated good reliability and validity in previous research. Confirmatory factor analysis findings from previous research with the CGSQ have supported the existence of three related dimensions of caregiver strain (Brannan et al., 1997). The three CGSQ subscales demonstrated adequate internal consistency with alpha coefficients ranging from .73 to .91 (Heflinger, Northrup, Sonnichsen, & Brannan, 1998). In addition, the CGSQ subscales were found to correlate with measures of family functioning and caregiver distress in expected ways, providing evidence of construct validity (Brannan et al., 1997). The predictive validity of the CGSQ is supported by findings that the prediction of service utilization pattern by the CGSQ was above that provided by measures of the child's clinical and functional status (Foster, Summerfelt, & Saunders, 1996; Lambert, Brannan, Breda, Heflinger, & Bickman, 1998).

### **Child Behavioral Checklist 1½–5 (CBCL 1½–5)**

The CBCL 1½–5 is administered to caregivers of children participating in the outcome study. It measures behavioral and emotional problems in children between the ages of 1½ to 5.

The CBCL 1½–5 includes three main sections. For the national evaluation, caregivers are required only to complete the behavioral and emotional problems section. In this section, caregivers report on 99 problem items by indicating the degree to which each statement (e.g., Cruel to animals) describes their child. Response options are the same for all items in this section: (0) *not true*, (1) *somewhat or sometimes true*, and (2) *very true or often true*.

Using a national normative sample and large clinical samples as norms, the checklist produces seven narrow-band syndrome T-scores: emotionally reactive, anxious/depressed, somatic complaints, withdrawn, sleep problems, attention problems, and aggressive behavior; two broadband syndrome T-scores: internalizing and externalizing; and a total problems T-score.

Reported test–retest reliabilities for the seven narrow-band scales were between .68 and .92. The test–retest reliabilities for the Internalizing and Total Problems scales were both .90, while the Externalizing scale had a test–retest reliability of .87. The average test–retest reliability across all scales was .85. Finally, the CBCL 1½–5 demonstrates adequate content, criterion-related, and construct validity using a variety of techniques (Achenbach & Rescorla, 2000).

### **Child Behavioral Checklist 6–18 (CBCL 6–18)**

The CBCL 6–18 is administered to caregivers of children and youth participating in the longitudinal child and family outcome study. The CBCL 6–18 is designed to provide a standardized measure of behavioral and emotional problems among children between the ages of 6 and 18. The CBCL 6–18 has been widely used in children's mental health services to assess social competence, behaviors, and feelings. It elicits a rich and detailed description of behaviors and symptoms that provides more information than diagnosis alone provides.

The CBCL 6–18 contains three main sections. For the national evaluation, caregivers are required only to complete the social competence section and the behavioral and emotional problem section. The social competence section collects information related to involvement in organizations, sports, peer relations, and school performance (e.g., “About how many times a week does your child do things with any friends outside of regular school hours?”). Response options for this section vary.

The behavioral and emotional problem section contains 113 items and documents the presence of various problems and symptoms (e.g., argumentativeness, withdrawal, aggression). Response options are the same for all items in this section: (0) *not true*, (1) *somewhat or sometimes true*, and (2) *very true or often true*.

The checklist produces a total problems T-score; two broadband syndrome T-scores; eight narrowband syndrome T-scores; competence T-scores in activities, social situations, and school; and a total competence T-score. The social competence items are scored to provide a more strengths-based perspective, but should be interpreted cautiously due to cultural biases and a response format that often leads to incomplete data (Drotar, Stein, & Perrin, 1995).

Achenbach and Rescorla (2001) have reported a variety of information regarding internal consistency, test–retest reliability, construct validity, and criterion-related validity. Good internal consistency was found for the Internalizing, Externalizing, and Total Problems scales (alpha  $\geq$  .90). The CBCL 6–18 demonstrated good test–retest reliability after 8 days (Pearson  $r$  at or above .80 for all scales). Moderate to strong correlation with the Connor Parent Rating Scale–Revised and the Behavior Assessment System for Children (BASC) Scales (Pearson  $r$  coefficients ranged from .34 to .89) supported the construct validity of the CBCL 6–18.

The CBCL 6–18 was, for most items and scales, capable of discriminating between children referred to clinics for needed mental health services and those youth not referred (Achenbach & Rescorla, 2001). A variety of other studies have also shown good criterion-related or discriminant validity (e.g., Barkley, 1988; McConaughy, 1993). Inter-observer agreement was evident in a meta-analysis of 119 studies that used the CBCL 6–18. In 269 separate samples, statistically significant correlations (using Pearson  $r$ ) were found among ratings completed by parents, mental health workers, teachers, peers, observers, and adolescents themselves (Achenbach, McConaughy, & Howell, 1987).

The instrument has been nationally normed on a proportionally representative sample of children across income and racial/ethnic groups. Racial/ethnic differences in total and subscale scores of the CBCL 6–18 disappeared when controlling for socioeconomic status, suggesting a lack of instrument bias related to racial/ethnic differences.

### **Child Information Update Form (CIUF).**

The CIUF is the followup version of the EDIF (described below). The purpose of the CIUF is to collect updated demographic, diagnostic, and enrollment information at followup on children participating in the longitudinal child and family outcome study. Information for completing the CIUF is obtained from record review and youth and caregiver report.

The CIUF contains seven items and only repeats questions from EDIF that contain information that could have changed from baseline to followup. As the CIUF collects descriptive information, conventional assessments of reliability and validity are not appropriate for this form.

### **Columbia Impairment Scale (CIS)**

The CIS evaluates level of impairment in four basic areas of functioning and provides a global measure of impairment. The CIS lists 13 problems commonly encountered among youth. Within each of the four functioning areas (interpersonal relations, functioning in job or schoolwork, use of leisure time, and broad psychopathological domains), caregivers rate the extent to which each item is a problem for his/her child, using a 4-point scale: (0) *no problem* to (4) *a very big problem*. Response options 1, 2, and 3 indicate the extent to which a particular item is of *some problem*; 3 indicates a greater level of impairment and 1 indicates a lower level of impairment.

Reliability and validity were measured on a sample from an ethnically, geographically, and socioeconomically diverse population ranging in age from 9 to 17 ( $n = 121$ ) and a demographically comparable sample of clinical subjects ( $n = 61$ ). Validity was determined by comparing scores from the CIS with those from the clinician-scored Children's Global Assessment Scale (CGAS), with a correlation of  $-0.73$  between the CIS and CGAS (scales for the two measures move in opposite directions). There was high internal consistency across the four conceptual domains measured by the CIS (range  $.43$  to  $.77$ ), and the measure was able to discriminate between clinical and community subjects ( $p < .001$ ). The CIS has good test-retest reliability, with an intraclass correlation coefficient =  $.89$ .

### **Cultural Competence and Service Provision Questionnaire (CCSP)**

The CCSP consists of three questions that assess the importance of culture in the lives of the respondent and 13 questions that assess caregiver's perspective on the understanding, knowledge, and inclusion of the child's culture in services provided to the child.

Formal reliability and validity information for the CCSPQ is not available. Empirical assessment of the CCSP's measurement quality will be conducted when a sufficient amount of data have been received.

### **Delinquency Survey-Revised (DS-R)**

The DS-R gathers information reported by youth about their contacts with law enforcement and other delinquent behavior. The questionnaire consists of 29 questions that assess the youth's destructive and violent behavior toward others in the community and contact with law enforcement, including involvement with criminal offenses, arrests, and probation.

Analysis of 149 completed DS-Rs submitted by communities funded in 2002 and 2003 revealed high internal consistency on DS-R items measuring the frequency and type of delinquent behavior in the past 6 months (Cronbach's  $\alpha = .86$ ).

### **Education Questionnaire-Revised (EQ-R)**

The EQ-R was developed to collect, from caregivers, information on their child's educational status. The EQ-R contains 15 questions with subparts covering topics including school

attendance, grade level, school achievement, alternative or special school and classroom placements, and reasons for having an Individualized Education Plan (IEP). Additional questions also provide information on overall academic performance and whether the child has been suspended or expelled from school.

As a method for collecting descriptive information, conventional assessments of reliability and validity are not appropriate for the EQ-R. However, review and refinement of the measure were conducted for communities funded in 2002 and 2003, building on the questionnaire used in the evaluation with communities funded in 1993 and 1994, 1997, 1998, and 1999 and 2000, and feedback from grant communities.

### **Enrollment and Information Form (EDIF)**

The EDIF is a 16-item questionnaire that collects demographic, diagnostic, and system of care enrollment information at baseline on all children receiving CMHS-funded system of care services. Information for the EDIF is gathered from record review and youth and caregiver report. The EDIF is completed at baseline only.

Since the EDIF collects descriptive information, conventional assessments of reliability and validity are not appropriate for this form.

### **Family Life Questionnaire (FLQ)**

The FLQ consists of 10 statements about activities the family may do together and how the family interacts. This questionnaire was designed to assess aspects of family life that may change as a result of changes in children's functional impairment.

Formal reliability and validity information for the FLQ is not available. Empirical assessment of the FLQ's measurement quality will be conducted when a sufficient amount of data have been received.

### **GAIN Quick-R: Substance Problem Scale (GAIN)**

The GAIN "documents participant-reported problems associated with the use and abuse of and dependence on drugs and alcohol" (Titus & Dennis, 2005, p. 11). This questionnaire is drawn from the Global Appraisal of Individual Needs-Quick (GAIN-Q, [http://www.chestnut.org/LI/gain/GAIN\\_Q/index.html](http://www.chestnut.org/LI/gain/GAIN_Q/index.html)). There is one screener item and 16 core items. Youth are asked to respond *no* or *yes* to each item. The 16 core items parallel those used to obtain a *DSM-IV* diagnosis of substance use. Though typically used to assess issues present during the past 12 months, the GAIN will assess issues that occurred in the past 6 months, the timeframe used throughout the national evaluation.

The overall alpha coefficient reported by Titus and Dennis (2005) for the 16 core items of the GAIN for adolescents (using a 12-month timeframe) is .82. Two subscales result from the 16 core GAIN items: the nine-item Substance Use and Abuse Index (SAUI-9) and the seven-item Substance Dependence Index (SDI-7). The alpha coefficients for these indices are .63 and .75, respectively.

### **Living Situations Questionnaire (LSQ)**

The Living Situations Questionnaire (LSQ) is a modified version of the restrictiveness of living situations questionnaire (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992). The LSQ documents the physical setting in which youth lived during a 6-month time period and with whom the child was living in that setting. Information gathered from the LSQ can be used to create the same living situation categories assessed in the ROLES, which was developed to operationalize and assess the restrictiveness of children's living situations.

No formal reliability and validity information is available on the LSQ or the ROLES; however, expected relationships have been found between levels of restrictiveness, as assessed with the ROLES, and programmatic variables. The ROLES was used to document changes in the restrictiveness of placements over time as a quality assurance indicator for children in foster care (Thomlison, 1993) and as a process outcome for a therapeutic case management program for children with severe emotional disturbance (Yoe, Bruns, & Burchard, 1995). A revised version of the ROLES (the ROLES-R) has been used in the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program.

### **Multi-Sector Service Contacts–Revised (MSSC–R)**

The MSSC–R was developed to record caregivers' reports of services used in multiple child-serving sectors. Development of the MSSC–R followed from previous efforts in the field of mental health services research to collect caregiver reports of service use. The MSSC–R provides standard descriptions of types of services, but the names of the services as well as the service settings should be customized for each site. The standard descriptions allow cross-site comparisons, and the use of local service and agency names, those familiar to caregivers, improves the reporting of service contacts. The MSSC–R captures the different locations a child and/or family may have received any of the services in the 6-month period prior to the interview and whether each of the locations is convenient to the child and/or family. In addition, for each specific service asked, the MSSC–R records how much of each service type was received and how well the service meets the needs of the child and/or family. The MSSC–R also contains two questions related to the caregiver's service experience.

Information from the MSSC–R will be compared with communities' fiscal MISs to check the accuracy with which services provided in the mental health sector are reported by caregivers. Based on reliability analysis of the national evaluation data collected from communities funded in 1997 and 1998, Cronbach's alpha coefficient was 0.98 for the service items that asked about whether a child received a service in the previous 6 months.

### **Revised Children's Manifest Anxiety Scale (RCMAS)**

The RCMAS (Reynolds & Richmond, 1978) assesses the level and nature of anxiety experienced by children and youth aged 6–19. It examines both the source and the cause of stress in a person's life. The scale can also be used to identify the relationship between anxiety and performance in other aspects of the child's or youth's life.

The RCMAS contains 37 items. Each item is a statement that embodies a feeling or action that reflects an aspect of anxiety. The instrument includes questions about what the youth worries

about, how often the youth worries, and how the youth feels, physiologically, as a result of his/her worry. Youth respond to each description with either *yes* or *no*.

Internal consistency; long-term reliability; and concurrent, convergent, and divergent validity

have been demonstrated. Reynolds and Richmond (1978) reported that the items on the RCMAS yield a Kuder-Richardson (KR) reliability estimate of .83, demonstrating internal consistency. A cross-validation assessment conducted with 167 middle- and high-school-age children yielded a KR reliability estimate of .85. Comparable internal consistency was also demonstrated with kindergarten-age children. The measure has been shown to have high short-term (i.e., retesting at 1 and 5 weeks) test-retest reliability (Pearson correlations from .60 to .88, significant at  $p \leq .01$ ), and fairly high long-term (i.e., retest at 9 months) retest reliability ( $r = .68$ ).

The RCMAS is highly correlated with the trait measure of anxiety, STAIC ( $r = .85$ ,  $p \leq .05$ ). A study by Mattison, Bagnato, and Brubaker (1988) showed that the RCMAS is able to discriminate between children with a *DSM-III* anxiety disorder and other *DSM-III* psychiatric diagnoses.

### **Reynolds Adolescent Depression Scale–2nd Edition (RADS–2)**

The RADS–2 measures adolescent depression and is comprised of four subscales: dysphoric mood, anhedonia/negative affect, negative self-evaluation, and somatic complaints.

The RADS–2 contains 30 items that state a feeling. Youth rate how often each statement describes how they feel using a 4-point scale: (1) *almost never*, (2) *hardly ever*, (3) *sometimes*, and (4) *most of the time*. Questions include feelings of happiness, sadness, fear, anxiety, loneliness, anger, and love.

Validity of the RADS–2 has been examined with respect to content validity, criterion-related validity, construct validity (convergent, discriminant, and factorial), and clinical validity (Krefetz, Steer, Gulab, & Beck, 2002; Reynolds & Mazza, 1998). Reliability and validity studies included a school-based sample of over 9,000 adolescents and a clinical sample of 297 adolescents with *DSM-III-R* or *DSM-IV* diagnoses who were evaluated in both school and clinical settings. Reynolds (1986) examined the reliability and validity of the RADS–2 in a sample of 89 young adolescents from an inner-city school. The study found an internal consistency reliability of .91 on the initial assessment and .93 for the retest. The test-retest reliability of the RADS–2 was .87. The RADS–2 was able to discriminate depressed and non-depressed adolescents, with a sensitivity rate of 89 percent and specificity of 90 percent, and an overall correct classification of 90 percent. Total scores for the RADS–2 have a correlation of .84 with the Beck Depression Inventory ( $p < .001$ ) and .76 with the Hamilton Depression Rating Scale.

### **Substance Use Survey–Revised (SUS–R)**

The SUS–R assesses youth’s report of their substance use for alcohol, tobacco, and other drugs. The first set of questions measure a youth’s alcohol use, including history and frequency of drinking behaviors, and cigarette use. The next set of questions focuses on the youth’s illegal substance use. Youth are asked whether they ever used the substance, how old they were when

they first tried the substance, how long it has been since they last used the substance, and frequency of use during the past 30 days. The remaining questions assess youth's use of prescription drugs without a physician's prescription and abuse of nonprescription or over-the-counter drugs.

Reliability and validity information for the SUS-R used in this study is not available.

### **Vineland Screener 0–Under 3 (VS1), 3–5 (VS2), 6–12 (VS3)**

The Vineland Screener (Sparrow, Carter, & Cicchetti, 1993) is a developmental assessment. There are multiple versions of the Vineland Screener, each targeting a narrow age range and including assessment items that are appropriate for the development of children within that age range. The national evaluation uses three versions of the screener: ages 0 to under 3 years (VS1), ages 3 to under 6 years (VS2), and ages 6 to under 12 years (VS3).

The VS1 and VS2 assess development within four domains: communication, daily living skills, socialization, and motor skills. Both of these screeners have 60 items (15 items per domain). The VS3 includes all of the domains that are in the VS1 and VS2 except for motor skills, and has a total of 45 items. For each item, the interviewer indicates how often the child does the behavior, with the scoring referring to the information probed for rather than the initial question. Scoring options include *Yes, usually*; *Sometimes, partially*; *No, never*; *No opportunity*; and *Don't know*.

The Vineland normative data were obtained from a representative national sample matched to the 1980 census on the basis of gender, race/ethnicity, community size, region of the country, and parents' educational level. This sample of 536 children was also used to derive the norms for the Vineland Screener (Canino, Costello, & Angold, 1999; Coll, Buckner, Brooks, Weinreb, & Bassuk, 1998).

The Vineland Screener is highly correlated with the in-depth Vineland Survey Form, with correlations of at least 0.89 (range: 0.87–0.98) on each domain and the composite score. The instrument has interrater reliability of  $\alpha = 0.98$  among lay interviewers.

### **Youth Information Questionnaire (YIQ)**

The YIQ contains 25 items that capture a range of issues and information that are important for understanding many facets of the youth's life. The YIQ includes questions about the youth's acculturation, employment, peer relationships, presenting problems, suicidality, and neighborhood safety. A subset of 18 YIQ items (i.e., those data elements that may change over time) will also be asked at each followup data collection point (e.g., 6 months, 12 months, 18 months, etc.).

As a method for collecting descriptive information, conventional assessments of reliability and validity are not appropriate for the YIQ. However, data collected with the YIQ will be compared to descriptive data provided by the caregivers to check for consistency.

### **Youth Services Survey (YSS)**

The YSS (Brunk, Koch, & McCall, 2000) contains 21 items scored on a 5-point scale and one open-ended question. The measure assesses perceptions of service across five domains: access, participation in treatment, cultural sensitivity, satisfaction, and outcomes.

Based on reliability analysis of the State Indicator Pilot Project, which evaluated data from Colorado, Kentucky, Oklahoma, Texas, Virginia, and the District of Columbia, Cronbach's alpha for the domain measuring access to services is .705, participation in treatment is .823, cultural sensitivity of staff is .896, satisfaction with services is .941, and perceived outcome of service is .864.

### **Youth Services Survey for Families (YSS-F)**

The YSS-F (Brunk, Koch, & McCall, 2000) contains 21 items scored on a 5-point scale and one open-ended question. The measure assesses perceptions of service across five domains: access, participation in treatment, cultural sensitivity, satisfaction, and outcomes.

Based on reliability analysis of the State Indicator Pilot Project, which evaluated data from Colorado, Kentucky, Oklahoma, Texas, Virginia, and the District of Columbia, Cronbach's alpha for the domain measuring access to services is .725, participation in treatment is .772, cultural sensitivity of staff is .907, satisfaction with services is .943, and perceived outcome of service is .905.

## **APPENDIX D**

### **DESCRIPTIVE AND OUTCOMES DATA TABLES**

#### **METHODS AND STUDY SAMPLE**

The longitudinal outcome study of grant communities assessed children and their families every 6 months, for up to 36 months, regardless of whether the children continued to receive services through system of care programs. This allowed comparison of clinical and functional outcomes for all children who participated in the outcome study, regardless of whether they remained in or exited system of care services. In the evaluation during Years 2 through 4 of funding, each grant community is expected to enroll approximately 284 families for communities funded in 1997 and 1998 and 276 families for communities funded in 1999 and 2000, although this figure may vary slightly for communities funded to serve smaller numbers of children (e.g., funding in some communities may be directed primarily toward infrastructure development, or the number of children meeting service criteria for serious emotional disturbance may be lower). While in most grant communities all willing families need to be recruited into the outcome study, in some larger communities, sampling strategies may need to be employed to select a sufficient number of families at random from the pool of children who enter the system of care program. Sample size in analyses conducted in this report fluctuates due to differences in enrollment and data completion rates across grant communities. Table D-1 presents study enrollment and data completion rates through March 2005 for each community funded from 1997 through 2000.

Table D-1. Study Enrollment and Program Interview Completion as of March 2005

Grant Communities Funded in 1997 and 1998																	
Community	Descriptive Sample <sup>a</sup>	Outcome Sample <sup>b</sup>	Eligible for Interview at Each Assessment Point <sup>c</sup> 6-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 12-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 18-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 24-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 30-Month	Completed Interview at Each Assessment Point <sup>d</sup> 6-Month	Completed Interview at Each Assessment Point <sup>d</sup> 12-Month	Completed Interview at Each Assessment Point <sup>d</sup> 18-Month	Completed Interview at Each Assessment Point <sup>d</sup> 24-Month	Completed Interview at Each Assessment Point <sup>d</sup> 30-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 6-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 12-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 18-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 24-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 30-Month
1	85	86	58	58	58	58	58	6	0	0	0	0	10.3%	0.0%	0.0%	0.0%	0.0%
2	521	184	165	134	109	97	72	32	19	5	3	3	19.4%	14.2%	4.6%	3.1%	4.2%
3	181	182	182	178	177	172	161	32	21	12	2	0	17.6%	11.8%	6.8%	1.2%	0.0%
4	257	84	84	81	70	63	49	32	25	14	1	0	38.1%	30.9%	20.0%	1.6%	0.0%
5	274	94	94	89	85	72	61	35	26	16	13	13	37.2%	29.2%	18.8%	18.1%	21.3%
6	225	148	148	144	142	133	125	58	40	28	17	10	39.2%	27.8%	19.7%	12.8%	8.0%
7	209	160	155	123	111	96	75	81	61	50	33	9	52.3%	49.6%	45.0%	34.4%	12.0%
8	446	221	221	217	190	154	119	117	100	77	56	46	52.9%	46.1%	40.5%	36.4%	38.7%
9	2224	317	317	296	267	241	203	136	108	57	44	15	42.9%	36.5%	21.3%	18.3%	7.4%
10	322	211	208	185	162	146	120	120	94	63	54	37	57.7%	50.8%	38.9%	37.0%	30.8%
11	396	284	249	194	188	170	147	149	111	78	62	42	59.8%	57.2%	41.5%	36.5%	28.6%
12	678	629	628	606	516	417	380	312	245	172	134	86	49.7%	40.4%	33.3%	32.1%	22.6%
13	517	289	289	242	178	140	104	155	94	61	46	30	53.6%	38.8%	34.3%	32.9%	28.8%
14	631	278	261	247	228	205	189	160	126	98	84	63	61.3%	51.0%	43.0%	41.0%	33.3%
15	1177	244	244	223	196	162	128	155	154	133	110	81	63.5%	69.1%	67.9%	67.9%	63.3%
16	485	117	117	113	112	97	80	78	63	26	17	7	66.7%	55.8%	23.2%	17.5%	8.8%
17	345	215	215	215	203	186	166	158	146	120	107	90	73.5%	67.9%	59.1%	57.5%	54.2%
18	153	155	154	154	153	133	119	118	80	60	43	25	76.6%	51.9%	39.2%	32.3%	21.0%
19	290	297	297	280	250	224	206	231	200	169	132	107	77.8%	71.4%	67.6%	58.9%	51.9%
20	796	336	336	329	317	290	242	262	214	188	140	86	78.0%	65.0%	59.3%	48.3%	35.5%
21	318	252	223	183	149	141	135	222	169	117	74	62	99.6%	92.3%	78.5%	52.5%	45.9%
22	811	306	306	306	306	306	271	240	231	220	181	106	78.4%	75.5%	71.9%	59.2%	39.1%
23	483	466	466	439	400	359	321	353	315	287	227	162	75.8%	71.8%	71.8%	63.2%	50.5%

Table D-1. Study Enrollment and Program Interview Completion as of March 2005, continued

Grant Communities Funded in 1999 and 2000																	
Community	Descriptive Sample <sup>a</sup>	Outcome Sample <sup>b</sup>	Eligible for Interview at Each Assessment Point <sup>c</sup> 6-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 12-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 18-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 24-Month	Eligible for Interview at Each Assessment Point <sup>c</sup> 30-Month	Completed Interview at Each Assessment Point <sup>d</sup> 6-Month	Completed Interview at Each Assessment Point <sup>d</sup> 12-Month	Completed Interview at Each Assessment Point <sup>d</sup> 18-Month	Completed Interview at Each Assessment Point <sup>d</sup> 24-Month	Completed Interview at Each Assessment Point <sup>d</sup> 30-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 6-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 12-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 18-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 24-Month	Interview Completion Rate at Each Assessment Point <sup>e</sup> 30-Month
24	210	68	61	49	46	36	18	16	5	3	2	0	26.2%	10.2%	10.9%	8.3%	11.1%
25	315	123	119	98	60	49	38	38	18	4	5	3	31.9%	18.4%	6.7%	10.2%	7.9%
26	317	39	37	34	29	25	21	15	10	6	4	1	40.5%	29.4%	34.5%	24.0%	19.0%
27	100	57	53	38	26	19	18	23	15	9	6	7	43.4%	39.5%	57.7%	47.4%	33.3%
28	624	197	193	152	111	86	27	105	68	42	14	9	54.4%	44.7%	61.3%	48.8%	51.9%
29	200	200	200	179	155	119	68	157	123	99	48	36	78.5%	68.7%	79.4%	83.2%	70.6%
30	289	152	151	139	123	111	84	92	72	52	39	22	60.9%	51.8%	58.5%	46.8%	46.4%
31	403	292	291	279	232	189	148	158	102	71	50	33	54.3%	36.6%	44.0%	37.6%	33.8%
32	264	124	115	98	80	63	39	82	58	42	29	18	71.3%	59.2%	72.5%	66.7%	74.4%
33	573	366	366	347	297	241	179	173	134	103	41	18	47.3%	38.6%	45.1%	42.7%	22.9%
34	228	66	61	55	34	20	10	33	15	9	4	1	54.1%	27.3%	44.1%	45.0%	40.0%
35	238	217	217	203	187	177	157	79	46	18	12	11	36.4%	22.7%	24.6%	10.2%	7.6%
36	489	253	253	233	186	173	141	138	101	61	45	32	54.5%	43.3%	54.3%	35.3%	31.9%
37	249	122	121	117	102	91	77	70	52	34	30	13	57.9%	44.4%	51.0%	37.4%	39.0%
38	170	156	144	121	102	79	77	109	80	60	53	39	75.7%	66.1%	78.4%	75.9%	68.8%
39	334	205	205	199	191	180	160	173	142	119	103	91	84.4%	71.4%	74.3%	66.1%	64.4%
40	300	278	276	239	198	176	145	181	145	121	100	69	65.6%	60.7%	73.2%	68.8%	69.0%
41	64	65	48	38	34	34	26	3	17	0	0	0	6.3%	44.7%	50.0%	0.0%	0.0%
42	156	90	85	76	70	60	41	51	34	31	21	18	60.0%	44.7%	48.6%	51.7%	51.2%
43	268	151	151	149	141	126	108	116	113	93	81	62	76.8%	75.8%	80.1%	73.8%	75.0%
44	938	338	337	316	246	206	152	157	96	58	36	13	46.6%	30.4%	39.0%	28.2%	23.7%
45	948	411	406	392	344	283	227	233	198	125	81	59	57.4%	50.5%	57.6%	44.2%	35.7%

<sup>a</sup> Descriptive Sample was based on number of cases with at least one piece of descriptive information.

<sup>b</sup> Baseline Outcome Sample was based on number of cases with at least one of the required outcome instruments at baseline.

<sup>c</sup> Eligibility for Interview at Each Assessment Point was derived based on the following criteria: (a) data indicated that the child had been enrolled in the system for 6 months or longer (for 6-month followup), 12 months or longer (for 12-month followup), 18 months or longer (for 18-month followup), 24 months or longer (for 24-month followup), or 30 months or longer (for 30-month followup); and (c) the child had at least one of the required outcome instruments administered at intake.

<sup>d</sup> Completed Interview at Each Assessment Point was derived based on the following criteria: (a) 6-month outcome sample: cases with 6-month data on at least one of the required outcome instruments; (b) 12-month outcome sample: cases with 12-month data on at least one of the required outcome instruments; (c) 18-month outcome sample: cases with 18-month data on at least one of the required outcome instruments; (d) 24-month outcome sample: cases with 24-month data on at least one of the required outcome instruments; and (e) 30-month outcome sample: cases with 30-month data on at least one of the required outcome instruments.

<sup>e</sup> Interview Completion Rate at Each Assessment Point was calculated as follows: (Completed interview at each assessment point / Eligibility for interview at each assessment point) x 100%. For example, 6-month followup completion rate for Site 22 was calculated as:  $(240 / 306) \times 100\% = 78.4\%$ .

## **DEMOGRAPHIC CHARACTERISTICS, CLINICAL STATUS, AND CHILD AND FAMILY OUTCOMES**

The rest of this appendix provides detailed information on the baseline child and family characteristics (Table D-2). Information on child and family clinical and functional outcome indicators at intake, 6 months, 12 months, 18 months, 24 months, and 30 months are presented for children and families enrolled in grant communities funded in 1997 and 1998 (Table D-3, Part 1) and grant communities funded in 1999 and 2000 (Table D-3, Part 2). These pieces of information on the outcomes at each data collection point do not represent changes over time. Rather, they provide *descriptive* information on these outcomes at each data collection point. Some children and families may not have data collected across all data collection points.

**Table D-2. Baseline Child and Family Characteristics**

	Grant Communities Funded in 1997 and 1998 Overall Sample	Grant Communities Funded in 1997 and 1998 Descriptive Sample	Grant Communities Funded in 1997 and 1998 Outcome Sample	Grant Communities Funded in 1999 and 2000 Overall Sample	Grant Communities Funded in 1999 and 2000 Descriptive Sample	Grant Communities Funded in 1999 and 2000 Outcome Sample
<b>Gender</b>	<b>(n = 12,293)</b>	<b>(n = 6, 792)</b>	<b>(n = 5,501)</b>	<b>(n = 7,676)</b>	<b>(n = 3,825)</b>	<b>(n = 3,851)</b>
Male	66.0%	65.7%	66.3%	66.1%	64.0%	68.2%
Female	34.0%	34.3%	33.7%	33.9%	36.0%	31.8%
<b>Age</b>	<b>(n = 12,213)</b>	<b>(n = 6, 746)</b>	<b>(n = 5,467)</b>	<b>(n = 7,672)</b>	<b>(n = 3,821)</b>	<b>(n = 3,851)</b>
Mean	11.1 years	10.6 years	11.8 years	12.2 years	12.2 years	12.2 years
0–5 Years	18.7%	26.9%	8.5%	4.2%	4.8%	3.6%
6–11 Years	24.9%	19.8%	31.3%	33.2%	32.1%	34.4%
12–15 Years	37.7%	33.5%	42.8%	44.8%	44.1%	45.6%
16 Years or Older	18.8%	19.9%	17.4%	17.7%	19.1%	16.4%
<b>Race and Ethnicity<sup>a</sup></b>	<b>(n = 10,927)</b>	<b>(n = 6, 129)</b>	<b>(n = 4,798)</b>	<b>(n = 7511)</b>	<b>(n = 3,714)</b>	<b>(n = 3,797)</b>
African American	22.1%	23.6%	20.1%	31.2%	30.3%	32.0%
American Indian	6.8%	4.1%	10.3%	11.3%	14.2%	8.5%
Asian	1.0%	0.9%	1.0%	0.7%10.3%	0.7%	0.8%
Hispanic Ethnicity	10.9%	9.3%	12.9%	0.4%	7.5%	13.1%
Native Hawaiian or Pacific Islander	0.5%	0.6%	0.5%	52.0%	0.4%	0.4%
White	63.5%	64.8%	61.9%	1.4%	49.8%	54.0%
Other	1.3%	1.5%	1.1%	7.7%	1.6%	1.2%
Bi-racial/Multiracial	6.2%	5.0%	7.6%	(n = 7511)	5.2%	10.2%

<sup>a</sup> Because an individual may chose more than one racial background, the race variable may sum to more than 100%.

**Table D-2. Baseline Child and Family Characteristics, continued**

	<b>Grant Communities Funded in 1997 and 1998 Overall Sample</b>	<b>Grant Communities Funded in 1997 and 1998 Descriptive Sample</b>	<b>Grant Communities Funded in 1997 and 1998 Outcome Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Overall Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Descriptive Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Outcome Sample</b>
<b>Custody</b>	<b>(n = 9,200)</b>	<b>(n = 3, 934)</b>	<b>(n = 5,266)</b>	<b>(n = 7,390)</b>	<b>(n = 3,581)</b>	<b>(n = 3,809)</b>
Two Parents	25.8%	24.7%	26.7%	24.3%	25.0%	23.7%
Mother	44.1%	43.2%	44.7%	42.2%	39.9%	44.4%
Father	4.4%	4.5%	4.3%	4.2%	3.9%	4.5%
Adoptive Parent(s)	3.8%	3.5%	4.0%	4.8%	3.6%	5.8%
Foster Parent(s) or Ward of State	10.2%	10.6%	9.9%	10.8%	13.4%	8.3%
Grandparents	6.1%	6.3%	5.8%	7.2%	6.7%	7.6%
Other	5.7%	7.1%	4.5%	6.5%	7.3%	5.6%
<b>Poverty Level</b>	<b>(n = 7,061)</b>	<b>(n = 2,759)</b>	<b>(n = 4,302)</b>	<b>(n = 5,249)</b>	<b>(n = 1,973)</b>	<b>(n = 3,276)</b>
Below Poverty	58.4%	61.6%	56.4%	54.0%	54.7%	53.5%
At Poverty	9.7%	9.9%	9.6%	8.7%	9.6%	8.2%
Above Poverty	31.9%	28.5%	34.0%	37.3%	35.7%	38.2%
<b>Medicaid Recipient</b>	<b>(n = 10,843)</b>	<b>(n = 5,536)</b>	<b>(n = 5,307)</b>	<b>(n = 7,291)</b>	<b>(n = 3,518)</b>	<b>(n = 3,773)</b>
Yes	71.9%	73.8%	69.8%	73.7%	75.2%	72.3%
<b>Number of Child Risk Factors</b>	<b>(n = 9,343)</b>	<b>(n = 3,956)</b>	<b>(n = 5,387)</b>	<b>(n = 6,660)</b>	<b>(n = 2,858)</b>	<b>(n = 3,802)</b>
Mean	1.5	1.5	1.5	1.4	1.3	1.6
No Risk Factors	33.3%	32.4%	33.9%	33.5%	39.2%	29.2%
One Risk Factor	25.3%	26.4%	24.4%	25.5%	25.8%	25.2%
Two Risk Factors	19.1%	19.6%	18.7%	19.1%	16.7%	20.9%
Three or More Risk Factors	22.3%	21.5%	23.0%	21.1%	18.3%	24.6%

**Table D-2. Baseline Child and Family Characteristics, continued**

	<b>Grant Communities Funded in 1997 and 1998 Overall Sample</b>	<b>Grant Communities Funded in 1997 and 1998 Descriptive Sample</b>	<b>Grant Communities Funded in 1997 and 1998 Outcome Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Overall Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Descriptive Sample</b>	<b>Grant Communities Funded in 1999 and 2000 Outcome Sample</b>
<b>Number of Family Risk Factors</b>	<b>(n = 9,053)</b>	<b>(n = 3,862)</b>	<b>(n = 5,191)</b>	<b>(n = 6,319)</b>	<b>(n = 2,581)</b>	<b>(n = 3,738)</b>
Mean	2.6	2.4	2.7	2.6	2.5	2.7
No Risk Factors	14.7%	18.0%	12.2%	14.9%	16.4%	13.9%
One Risk Factor	16.7%	17.7%	16.0%	17.2%	18.8%	16.1%
Two Risk Factors	18.3%	18.5%	18.2%	16.5%	16.7%	16.4%
Three or More Risk Factors	50.3%	45.9%	53.6%	51.4%	48.0%	53.6%
<b>Referral Sources</b>	<b>(n =8,828)</b>	<b>(n = 3,729)</b>	<b>(n = 5,099)</b>	<b>(n = 6,753)</b>	<b>(n = 3,406)</b>	<b>(n = 3,347)</b>
Court	9.9%	11.7%	8.6%	8.0%	7.8%	8.1%
Corrections	9.0%	10.9%	7.6%	2.2%	2.1%	2.3%
School	19.1%	19.4%	18.8%	13.6%	10.9%	16.5%
Mental Health Centers	24.3%	16.9%	29.6%	44.1%	41.1%	47.3%
Substance Abuse Treatment Clinics	0.2%	0.1%	0.2%	0.0%	0.0%	0.1%
Physical Health Care Agencies	1.6%	1.5%	1.7%	0.7%	0.9%	0.4%
Child Welfare Agencies	12.2%	12.2%	12.1%	11.2%	12.4%	10.0%
Caregiver	9.5%	10.1%	9.1%	9.0%	11.2%	6.8%
Self	2.0%	1.7%	2.3%	1.5%	1.5%	1.5%
Other	12.3%	15.5%	9.9%	9.7%	12.2%	7.1%

**Table D-2. Baseline Child and Family Characteristics, continued**

	Grant Communities Funded in 1997 and 1998 Overall Sample	Grant Communities Funded in 1997 and 1998 Descriptive Sample	Grant Communities Funded in 1997 and 1998 Outcome Sample	Grant Communities Funded in 1999 and 2000 Overall Sample	Grant Communities Funded in 1999 and 2000 Descriptive Sample	Grant Communities Funded in 1999 and 2000 Outcome Sample
<b>Child Risk Factors</b>						
Previous Psychiatric Hospitalization	24.4% (n = 9,215)	23.1% (n = 3,900)	25.3% (n = 5,315)	33.2% (n = 6,318)	26.4% (n = 2,571)	37.8% (n = 3,747)
Physically Abused	26.6% (n = 8,986)	26.5% (n = 3,805)	26.6% (n = 5,181)	26.5% (n = 6,294)	26.4% (n = 2,629)	26.6% (n = 3,665)
Sexually Abused	20.8% (n = 8,791)	18.8% (n = 3,742)	22.3% (n = 5,049)	22.2% (n = 6,150)	21.5% (n = 2,592)	22.8% (n = 3,558)
Run Away	33.4% (n = 9,118)	33.4% (n = 3,836)	33.4% (n = 5,282)	29.1% (n = 6,398)	25.9% (n = 2,643)	31.4% (n = 3,755)
Attempted Suicide	14.3% (n = 9,140)	13.2% (n = 3,842)	15.1% (n = 5,298)	15.6% (n = 6,340)	10.7% (n = 2,606)	19.0% (n = 3,734)
Substance Abuse	24.0% (n = 9,229)	28.0% (n = 3,883)	21.0% (n = 5,346)	17.6% (n = 6,440)	18.9% (n = 2,678)	16.6% (n = 3,762)
Sexually Abusive to Others	7.3% (n = 9,027)	7.0% (n = 3,822)	7.6% (n = 5,205)	8.3% (n = 6,344)	8.2% (n = 2,627)	8.4% (n = 3,717)
<b>Family Risk Factors</b>						
Domestic Violence	49.2% (n = 8,886)	45.6% (n = 3,691)	51.7% (n = 5,175)	51.3% (n = 6,031)	51.2% (n = 2,436)	51.3% (n = 3,595)
Mental Illness in Biological Family	53.1% (n = 8,732)	49.8% (n = 3,655)	55.4% (n = 5,077)	59.4% (n = 5,849)	56.9% (n = 2,314)	61.0% (n = 3,535)
Psychiatric Hospitalization of Biological Parents	38.4% (n = 4,188)	36.1% (n = 1,578)	39.8% (n = 2,610)	41.4% (n = 3,194)	37.6% (n = 1,174)	43.6% (n = 2,020)
Biological Parents Convicted of a Crime	46.4% (n = 8,568)	44.1% (n = 3,536)	48.0% (n = 5,032)	48.4% (n = 5,739)	47.1% (n = 2,261)	49.2% (n = 3,478)
Substance Abuse in Biological Family	65.7% (n = 8,851)	64.1% (n = 3,703)	66.7% (n = 5,148)	65.3% (n = 5,999)	66.3% (n = 2,382)	64.7% (n = 3,617)
Treatment Received for Substance Abuse	52.6% (n = 5,183)	52.5% (n = 2,077)	52.7% (n = 3,106)	56.3% (n = 3,429)	55.0% (n = 1,340)	57.1% (n = 2,089)

**Table D-2. Baseline Child and Family Characteristics, continued**

	Grant Communities Funded in 1997 and 1998 Overall Sample	Grant Communities Funded in 1997 and 1998 Descriptive Sample	Grant Communities Funded in 1997 and 1998 Outcome Sample	Grant Communities Funded in 1999 and 2000 Overall Sample	Grant Communities Funded in 1999 and 2000 Descriptive Sample	Grant Communities Funded in 1999 and 2000 Outcome Sample
<b>Diagnosis<sup>b</sup></b>	<b>(n = 7,341)</b>	<b>(n = 3,071)</b>	<b>(n = 4,270)</b>	<b>(n = 5,556)</b>	<b>(n = 2,653)</b>	<b>(n = 2,903)</b>
Conduct Disorder	13.3%	16.0%	11.4%	9.0%	8.4%	9.6%
ADHD	33.3%	27.2%	37.8%	41.7%	38.5%	44.6%
Oppositional Defiant Disorder	25.7%	22.7%	27.8%	28.5%	28.9%	28.1%
Mood Disorder	30.2%	28.7%	31.4%	36.1%	33.7%	38.3%
Adjustment Disorder	13.8%	14.4%	13.3%	10.2%	13.2%	7.5%
Substance Use	9.6%	10.8%	8.7%	4.9%	5.3%	4.7%
Post-Traumatic Stress Disorder	8.3%	7.4%	8.9%	9.2%	9.0%	9.5%
Impulsive Control Disorder	4.5%	4.8%	4.3%	4.3%	3.8%	4.8%
Disruptive Behavior Disorder	5.7%	6.2%	5.4%	5.8%	6.4%	5.3%
Learning and Related Disorders	5.4%	5.4%	5.5%	4.6%	4.3%	5.0%
Mental Retardation	3.1%	2.8%	3.3%	4.5%	4.5%	4.5%
Anxiety Disorder	4.1%	3.2%	4.8%	5.3%	4.3%	6.2%
Psychosis	2.0%	1.5%	2.4%	3.0%	1.7%	4.2%
Autism and Related disorder	1.4%	0.7%	1.9%	2.4%	2.2%	2.6%
Personality Disorder	1.8%	1.7%	1.9%	1.6%	0.9%	2.2%
V Code	5.9%	5.8%	6.0%	5.3%	5.3%	5.2%
Other	7.1%	5.5%	8.2%	7.5%	7.6%	7.4%

<sup>b</sup> Because children may have more than one diagnosis, the diagnosis variables may sum to more than 100%.

**Table D-2. Baseline Child and Family Characteristics, continued**

	Grant Communities Funded in 1997 and 1998 Overall Sample	Grant Communities Funded in 1997 and 1998 Descriptive Sample	Grant Communities Funded in 1997 and 1998 Outcome Sample	Grant Communities Funded in 1999 and 2000 Overall Sample	Grant Communities Funded in 1999 and 2000 Descriptive Sample	Grant Communities Funded in 1999 and 2000 Outcome Sample
<b>Presenting Problems<sup>c</sup></b>	<b>(n = 8,478)</b>	<b>(n = 3,863)</b>	<b>(n = 4,615)</b>	<b>(n = 7,214)</b>	<b>(n = 3,498)</b>	<b>(n = 3,716)</b>
Mean	5.2	5.0	5.4	6.5	5.5	7.4
Sadness	22.4%	20.4%	24.1%	35.4%	35.5%	35.3%
Suicide Ideation	12.6%	12.4%	12.8%	18.0%	16.4%	19.4%
Suicide Attempt	6.2%	6.3%	6.1%	8.8%	6.6%	10.9%
Physical Aggression	41.2%	40.7%	41.6%	47.7%	43.2%	51.9%
Property Damage	19.8%	18.1%	21.1%	22.5%	16.6%	28.0%
Runaway	14.3%	14.2%	14.4%	13.6%	11.6%	15.5%
Hyperactive–Impulsive	29.3%	26.2%	31.9%	40.7%	34.7%	46.3%
Attentional Difficulties	27.8%	24.5%	30.5%	41.0%	34.5%	47.1%
Police Contact	22.2%	24.2%	20.6%	22.2%	19.2%	25.0%
Academic Difficulties	33.8%	33.5%	34.0%	43.2%	39.6%	46.7%
Non-Compliance	45.4%	46.2%	44.7%	47.1%	39.8%	54.0%
Poor Self-Esteem	22.8%	19.5%	25.6%	31.8%	26.8%	36.4%
Truancy	17.0%	18.7%	15.6%	12.8%	11.7%	13.9%
Alcohol and Substance Use	14.7%	16.2%	13.4%	12.0%	12.6%	11.4%
Poor Peer Interaction	25.8%	24.0%	27.3%	30.8%	26.0%	35.4%
Extreme Verbal Abuse	20.6%	18.2%	22.6%	23.2%	17.0%	29.1%
Theft	16.5%	16.3%	16.7%	15.1%	11.7%	18.4%
Anxious	20.0%	18.6%	21.1%	31.2%	27.3%	34.9%
Sleep Disorders	10.7%	9.2%	11.9%	15.5%	11.6%	19.1%
Eating Disorders	5.5%	4.5%	6.4%	7.0%	5.2%	8.7%
Somatic Complaints	5.7%	4.9%	6.3%	7.6%	5.5%	9.6%
Self-Injury	9.1%	8.4%	9.8%	13.9%	12.2%	15.6%

**Table D-2. Baseline Child and Family Characteristics, continued**

	Grant Communities Funded in 1997 and 1998 Overall Sample	Grant Communities Funded in 1997 and 1998 Descriptive Sample	Grant Communities Funded in 1997 and 1998 Outcome Sample	Grant Communities Funded in 1999 and 2000 Overall Sample	Grant Communities Funded in 1999 and 2000 Descriptive Sample	Grant Communities Funded in 1999 and 2000 Outcome Sample
<b>Presenting Problems,<sup>c</sup> continued</b>	<b>(n = 8,478)</b>	<b>(n = 3,863)</b>	<b>(n = 4,615)</b>	<b>(n = 7,214)</b>	<b>(n = 3,498)</b>	<b>(n = 3,716)</b>
Social Contact Avoidance	7.7%	6.8%	8.3%	12.0%	8.9%	14.9%
Sexual Assault	4.3%	3.9%	4.7%	5.2%	4.6%	5.8%
Threat to Life of Others	9.3%	9.1%	9.5%	12.6%	10.2%	14.9%
Fire Setting	5.7%	5.2%	6.1%	6.9%	4.9%	8.8%
Cruelty to Animals	3.6%	2.9%	4.3%	5.9%	4.3%	7.4%
Inappropriate Bowel Movements	2.4%	2.0%	2.7%	3.0%	2.3%	3.7%
Over-Dependence on Adults	6.2%	5.0%	7.2%	11.4%	7.2%	15.3%
Bladder Difficulties	3.1%	2.9%	3.3%	5.2%	3.8%	6.5%
Sexual Acting Out	7.0%	6.9%	7.0%	9.5%	9.1%	9.8%
Strange Behaviors	9.5%	8.4%	10.4%	15.8%	11.0%	20.3%
Other Problems	21.3%	20.3%	22.1%	20.0%	21.8%	18.3%

<sup>c</sup> Because children may present with more than one problem, the variable presenting problems may sum to more than 100%.

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months

	Grant Communities Funded in 1997 and 1998 Intake Mean (SD)	Grant Communities Funded in 1997 and 1998 6 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 12 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 18 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 24 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 30 Months Mean (SD)
<b>Child Behavior Checklist (CBCL)</b>						
Activities Competence	40.7 (9.0) (n = 3,631)	40.2 (9.2) (n = 2,472)	39.7 (9.9) (n = 2,071)	39.4 (10.1) (n = 1,589)	39.0 (10.6) (n = 1,246)	38.7 (9.9) (n = 842)
Social Competence	36.3 (8.9) (n = 3,592)	37.2 (9.2) (n = 2,445)	37.2 (9.6) (n = 2,061)	37.8 (10.1) (n = 1,588)	37.5 (10.4) (n = 1,237)	38.0 (10.1) (n = 843)
School Competence	34.9 (8.6) (n = 3,091)	36.0 (9.2) (n = 2,108)	35.7 (9.9) (n = 1,776)	36.3 (10.3) (n = 1,338)	36.4 (11.0) (n = 1,030)	36.4 (10.4) (n = 688)
Internalizing Problems	64.6 (11.3) (n = 4,149)	62.1 (11.7) (n = 2,797)	60.5 (11.9) (n = 2,335)	59.5 (12.1) (n = 1,789)	58.4 (12.1) (n = 1,407)	57.3 (12.7) (n = 978)
Externalizing Problems	69.6(10.7) (n = 4,150)	66.8 (11.3) (n = 2,798)	65.1 (11.5) (n = 2,336)	63.8 (12.0) (n = 1,789)	63.0 (12.0) (n = 1,408)	62.0 (12.2) (n = 979)
<b>Total Problems</b>	<b>69.7 (10.3)</b> <b>(n = 4,150)</b>	<b>67.0 (11.1)</b> <b>(n = 2,796)</b>	<b>65.2 (11.3)</b> <b>(n = 2,335)</b>	<b>63.7 (11.9)</b> <b>(n = 1,786)</b>	<b>62.8 (12.0)</b> <b>(n = 1,406)</b>	<b>61.7 (12.5)</b> <b>(n = 978)</b>

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake Mean (SD)	Grant Communities Funded in 1997 and 1998 6 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 12 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 18 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 24 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 30 Months Mean (SD)
<b>Child and Adolescent Functional Assessment Scale (CAFAS)</b>						
<b>Mean Total Scale Score</b>	<b>105.4 (46.3)</b> <b>(n = 4,331)</b>	<b>91.4 (47.9)</b> <b>(n = 2,849)</b>	<b>86.0 (48.9)</b> <b>(n = 2,340)</b>	<b>81.8 (49.0)</b> <b>(n = 1,790)</b>	<b>77.2 (49.1)</b> <b>(n = 1,431)</b>	<b>74.2 (49.7)</b> <b>(n = 991)</b>
Home Role <sup>a</sup>	70.5% (n = 4,308)	60.0% (n = 2,873)	56.4% (n = 2,363)	53.6% (n = 1,795)	51.0% (n = 1,428)	47.4% (n = 987)
School Role	76.0% (n = 4,305)	67.5% (n = 2,862)	64.2% (n = 2,363)	62.8% (n = 1,800)	58.3% (n = 1,420)	54.4% (n = 990)
Community Role	40.1% (n = 4,321)	31.9% (n = 2,881)	28.7% (n = 2,368)	25.1% (n = 1,808)	22.9% (n = 1,431)	21.6% (n = 993)
Behavior Toward Others	71.7% (n = 4,319)	59.6% (n = 2,881)	56.9% (n = 2,370)	54.1% (n = 1,808)	52.7% (n = 1,433)	48.8% (n = 994)
Mood and Emotions	62.6% (n = 4,318)	52.3% (n = 2,879)	49.1% (n = 2,369)	47.8% (n = 1,809)	41.3% (n = 1,434)	42.5% (n = 989)
Harmful Behavior	24.3% (n = 4,318)	16.5% (n = 2,878)	13.8% (n = 2,370)	12.3% (n = 1,810)	11.4% (n = 1,434)	10.7% (n = 991)
Substance Abuse	14.6% (n = 4,314)	11.3% (n = 2,880)	11.3% (n = 2,369)	11.5% (n = 1,806)	9.8% (n = 1,432)	11.2% (n = 992)
Thinking	17.1% (n = 4,317)	14.6% (n = 2,876)	12.7% (n = 2,365)	11.1% (n = 1,807)	11.0% (n = 1,433)	11.1% (n = 992)

<sup>a</sup> For Home Role to Thinking scales, the percentages represented those with moderate or severe level of functional impairment.

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake Mean (SD)	Grant Communities Funded in 1997 and 1998 6 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 12 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 18 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 24 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 30 Months Mean (SD)
<b>Behavioral and Emotional Rating Scale (BERS)</b>						
Intrapersonal Strengths	8.6 (3.0) (n = 3,909)	9.1 (3.0) (n = 2,701)	9.3 (2.9) (n = 2,257)	9.3 (3.0) (n = 1,809)	9.5 (3.0) (n = 1,441)	9.7 (3.1) (n = 995)
Interpersonal Strengths	7.2 (2.8) (n = 3,905)	7.7 (2.8) (n = 2,704)	8.0 (2.8) (n = 2,257)	8.1 (2.9) (n = 1,811)	8.3 (2.9) (n = 1,442)	8.5 (3.0) (n = 996)
School Functioning	7.2 (2.8) (n = 3,644)	7.7 (2.7) (n = 2,529)	7.9 (2.8) (n = 2,117)	7.9 (2.8) (n = 1,642)	7.9 (2.9) (n = 1,276)	8.0 (2.9) (n = 851)
Family Involvement	8.2 (2.9) (n = 3,858)	8.6 (2.9) (n = 2,667)	8.8 (2.8) (n = 2,219)	8.8 (2.8) (n = 1,773)	9.0 (2.8) (n = 1,412)	9.1 (3.0) (n = 979)
Affective Strengths	9.5 (3.4) (n = 3,906)	9.9 (3.4) (n = 2,701)	10.0 (3.3) (n = 2,259)	10.0 (3.3) (n = 1,810)	10.2 (3.3) (n = 1,442)	10.3 (3.4) (n = 996)
<b>Strengths Quotient</b>	<b>86.2 (16.7)</b> <b>(n = 3,918)</b>	<b>89.3 (17.2)</b> <b>(n = 2,708)</b>	<b>90.5 (17.0)</b> <b>(n = 2,264)</b>	<b>90.4 (17.3)</b> <b>(n = 1,813)</b>	<b>91.4 (17.5)</b> <b>(n = 1,444)</b>	<b>91.9 (17.9)</b> <b>(n = 998)</b>
<b>Family Functioning Scale (FAD)—Caregiver</b>						
Problem Solving	2.8 (0.4) (n = 3,176)	2.9 (0.4) (n = 2,259)	2.9 (0.4) (n = 1,858)	2.9 (0.4) (n = 1,500)	2.9 (0.4) (n = 1,153)	3.0 (0.4) (n = 771)
Communication	2.8 (0.4) (n = 3,171)	2.9 (0.4) (n = 2,256)	2.9 (0.4) (n = 1,859)	2.9 (0.4) (n = 1,501)	2.9 (0.4) (n = 1,153)	3.0 (0.4) (n = 769)
Roles	2.5 (0.4) (n = 3,175)	2.6 (0.4) (n = 2,255)	2.6 (0.4) (n = 1,861)	2.6 (0.4) (n = 1,501)	2.6 (0.4) (n = 1,153)	2.7 (0.4) (n = 770)
Affective Responsiveness	2.9 (0.5) (n = 3,174)	3.0 (0.5) (n = 2,255)	3.0 (0.4) (n = 1,861)	3.0 (0.5) (n = 1,501)	3.0 (0.5) (n = 1,154)	3.0 (0.5) (n = 768)
Affective Involvement	2.7 (0.5) (n = 3,172)	2.8 (0.5) (n = 2,248)	2.8 (0.4) (n = 1,861)	2.8 (0.5) (n = 1,497)	2.8 (0.5) (n = 1,153)	2.8 (0.5) (n = 771)
Behavior Control	3.2 (0.4) (n = 3,174)	3.2 (0.4) (n = 2,255)	3.2 (0.4) (n = 1,860)	3.2 (0.4) (n = 1,499)	3.2 (0.4) (n = 1,154)	3.3 (0.4) (n = 770)
<b>General Functioning</b>	<b>2.9 (0.5)</b> <b>(n = 3,814)</b>	<b>3.0 (0.4)</b> <b>(n = 2,659)</b>	<b>3.0 (0.4)</b> <b>(n = 2,208)</b>	<b>3.0 (0.4)</b> <b>(n = 1,743)</b>	<b>3.0 (0.4)</b> <b>(n = 1,374)</b>	<b>3.0 (0.4)</b> <b>(n = 944)</b>

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake Mean (SD)	Grant Communities Funded in 1997 and 1998 6 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 12 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 18 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 24 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 30 Months Mean (SD)
<b>Family Functioning Scale (FAD)–Youth</b>						
Problem Solving	2.7 (0.4) (n = 1,996)	2.7 (0.4) (n = 1,381)	2.7 (0.4) (n = 1,166)	2.8 (0.4) (n = 964)	2.8 (0.4) (n = 754)	2.9 (0.4) (n = 530)
Communication	2.6 (0.4) (n = 1,993)	2.7 (0.4) (n = 1,383)	2.7 (0.4) (n = 1,161)	2.7 (0.4) (n = 962)	2.7 (0.4) (n = 757)	2.8 (0.4) (n = 534)
Roles	2.6 (0.4) (n = 2,004)	2.6 (0.3) (n = 1,387)	2.7 (0.4) (n = 1,170)	2.7 (0.4) (n = 966)	2.7 (0.3) (n = 757)	2.7 (0.4) (n = 536)
Affective Responsiveness	2.6 (0.5) (n = 1,992)	2.7 (0.4) (n = 1,384)	2.7 (0.4) (n = 1,161)	2.7 (0.4) (n = 962)	2.7 (0.4) (n = 758)	2.8 (0.5) (n = 534)
Affective Involvement	2.6 (0.5) (n = 1,992)	2.6 (0.5) (n = 1,377)	2.6 (0.5) (n = 1,156)	2.6 (0.5) (n = 956)	2.7 (0.5) (n = 757)	2.7 (0.5) (n = 529)
Behavior Control	3.0 (0.4) (n = 2,005)	3.1 (0.4) (n = 1,394)	3.1 (0.4) (n = 1,169)	3.1 (0.4) (n = 966)	3.1 (0.4) (n = 760)	3.1 (0.4) (n = 531)
<b>General Functioning</b>	<b>2.7 (0.5)</b> <b>(n = 2,348)</b>	<b>2.8 (0.4)</b> <b>(n = 1,605)</b>	<b>2.8 (0.4)</b> <b>(n = 1,362)</b>	<b>2.8 (0.4)</b> <b>(n = 1,101)</b>	<b>2.9 (0.4)</b> <b>(n = 883)</b>	<b>2.9 (0.4)</b> <b>(n = 635)</b>
<b>Caregiver Strain Questionnaire (CGSQ)</b>						
Subjective Externalizing Strain	2.4 (1.0) (n = 4,186)	2.2 (0.9) (n = 2,870)	2.2 (0.9) (n = 2,372)	2.1 (0.9) (n = 1,844)	2.1 (0.9) (n = 1,437)	2.0 (0.9) (n = 976)
Subjective Internalizing Strain	3.6 (1.0) (n = 4,178)	3.3 (1.0) (n = 2,860)	3.1 (1.1) (n = 2,367)	3.0 (1.1) (n = 1,842)	2.9 (1.1) (n = 1,435)	2.8 (1.1) (n = 976)
Objective Strain	2.7 (1.1) (n = 4,187)	2.4 (1.0) (n = 2,869)	2.3 (1.0) (n = 2,372)	2.2 (1.0) (n = 1,843)	2.1 (1.0) (n = 1,437)	2.0 (1.0) (n = 974)
<b>Global Strain</b>	<b>2.9 (0.9)</b> <b>(n = 4,187)</b>	<b>2.7 (0.9)</b> <b>(n = 2,872)</b>	<b>2.5 (0.9)</b> <b>(n = 2,375)</b>	<b>2.4 (0.9)</b> <b>(n = 1,844)</b>	<b>2.4 (0.9)</b> <b>(n = 1,438)</b>	<b>2.3 (0.9)</b> <b>(n = 975)</b>

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake Mean (SD)	Grant Communities Funded in 1997 and 1998 6 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 12 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 18 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 24 Months Mean (SD)	Grant Communities Funded in 1997 and 1998 30 Months Mean (SD)
<b>Family Resource Scale (FRS)</b>						
Basic Needs	4.4 (0.6) (n = 4,219)	4.4 (0.6) (n = 2,904)	4.5 (0.6) (n = 2,387)	4.5 (0.6) (n = 1,855)	4.5 (0.6) (n = 1,440)	4.5 (0.6) (n = 977)
Quality of Life	4.2 (0.9) (n = 3,875)	4.2 (0.8) (n = 2,636)	4.2 (0.8) (n = 2,162)	4.2 (0.8) (n = 1,678)	4.2 (0.8) (n = 1,298)	4.3 (0.8) (n = 858)
Cash and Recreation	3.0 (1.0) (n = 4,149)	3.1 (1.0) (n = 2,851)	3.1 (1.0) (n = 2,351)	3.1 (1.0) (n = 1,814)	3.1 (1.0) (n = 1,396)	3.2 (1.0) (n = 951)
Time	3.3 (0.9) (n = 4,188)	3.4 (0.9) (n = 2,890)	3.4 (0.9) (n = 2,380)	3.5 (0.9) (n = 1,845)	3.5 (0.9) (n = 1,435)	3.6 (0.9) (n = 969)
Health and Social Services	4.0 (1.1) (n = 3,480)	4.1 (1.0) (n = 2,378)	4.1 (1.0) (n = 1,901)	4.1 (1.0) (n = 1,456)	4.1 (1.0) (n = 1,120)	4.1 (1.0) (n = 767)
Childcare	3.1 (1.5) (n = 2,617)	3.1 (1.5) (n = 1,649)	3.2 (1.5) (n = 1,252)	3.1 (1.5) (n = 881)	3.1 (1.5) (n = 675)	3.2 (1.5) (n = 442)

**Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Restrictiveness of Living Environments and Placement Stability Scale—Revised Version (ROLES–R)</b>						
<b>Living Arrangement</b>	<b>(n = 4,544)</b>	<b>(n = 3,088)</b>	<b>(n = 2,549)</b>	<b>(n = 1,971)</b>	<b>(n = 1,547)</b>	<b>(n = 1,042)</b>
No Place to Stay	0.3%	0.6%	0.3%	0.2%	0.3%	0.4%
Independent Living by Self	0.0%	0.2%	0.3%	0.5%	0.5%	1.2%
Independent Living with Partner–Friend	0.2%	0.2%	0.5%	0.7%	1.0%	1.0%
Two Parents/Caregivers, At Least One Biological Parent	34.2%	34.0%	32.1%	32.6%	31.7%	29.9%
Biological Mother Only	32.8%	30.4%	32.3%	31.8%	32.2%	31.3%
Biological Father Only	2.6%	2.7%	2.9%	2.9%	3.4%	2.3%
Split Parenting	0.6%	0.4%	0.4%	0.4%	0.5%	0.4%
School Dormitory	0.1%	0.1%	0.1%	0.1%	0.2%	0.2%
Home of a Relative	9.6%	9.1%	8.5%	8.3%	8.7%	9.0%
Adoptive Home	3.4%	4.0%	4.8%	4.4%	4.6%	4.9%
Home of a Friend	0.4%	0.6%	0.5%	0.7%	1.1%	0.7%
Camp	0.0%	0.1%	0.0%	0.0%	0.1%	0.0%
Supervised Independent Living	0.1%	0.1%	0.0%	0.1%	0.0%	0.1%
Foster Care	4.0%	3.8%	3.3%	3.3%	3.0%	3.6%
Specialized Foster Care	0.3%	0.4%	0.2%	0.5%	0.5%	0.5%
Therapeutic Foster Care	1.1%	1.2%	1.2%	1.1%	1.2%	1.5%
Individual Home Emergency Shelter	0.4%	0.1%	0.0%	0.0%	0.0%	0.0%
Group Emergency Shelter	0.4%	0.4%	0.2%	0.2%	0.3%	0.3%
Group Home	2.6%	3.2%	3.5%	2.8%	3.4%	4.2%
Residential Job Corp–Vocational Center	0.0%	0.0%	0.2%	0.2%	0.4%	0.2%
Residential Treatment Center (non-drug/alcohol)	1.8%	3.0%	2.7%	3.1%	2.4%	2.7%

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Restrictiveness of Living Environments and Placement Stability Scale–Revised Version (ROLES–R), continued</b>						
<b>Living Arrangement, continued</b>	<b>(n = 4,544)</b>	<b>(n = 3,088)</b>	<b>(n = 2,549)</b>	<b>(n = 1,971)</b>	<b>(n = 1,547)</b>	<b>(n = 1,042)</b>
Drug/Alcohol Residential Treatment Center	0.3%	0.3%	0.3%	0.4%	0.3%	0.2%
Medical Hospital (non-psychiatric)	0.0%	0.0%	0.1%	0.1%	0.0%	0.1%
Psychiatric Hospital	1.0%	0.7%	0.8%	0.8%	0.8%	0.2%
Juvenile Detention Center	3.0%	3.4%	3.3%	3.8%	2.8%	3.4%
Jail/Prison	0.1%	0.1%	0.3%	0.3%	0.3%	0.6%
Other	0.9%	1.0%	0.9%	1.2%	0.5%	1.2%
<b>Children with One or More Living Arrangements in Past 6 Months</b>	<b>(n = 4,546)</b>	<b>(n = 3,089)</b>	<b>(n = 2,550)</b>	<b>(n = 1,974)</b>	<b>(n = 1,549)</b>	<b>(n = 1,042)</b>
One	63.3%	70.7%	74.9%	76.2%	77.9%	79.6%
Two or More	36.7%	29.3%	25.1%	23.8%	22.1%	20.4%
<b>Education Questionnaire (EQ)</b>						
<b>School Performance Last 6 Months</b>	<b>(n = 3,782)</b>	<b>(n = 2,599)</b>	<b>(n = 2,210)</b>	<b>(n = 1,630)</b>	<b>(n = 1,305)</b>	<b>(n = 857)</b>
Grade Average A	6.7%	7.7%	8.1%	7.7%	7.8%	8.3%
Grade Average B	18.5%	23.2%	24.2%	26.7%	27.1%	26.1%
Grade Average C	26.4%	28.7%	31.4%	31.5%	32.1%	34.5%
Grade Average D	12.7%	10.4%	10.4%	9.8%	9.5%	10.2%
Failing All or Most Classes	24.4%	17.7%	15.7%	14.2%	13.1%	12.0%
School Does Not Grade	10.0%	10.7%	9.1%	9.0%	8.7%	8.1%
Other	1.4%	1.6%	1.0%	1.1%	1.6%	0.8%

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Caregiver Perception: Do Child's Grades Match Ability or Could Child Do Better?</b>	<b>(n = 3,563)</b>	<b>(n = 2,526)</b>	<b>(n = 2,183)</b>	<b>(n = 1,611)</b>	<b>(n = 1,287)</b>	<b>(n = 850)</b>
Matches Ability	22.0%	29.4%	29.4%	29.5%	32.4%	33.2%
Could Do Better	78.0%	70.6%	70.6%	70.5%	67.6%	66.8%
<b>Child Had Individualized Education Plan in Last 6 Months</b>	<b>(n = 3,948)</b>	<b>(n = 2,674)</b>	<b>(n = 2,249)</b>	<b>(n = 1,654)</b>	<b>(n = 1,313)</b>	<b>(n = 852)</b>
Had IEP	52.1%	58.4%	62.3%	61.2%	62.1%	62.1%
Did Not Have IEP	47.9%	41.6%	37.7%	38.8%	37.9%	37.9%
<b>Reasons for IEP</b>	<b>(n = 1,982)</b>	<b>(n = 1,527)</b>	<b>(n = 1,383)</b>	<b>(n = 999)</b>	<b>(n = 789)</b>	<b>(n = 525)</b>
Behavioral/Emotional Problems	72.9%	76.9%	77.2%	77.0%	78.1%	76.6%
Learning Disability	47.6%	50.5%	54.4%	55.4%	55.0%	58.7%
Physical Disability	2.7%	2.5%	2.0%	1.4%	2.8%	1.9%
Developmental Disability/Mental Retardation	9.2%	10.7%	9.5%	11.7%	13.3%	14.7%
Vision or Hearing Impairment	2.5%	2.3%	2.5%	1.8%	3.3%	2.5%
Speech Impairment	9.0%	8.1%	8.2%	9.8%	8.2%	8.0%
Other Reason	6.3%	5.2%	5.2%	6.6%	3.7%	5.7%
<b>School Attendance in Last 6 Months</b>	<b>(n = 3,926)</b>	<b>(n = 2,673)</b>	<b>(n = 2,241)</b>	<b>(n = 1,639)</b>	<b>(n = 1,310)</b>	<b>(n = 870)</b>
Attended Regularly	73.1%	81.1%	81.9%	82.8%	84.6%	86.2%
Attended More Often than Not	14.6%	11.3%	10.8%	10.7%	9.0%	8.6%
Attended Infrequently	12.3%	7.6%	7.2%	6.5%	6.3%	5.2%
<b>Special Education</b>						
Child Took Classes Where Everyone Attending Was in Special Education	36.3% (n = 2,830)	41.4% (n = 2,195)	43.5% (n = 2,015)	46.3% (n = 1,532)	45.1% (n = 1,252)	43.6% (n = 842)
Child Took Classes Where Some Attending Were in Special Education, Others Not	30.5% (n = 2,766)	32.5% (n = 2,152)	32.2% (n = 1,977)	30.2% (n = 1,504)	30.8% (n = 1,235)	33.7% (n = 831)

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Percent of Day Spent in Special Education Classes</b>	<b>(n = 2,618)</b>	<b>(n = 2,056)</b>	<b>(n = 1,915)</b>	<b>(n = 1,458)</b>	<b>(n = 1,172)</b>	<b>(n = 787)</b>
0–25%	61.8%	55.8%	55.0%	54.0%	54.4%	55.4%
26–50%	8.7%	9.3%	8.1%	8.6%	10.3%	10.7%
51–75%	6.6%	7.2%	7.2%	6.3%	8.7%	7.0%
76–100%	21.9%	26.6%	28.4%	29.9%	25.4%	25.7%
Other	0.9%	1.1%	1.4%	1.1%	1.1%	1.3%
<b>School Performance Last 6 Months: Grades 1 Through 6</b>	<b>(n = 1,475)</b>	<b>(n = 988)</b>	<b>(n = 776)</b>	<b>(n = 495)</b>	<b>(n = 401)</b>	<b>(n = 242)</b>
Grade Average A	8.5%	9.2%	9.0%	10.3%	8.2%	10.3%
Grade Average B	18.9%	22.0%	24.0%	25.1%	24.4%	25.6%
Grade Average C	26.4%	26.1%	30.2%	26.1%	29.4%	31.4%
Grade Average D	11.7%	9.0%	9.5%	9.1%	8.0%	7.0%
Failing All or Most Classes	15.4%	11.0%	7.6%	8.5%	8.0%	5.8%
School Does Not Grade	17.9%	21.3%	18.9%	19.8%	19.7%	18.6%
Other	1.3%	1.4%	0.8%	1.2%	2.2%	1.2%
<b>School Performance Last 6 Months: Grades 7 and 8</b>	<b>(n = 909)</b>	<b>(n = 566)</b>	<b>(n = 482)</b>	<b>(n = 351)</b>	<b>(n = 254)</b>	<b>(n = 186)</b>
Grade Average A	3.9%	4.2%	5.6%	5.1%	4.7%	8.1%
Grade Average B	16.5%	25.3%	23.4%	26.5%	25.6%	28.0%
Grade Average C	30.4%	34.1%	32.6%	37.6%	35.4%	31.2%
Grade Average D	14.7%	10.4%	13.7%	12.8%	10.2%	14.5%
Failing All or Most Classes	31.9%	21.9%	21.2%	14.0%	17.7%	14.0%
School Does Not Grade	1.9%	3.2%	2.3%	3.1%	4.7%	4.3%
Other	0.8%	0.9%	1.2%	0.9%	1.6%	0.0%

**Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>School Performance Last 6 Months: Grades 9 Through 12</b>	<b>(n = 1,059)</b>	<b>(n = 822)</b>	<b>(n = 786)</b>	<b>(n = 642)</b>	<b>(n = 538)</b>	<b>(n = 360)</b>
Grade Average A	6.7%	7.7%	8.4%	6.9%	7.4%	7.5%
Grade Average B	19.7%	23.2%	25.3%	29.6%	30.9%	25.3%
Grade Average C	26.3%	30.4%	34.2%	34.3%	33.3%	39.2%
Grade Average D	14.2%	13.3%	9.9%	8.3%	10.4%	10.0%
Failing All or Most Classes	31.0%	21.9%	18.7%	17.6%	15.1%	14.7%
School Does Not Grade	1.5%	1.7%	2.9%	2.8%	2.6%	3.1%
Other	0.7%	1.8%	0.5%	0.6%	0.4%	0.3%
<b>Type of Educational Placement<sup>b</sup></b>	<b>(n = 3,913)</b>	<b>(n = 2,678)</b>	<b>(n = 2,286)</b>	<b>(n = 1,677)</b>	<b>(n = 1,303)</b>	<b>(n = 877)</b>
Regular Public Day School	80.7%	78.4%	76.3%	76.5%	76.7%	76.2%
Regular Private or Boarding School	2.2%	1.9%	1.9%	1.8%	1.9%	1.7%
Home Schooling	2.0%	1.5%	1.5%	1.4%	0.9%	0.9%
Home-based Instruction	1.7%	1.5%	1.3%	1.1%	0.8%	1.0%
Combination Home Schooling/Home-based Instruction	1.2%	0.8%	0.7%	0.5%	0.2%	0.2%
Alternative/Special Day School	19.3%	18.7%	19.9%	18.7%	17.9%	14.9%
School in 24-Hour Hospital Setting	4.3%	2.2%	1.7%	1.4%	1.5%	1.3%
School in 24-Hour Juvenile Justice Facility	4.0%	3.4%	4.1%	3.6%	3.5%	3.4%
School in 24-Hour Residential Treatment Center	4.0%	4.6%	4.7%	4.7%	4.1%	3.5%
Other	6.5%	5.3%	4.8%	3.9%	3.8%	4.8%

<sup>b</sup> Because an individual may have more than one educational placement, the educational placement variable may add to more than 100%.

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Disciplinary Actions in Past 6 Months</b>						
Detention	35.6% (n = 3,899)	30.3% (n = 2,462)	27.0% (n = 2,063)	25.3% (n = 1,507)	24.7% (n = 1,200)	19.1% (n = 791)
Suspension	42.7% (n = 3,974)	34.4% (n = 2,494)	33.2% (n = 2,087)	29.5% (n = 1,531)	29.3% (n = 1,211)	23.5% (n = 804)
Expulsion	7.5% (n = 3,926)	5.5% (n = 2,483)	4.4% (n = 2,081)	4.8% (n = 1,516)	4.1% (n = 1,205)	2.5% (n = 799)
<b>Delinquency Survey (DS)</b>						
<b>Juvenile Delinquency in Past 6 Months</b>						
Accused of Breaking the Law	33.6% (n = 2,381)	26.1% (n = 1,665)	25.1% (n = 1,436)	23.1% (n = 1,168)	18.8% (n = 931)	16.5% (n = 655)
Arrested	27.0% (n = 2,438)	18.8% (n = 1,710)	17.0% (n = 1,455)	15.6% (n = 1,195)	12.2% (n = 954)	10.3% (n = 662)
Convicted of a Crime	22.5% (n = 2,552)	16.3% (n = 1,735)	14.8% (n = 1,475)	14.2% (n = 1,198)	11.4% (n = 959)	13.0% (n = 670)
On Probation	33.5% (n = 2,539)	32.5% (n = 1,752)	31.2% (n = 1,496)	26.6% (n = 1,214)	21.1% (n = 970)	19.7% (n = 679)
In Detention Center/Jail	27.8% (n = 2,521)	20.3% (n = 1,733)	18.0% (n = 1,485)	17.5% (n = 1,209)	16.0% (n = 961)	13.0% (n = 679)

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Substance Use Survey A (SUS-A)</b>						
<b>Have You Ever Used:</b>						
Cigarettes	62.8% (n = 2,580)	60.5% (n = 1,761)	63.1% (n = 1,497)	64.0% (n = 1,218)	63.2% (n = 967)	61.0% (n = 680)
Alcohol	57.2% (n = 2,582)	56.4% (n = 1,766)	58.3% (n = 1,500)	61.3% (n = 1,221)	63.8% (n = 969)	63.4% (n = 681)
Marijuana/Hashish	48.0% (n = 2,572)	44.6% (n = 1,763)	48.9% (n = 1,501)	51.5% (n = 1,220)	50.9% (n = 968)	51.0% (n = 680)
Cocaine in a Powder Form	8.2% (n = 2,573)	8.5% (n = 1,762)	9.9% (n = 1,501)	11.5% (n = 1,220)	11.4% (n = 968)	10.9% (n = 681)
LSD, Acid, PCP or Other Psychedelics	12.0% (n = 2,571)	11.1% (n = 1,762)	12.6% (n = 1,501)	13.5% (n = 1,219)	13.1% (n = 968)	12.9% (n = 681)
Non-Prescription or Over-the-Counter Drugs	10.7% (n = 2,572)	8.9% (n = 1,759)	9.4% (n = 1,497)	9.1% (n = 1,220)	8.1% (n = 967)	8.4% (n = 681)
Quaaludes (e.g., quads)	1.1% (n = 2,576)	1.1% (n = 1,762)	1.2% (n = 1,499)	1.7% (n = 1,219)	1.5% (n = 968)	1.5% (n = 680)
Heroin, Smack	2.5% (n = 2,573)	3.1% (n = 1,760)	2.7% (n = 1,501)	3.9% (n = 1,219)	4.0% (n = 968)	4.6% (n = 681)
Barbituates (e.g., downers)	3.6% (n = 2,576)	3.8% (n = 1,762)	4.2% (n = 1,500)	6.1% (n = 1,221)	5.3% (n = 967)	4.4% (n = 680)
Narcotics (e.g., morphine)	7.4% (n = 2,576)	6.8% (n = 1,762)	7.7% (n = 1,500)	7.7% (n = 1,221)	7.4% (n = 968)	7.5% (n = 681)
Crack or Rock in a Hard Chunk Form	4.4% (n = 2,574)	4.0% (n = 1,761)	4.8% (n = 1,501)	5.5% (n = 1,220)	5.7% (n = 968)	4.8% (n = 681)
Amphetamines	7.9% (n = 2,576)	8.7% (n = 1,763)	9.0% (n = 1,500)	9.2% (n = 1,219)	9.2% (n = 968)	10.0% (n = 681)
Tranquilizers (e.g., Valium)	5.0% (n = 2,576)	4.7% (n = 1,762)	5.5% (n = 1,500)	7.0% (n = 1,221)	5.6% (n = 968)	7.2% (n = 680)
Inhalants (e.g., spray cans)	9.8% (n = 2,573)	8.3% (n = 1,763)	8.5% (n = 1,501)	8.0% (n = 1,220)	9.1% (n = 968)	8.4% (n = 681)

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Substance Use Survey A (SUS-A), continued</b>						
<b>Substance Use in Last 6 Months</b>						
Cigarettes	43.1% (n = 2,578)	39.4% (n = 1,764)	39.7% (n = 1,500)	42.8% (n = 1,217)	41.9% (n = 968)	40.1% (n = 679)
Alcohol	36.2% (n = 2,579)	29.4% (n = 1,766)	30.0% (n = 1,499)	33.2% (n = 1,218)	32.5% (n = 968)	35.2% (n = 679)
Marijuana/Hashish	27.8% (n = 2,568)	20.4% (n = 1,761)	22.1% (n = 1,498)	22.8% (n = 1,219)	22.3% (n = 968)	23.8% (n = 680)
<b>Multi-Sector Service Contacts (MSSC)</b>						
<b>Traditional Services Received in Last 6 Months</b>						
Individual Therapy	n/a	75.1% (n = 2,743)	70.8% (n = 2,101)	68.9% (n = 1,507)	67.1% (n = 1,071)	66.0% (n = 679)
Case Management	n/a	73.3% (n = 2,735)	67.5% (n = 2,105)	63.5% (n = 1,505)	59.9% (n = 1,071)	57.0% (n = 683)
Assessment or Evaluation	n/a	63.4% (n = 2,722)	54.2% (n = 2,070)	52.7% (n = 1,481)	45.7% (n = 1,060)	47.5% (n = 674)
Medication Treatment/Monitoring	n/a	57.9% (n = 2,745)	56.5% (n = 2,101)	60.2% (n = 1,506)	58.9% (n = 1,076)	59.6% (n = 681)
Family Therapy	n/a	37.3% (n = 2,740)	31.9% (n = 2,100)	29.1% (n = 1,502)	25.7% (n = 1,068)	27.6% (n = 685)
Group Therapy	n/a	29.9% (n = 2,730)	31.1% (n = 2,092)	29.2% (n = 1,495)	27.5% (n = 1,072)	30.3% (n = 679)
Crisis Stabilization	n/a	19.4% (n = 2,725)	15.5% (n = 2,082)	13.5% (n = 1,492)	12.6% (n = 1,064)	13.4% (n = 681)

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Multi-Sector Service Contacts (MSSC), continued</b>						
<b>Innovative Services Received in Last 6 Months</b>						
Recreational Activities	n/a	33.0% (n = 2,731)	31.0% (n = 2,101)	30.3% (n = 1,502)	26.5% (n = 1,074)	30.0% (n = 684)
Family Support	n/a	30.6% (n = 2,729)	28.7% (n = 2,094)	27.5% (n = 1,493)	25.9% (n = 1,071)	25.7% (n = 686)
Transportation	n/a	20.8% (n = 2,727)	19.3% (n = 2,100)	19.5% (n = 1,501)	18.0% (n = 1,072)	18.6% (n = 682)
Flexible Funds	n/a	21.3% (n = 2,698)	18.3% (n = 2,091)	16.7% (n = 1,493)	13.1% (n = 1,067)	11.3% (n = 683)
Behavioral/Therapeutic Aide	n/a	18.1% (n = 2,733)	17.8% (n = 2,095)	15.4% (n = 1,502)	14.1% (n = 1,075)	14.9% (n = 685)
Family Preservation	n/a	13.0% (n = 2,710)	11.3% (n = 2,078)	7.9% (n = 1,492)	7.0% (n = 1,064)	6.8% (n = 681)
Respite	n/a	10.5% (n = 2,719)	9.6% (n = 2,090)	9.4% (n = 1,490)	10.2% (n = 1,071)	8.2% (n = 681)
Transition	n/a	1.9% (n = 2,696)	1.6% (n = 2,079)	1.9% (n = 1,491)	1.1% (n = 1,069)	1.8% (n = 678)
Independent Living	n/a	2.6% (n = 2,698)	3.1% (n = 2,079)	4.1% (n = 1,492)	3.2% (n = 1,068)	4.3% (n = 680)
Afterschool Programs	n/a	14.6% (n = 2,260)	12.5% (n = 1,839)	12.0% (n = 1,345)	11.1% (n = 996)	9.7% (n = 663)

Table D-3 (Part 1). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1997 and 1998 Intake %	Grant Communities Funded in 1997 and 1998 6 Months %	Grant Communities Funded in 1997 and 1998 12 Months %	Grant Communities Funded in 1997 and 1998 18 Months %	Grant Communities Funded in 1997 and 1998 24 Months %	Grant Communities Funded in 1997 and 1998 30 Months %
<b>Multi-Sector Service Contacts (MSSC), continued</b>						
<b>Restrictive Services Received in Last 6 Months</b>						
Day Treatment	n/a	10.4% (n = 2,737)	9.3% (n = 2,100)	7.6% (n = 1,504)	6.4% (n = 1,075)	7.6% (n = 686)
Inpatient Hospitalization	n/a	8.6% (n = 2,734)	7.3% (n = 2,102)	7.3% (n = 1,505)	7.5% (n = 1,076)	8.7% (n = 686)
Residential Treatment Center	n/a	7.6% (n = 2,741)	7.6% (n = 2,101)	9.1% (n = 1,504)	9.1% (n = 1,072)	10.2% (n = 684)
Therapeutic Group Home	n/a	6.3% (n = 2,736)	6.5% (n = 2,100)	6.3% (n = 1,504)	6.9% (n = 1,077)	8.7% (n = 686)
Therapeutic Foster Care	n/a	4.2% (n = 2,739)	4.5% (n = 2,102)	3.2% (n = 1,504)	4.2% (n = 1,075)	6.6% (n = 687)
Residential Camp	n/a	2.7% (n = 2,740)	2.2% (n = 2,104)	3.3% (n = 1,506)	1.7% (n = 1,076)	1.6% (n = 686)
<b>Average Number of Service Types Received in Last 6 Months</b>	n/a	<b>5.6</b> (n = 2,757)	<b>5.2</b> (n = 2,111)	<b>5.0</b> (n = 1,514)	<b>4.7</b> (n = 1,078)	<b>4.8</b> (n = 688)

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months

	Grant Communities Funded in 1999 and 2000 Intake Mean (SD)	Grant Communities Funded in 1999 and 2000 6 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 12 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 18 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 24 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 30 Months Mean (SD)
<b>Child Behavior Checklist (CBCL)</b>						
Activities Competence	40.5 (7.6) (n = 2,969)	40.2 (7.5) (n = 1,878)	40.2 (7.6) (n = 1,377)	40.0 (7.6) (n = 993)	40.4 (7.5) (n = 699)	40.1 (7.6) (n = 465)
Social Competence	38.2 (8.9) (n = 2,978)	38.5 (9.0) (n = 1,908)	38.6 (8.8) (n = 1,413)	38.8 (8.8) (n = 996)	39.3 (8.6) (n = 702)	38.5 (8.7) (n = 463)
School Competence	35.2 (8.6) (n = 3,033)	36.4 (8.6) (n = 1,919)	37.0 (8.6) (n = 1,410)	37.4 (8.9) (n = 989)	37.2 (9.0) (n = 716)	37.2 (8.8) (n = 465)
Internalizing Problems	64.3 (11.5) (n = 3,552)	62.1 (12.0) (n = 2,192)	61.0 (12.2) (n = 1,610)	60.5 (12.4) (n = 1,131)	60.0 (12.2) (n = 809)	60.0 (12.0) (n = 528)
Externalizing Problems	68.9 (10.9) (n = 3,552)	66.4 (11.3) (n = 2,192)	65.8 (11.4) (n = 1,610)	65.1 (11.7) (n = 1,131)	64.4 (11.7) (n = 809)	64.0 (11.6) (n = 528)
<b>Total Problems</b>	<b>70.0 (10.6)</b> <b>(n = 3,541)</b>	<b>67.3 (11.4)</b> <b>(n = 2,183)</b>	<b>66.4 (11.7)</b> <b>(n = 1,606)</b>	<b>65.8 (11.9)</b> <b>(n = 1,122)</b>	<b>65.2 (11.8)</b> <b>(n = 805)</b>	<b>65.0 (11.6)</b> <b>(n = 525)</b>

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake Mean (SD)	Grant Communities Funded in 1999 and 2000 6 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 12 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 18 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 24 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 30 Months Mean (SD)
<b>Child and Adolescent Functional Assessment Scale (CAFAS)</b>						
<b>Mean Total Scale Score</b>	<b>116.7 (48.7)</b> <b>(n = 3,316)</b>	<b>100.8 (50.5)</b> <b>(n = 2,079)</b>	<b>98.0 (51.2)</b> <b>(n = 1,499)</b>	<b>92.2 (51.4)</b> <b>(n = 1,082)</b>	<b>92.4 (51.3)</b> <b>(n = 769)</b>	<b>87.5 (52.1)</b> <b>(n = 484)</b>
Home Role <sup>a</sup>	74.2% (n = 3,316)	65.8% (n = 2,082)	64.9% (n = 1,497)	58.9% (n = 1,081)	60.3% (n = 768)	58.4% (n = 485)
School Role	81.6% (n = 3,302)	72.8% (n = 2,091)	72.9% (n = 1,518)	68.4% (n = 1,102)	67.8% (n = 798)	66.2% (n = 521)
Community Role	38.4% (n = 3,318)	27.9% (n = 2,083)	25.0% (n = 1,500)	21.7% (n = 1,083)	21.7% (n = 769)	19.7% (n = 488)
Behavior Toward Others	77.4% (n = 3,320)	69.5% (n = 2,086)	68.2% (n = 1,502)	63.5% (n = 1,085)	64.6% (n = 769)	58.9% (n = 487)
Mood and Emotions	73.3% (n = 3,320)	65.8% (n = 2,084)	64.6% (n = 1,500)	60.6% (n = 1,086)	60.2% (n = 769)	57.5% (n = 487)
Harmful Behavior	30.6% (n = 3,322)	21.6% (n = 2,084)	19.0% (n = 1,504)	17.0% (n = 1,087)	15.4% (n = 768)	14.4% (n = 487)
Substance Abuse	8.7% (n = 3,302)	6.4% (n = 2,077)	6.3% (n = 1,500)	5.6% (n = 1,081)	6.1% (n = 768)	4.7% (n = 487)
Thinking	30.4% (n = 3,321)	26.7% (n = 2,085)	23.7% (n = 1,504)	23.4% (n = 1,086)	25.8% (n = 768)	20.7% (n = 487)

<sup>a</sup> For Home Role to Thinking scales, the percentages represented those with moderate or severe level of functional impairment.

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake Mean (SD)	Grant Communities Funded in 1999 and 2000 6 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 12 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 18 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 24 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 30 Months Mean (SD)
<b>Behavioral and Emotional Rating Scale (BERS)</b>						
Intrapersonal Strengths	8.7 (3.2) (n = 3,510)	9.0(3.1) (n = 2,159)	9.0 (3.1) (n = 1,601)	9.2 (3.1) (n = 1,122)	9.2 (3.0) (n = 811)	9.2 (3.1) (n = 543)
Interpersonal Strengths	7.4 (2.9) (n = 3,515)	7.8 (2.8) (n = 2,161)	7.9 (2.8) (n = 1,605)	8.0 (2.8) (n = 1,121)	8.1 (2.8) (n = 812)	8.2 (2.9) (n = 544)
School Functioning	7.5 (2.9) (n = 3,234)	8.1 (2.9) (n = 1,987)	8.2 (2.9) (n = 1,486)	8.2 (2.9) (n = 1040)	8.3 (2.8) (n = 775)	8.1 (2.8) (n = 490)
Family Involvement	8.6 (2.9) (n = 3456)	8.9 (2.9) (n = 2,116)	8.9 (2.9) (n = 1,575)	9.0 (2.8) (n = 1,101)	9.1 (2.8) (n = 804)	9.0 (2.9) (n = 538)
Affective Strengths	9.7 (3.5) (n = 3,517)	10.0 (3.4) (n = 2,163)	9.9 (3.4) (n = 1,610)	10.0 (3.3) (n = 1,118)	10.2 (3.3) (n = 811)	10.1 (3.3) (n = 544)
<b>Strengths Quotient</b>	<b>87.7 (17.6)</b> <b>(n = 3,529)</b>	<b>90.0 (17.6)</b> <b>(n = 2,167)</b>	<b>90.3 (17.6)</b> <b>(n = 1,611)</b>	<b>90.8 (17.5)</b> <b>(n = 1,124)</b>	<b>91.8 (17.3)</b> <b>(n = 815)</b>	<b>91.3 (17.4)</b> <b>(n = 544)</b>
<b>Family Functioning Scale (FAD)–Caregiver</b>						
<b>General Functioning<sup>b</sup></b>	<b>2.9 (0.5)</b> <b>(n = 3,446)</b>	<b>2.9 (0.5)</b> <b>(n = 2,099)</b>	<b>3.0 (0.5)</b> <b>(n = 1,538)</b>	<b>3.0 (0.5)</b> <b>(n = 1,077)</b>	<b>3.0 (0.5)</b> <b>(n = 789)</b>	<b>3.0 (0.5)</b> <b>(n = 525)</b>
<b>Family Functioning Scale (FAD)–Youth</b>						
<b>General Functioning<sup>b</sup></b>	<b>2.7 (0.4)</b> <b>(n = 2,243)</b>	<b>2.8 (0.4)</b> <b>(n = 1,409)</b>	<b>2.8 (0.4)</b> <b>(n = 1,042)</b>	<b>2.8 (0.4)</b> <b>(n = 772)</b>	<b>2.9 (0.4)</b> <b>(n = 575)</b>	<b>2.8 (0.4)</b> <b>(n = 407)</b>

<sup>b</sup> Only the General Functioning Subscale items were collected for grant communities funded in 1999 and 2000.

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake Mean (SD)	Grant Communities Funded in 1999 and 2000 6 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 12 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 18 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 24 Months Mean (SD)	Grant Communities Funded in 1999 and 2000 30 Months Mean (SD)
<b>Caregiver Strain Questionnaire (CGSQ)</b>						
Subjective Externalizing Strain	2.4 (1.0) (n = 3,408)	2.2 (1.0) (n = 2,096)	2.1 (0.9) (n = 1,529)	2.0 (0.9) (n = 1075)	2.0 (0.9) (n = 783)	2.0 (0.8) (n = 520)
Subjective Internalizing Strain	3.7 (1.0) (n = 3,422)	3.4 (1.1) (n = 2,098)	3.3 (1.1) (n = 1,532)	3.2 (1.1) (n = 1,077)	3.0 (1.1) (n = 783)	3.0 (1.1) (n = 520)
Objective Strain	2.8 (1.1) (n = 3,416)	2.5 (1.1) (n = 2,097)	2.4 (1.0) (n = 1,528)	2.3 (1.1) (n = 1,074)	2.2 (1.0) (n = 782)	2.2 (1.0) (n = 522)
<b>Global Strain</b>	<b>3.0 (0.9) (n = 3,409)</b>	<b>2.7 (0.9) (n = 2,090)</b>	<b>2.6 (0.9) (n = 1,528)</b>	<b>2.5 (0.9) (n = 1,075)</b>	<b>2.4 (0.9) (n = 781)</b>	<b>2.4 (0.9) (n = 520)</b>
<b>Family Resource Scale (FRS)</b>						
Basic Needs	4.3 (0.7) (n = 3,442)	4.3 (0.7) (n = 2,112)	4.3 (0.7) (n = 1,537)	4.4 (0.7) (n = 1,084)	4.4 (0.7) (n = 795)	4.4 (0.7) (n = 527)
Quality of Life	4.0 (0.9) (n = 3,117)	4.0 (0.9) (n = 1,889)	4.1 (0.9) (n = 1,368)	4.1 (0.9) (n = 950)	4.1 (0.9) (n = 702)	4.1 (0.8) (n = 467)
Cash and Recreation	2.8 (1.1) (n = 3,399)	2.9 (1.0) (n = 2,082)	2.9 (1.0) (n = 1,519)	2.9 (1.0) (n = 1,065)	3.0 (1.0) (n = 777)	2.9 (1.0) (n = 522)
Time	3.2 (0.9) (n = 3,450)	3.3 (0.9) (n = 2,104)	3.3 (0.9) (n = 1,546)	3.3 (0.9) (n = 1,076)	3.4 (0.9) (n = 789)	3.4 (0.9) (n = 525)
Health and Social Services	3.9 (1.1) (n = 2,895)	3.9 (1.1) (n = 1,771)	4.0 (1.0) (n = 1,295)	3.9 (1.0) (n = 904)	4.0 (1.1) (n = 667)	3.9 (1.1) (n = 437)
Childcare	2.5 (1.5) (n = 2,194)	2.5 (1.4) (n = 1246)	2.5 (1.4) (n = 889)	2.7 (1.5) (n = 593)	2.7 (1.5) (n = 405)	2.7 (1.4) (n = 260)

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Restrictiveness of Living Environments and Placement Stability Scale Revised Version (ROLES-R)</b>						
<b>Living Arrangement</b>	<b>(n = 3,597)</b>	<b>(n = 2,228)</b>	<b>(n = 1,636)</b>	<b>(n = 1,145)</b>	<b>(n = 837)</b>	<b>(n = 559)</b>
No Place to Stay	0.1%	0.1%	0.1%	0.2%	0.0%	0.2%
Independent Living by Self	0.1%	0.3%	0.4%	0.4%	0.7%	0.9%
Independent Living with Partner-Friend	0.1%	0.2%	0.5%	0.8%	0.8%	1.3%
Two Parents/Caregivers, At Least One Biological Parent	29.5%	27.8%	28.5%	28.3%	24.6%	27.5%
Biological Mother Only	33.4%	33.8%	32.8%	32.1%	33.1%	31.7%
Biological Father Only	2.6%	2.5%	2.3%	2.7%	2.3%	3.2%
Split Parenting	0.3%	0.2%	0.2%	0.3%	0.4%	0.4%
School Dormitory	0.1%	0.1%	0.2%	0.2%	0.1%	0.2%
Home of a Relative	10.8%	11.2%	10.3%	10.3%	11.7%	12.0%
Adoptive Home	5.1%	5.8%	5.9%	5.8%	5.6%	5.4%
Home of a Friend	0.4%	0.4%	0.5%	0.5%	0.1%	0.2%
Camp	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%
Supervised Independent Living	0.2%	0.2%	0.2%	0.5%	0.4%	0.2%
Foster Care	3.3%	2.6%	2.3%	2.3%	2.6%	1.8%
Specialized Foster Care	0.2%	0.2%	0.2%	0.3%	0.4%	0.5%
Therapeutic Foster Care	1.3%	2.1%	2.0%	1.7%	2.2%	1.6%
Individual Home Emergency Shelter	0.2%	0.0%	0.1%	0.0%	0.0%	0.0%
Group Emergency Shelter	0.6%	0.2%	0.1%	0.2%	0.1%	0.0%
Group Home	2.6%	3.2%	3.0%	2.8%	2.9%	2.9%
Residential Job Corp-Vocational Center	0.0%	0.0%	0.0%	0.3%	0.1%	0.2%

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Restrictiveness of Living Environments and Placement Stability Scale Revised Version (ROLES-R), contineud</b>						
<b>Living Arrangement, continued</b>	<b>(n = 3,597)</b>	<b>(n = 2,228)</b>	<b>(n = 1,636)</b>	<b>(n = 1,145)</b>	<b>(n = 837)</b>	<b>(n = 559)</b>
Residential Treatment Center (non-drug/alcohol)	4.3%	4.8%	5.7%	4.9%	5.9%	5.5%
Drug/Alcohol Residential Treatment Center	0.5%	0.5%	0.4%	0.3%	0.0%	0.0%
Medical Hospital (non-psychiatric)	0.1%	0.0%	0.0%	0.1%	0.1%	0.0%
Psychiatric Hospital	2.0%	1.1%	1.0%	1.0%	1.6%	1.1%
Juvenile Detention Center	1.5%	1.5%	2.0%	3.1%	2.2%	1.6%
Jail/Prison	0.0%	0.3%	0.5%	0.3%	1.1%	1.3%
Other	0.9%	0.7%	0.7%	0.5%	1.2%	0.5
<b>Children with One or More Living Arrangements in Past 6 Months</b>	<b>(n = 3,601)</b>	<b>(n = 2,229)</b>	<b>(n = 1,639)</b>	<b>(n = 1,145)</b>	<b>(n = 838)</b>	<b>(n = 559)</b>
One	56.5%	67.8%	71.0%	72.2%	75.5%	75.8%
Two or More	43.5%	32.2%	29.0%	27.8%	24.5%	24.2%
<b>Education Questionnaire (EQ)</b>						
<b>School Performance Last 6 Months</b>	<b>(n = 3,384)</b>	<b>(n = 2,072)</b>	<b>(n = 1,490)</b>	<b>(n = 1,036)</b>	<b>(n = 748)</b>	<b>(n = 496)</b>
Grade Average A	6.4%	8.7%	9.0%	9.7%	10.0%	9.7%
Grade Average B	22.5%	27.5%	28.7%	28.7%	28.7%	31.0%
Grade Average C	29.1%	31.0%	32.3%	31.8%	32.6%	30.4%
Grade Average D	9.3%	8.4%	7.8%	7.6%	9.5%	8.9%
Failing All or Most Classes	20.4%	14.8%	12.1%	12.1%	10.0%	10.5%
School Does Not Grade	9.7%	8.0%	8.6%	9.3%	8.3%	8.7%
Other	2.6%	1.5%	1.5%	0.9%	0.8%	0.8%

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Caregiver Perception: Do Child's Grades Match Ability or Could Child Do Better?</b>	<b>(n = 3,356)</b>	<b>(n = 2,062)</b>	<b>(n = 1,490)</b>	<b>(n = 1,040)</b>	<b>(n = 751)</b>	<b>(n = 493)</b>
Matches Ability	24.7%	31.0%	32.2%	33.2%	31.4%	34.1%
Could Do Better	75.3%	69.0%	67.8%	66.8%	68.6%	65.9%
<b>Child Had Individualized Education Plan in Last 6 Months</b>	<b>(n = 3,385)</b>	<b>(n = 2,092)</b>	<b>(n = 1,499)</b>	<b>(n = 1,037)</b>	<b>(n = 750)</b>	<b>(n = 499)</b>
Had IEP	63.4%	69.1%	72.8%	73.2%	77.1%	77.2%
Did Not Have IEP	36.6%	30.9%	27.2%	26.8%	22.9%	22.8%
<b>Reasons for IEP</b>	<b>(n = 2,070)</b>	<b>(n = 1,384)</b>	<b>(n = 1,052)</b>	<b>(n = 741)</b>	<b>(n = 561)</b>	<b>(n = 374)</b>
Behavioral/Emotional Problems	85.7%	87.5%	88.2%	87.4%	87.7%	89.0%
Learning Disability	59.0%	58.2%	57.2%	53.2%	53.5%	52.7%
Physical Disability	3.9%	3.7%	3.1%	3.1%	3.2%	2.9%
Developmental Disability/Mental Retardation	13.0%	13.2%	14.0%	13.1%	12.7%	13.4%
Vision or Hearing Impairment	4.3%	2.9%	3.5%	3.6%	4.3%	3.7%
Speech Impairment	11.7%	10.3%	7.7%	7.0%	8.4%	7.5%
Other Reason	0.8%	0.6%	0.3%	0.5%	0.4%	1.1%
<b>School Attendance in Last 6 Months</b>	<b>(n = 3,434)</b>	<b>(n = 2,108)</b>	<b>(n = 1,515)</b>	<b>n = 1,050)</b>	<b>(n = 759)</b>	<b>(n = 501)</b>
Attended Regularly	73.8%	81.0%	82.3%	84.6%	85.5%	84.0%
Attended More Often than Not	15.0%	11.8%	11.6%	10.1%	9.2%	11.0%
Attended Infrequently	11.2%	7.3%	6.1%	5.3%	5.3%	5.0%

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Special Education</b>						
Child Took Classes Where Everyone Attending Was in Special Education	47.2% (n = 3,383)	50.8% (n = 2,065)	52.2% (n = 1,500)	50.9% (n = 1,036)	55.3% (n = 754)	56.5% (n = 494)
Child Took Classes Where Some Attending Were in Special Education, Others Not	30.6% (n = 3,321)	31.5% (n = 2,040)	28.7% (n = 1,475)	32.3% (n = 1,020)	33.8% (n = 746)	31.9% (n = 492)
<b>Percent of Day Spent in Special Education Classes</b>	<b>(n = 3,094)</b>	<b>(n = 1,905)</b>	<b>(n = 1,371)</b>	<b>(n = 932)</b>	<b>(n = 691)</b>	<b>(n = 433)</b>
0–25%	47.0%	43.6%	41.6%	44.4%	37.9%	39.0%
26–50%	8.8%	7.7%	8.2%	8.7%	9.7%	7.4%
51–75%	7.6%	7.9%	8.0%	7.7%	9.3%	7.9%
76–100%	34.6%	38.8%	40.6%	37.4%	41.8%	45.0%
Other	2.1%	2.0%	1.6%	1.7%	1.3%	0.7%
<b>School Performance Last 6 Months: Grades 1 Through 6</b>	<b>(n = 1,392)</b>	<b>(n = 779)</b>	<b>(n = 540)</b>	<b>(n = 360)</b>	<b>(n = 255)</b>	<b>(n = 154)</b>
Grade Average A	6.4%	9.6%	10.7%	12.8%	11.4%	11.0%
Grade Average B	24.1%	31.1%	29.8%	26.9%	29.8%	33.8%
Grade Average C	28.3%	30.0%	30.0%	26.7%	27.1%	27.3%
Grade Average D	8.9%	6.3%	5.6%	5.8%	11.4%	6.5%
Failing All or Most Classes	16.6%	9.5%	7.6%	10.6%	4.3%	7.1%
School Does Not Grade	12.9%	12.3%	13.9%	16.1%	14.9%	13.0%
Other	2.9%	1.2%	2.4%	1.1%	1.2%	1.3%

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>School Performance Last 6 Months: Grades 7 and 8</b>	<b>(n = 788)</b>	<b>(n = 511)</b>	<b>(n = 364)</b>	<b>(n = 260)</b>	<b>(n = 159)</b>	<b>(n = 104)</b>
Grade Average A	6.1%	8.4%	7.7%	8.5%	5.7%	5.8%
Grade Average B	21.1%	29.0%	29.9%	33.1%	22.6%	28.8%
Grade Average C	34.1%	31.5%	36.0%	38.8%	42.8%	37.5%
Grade Average D	11.2%	9.6%	8.8%	6.5%	9.4%	10.6%
Failing All or Most Classes	23.9%	16.8%	12.1%	8.1%	13.8%	12.5%
School Does Not Grade	2.5%	3.7%	3.8%	4.6%	5.7%	3.8%
Other	1.1%	1.0%	1.6%	0.4%	0.0%	1.0%
<b>School Performance Last 6 Months: Grades 9 Through 12</b>	<b>(n = 876)</b>	<b>(n = 612)</b>	<b>(n = 476)</b>	<b>(n = 344)</b>	<b>(n = 289)</b>	<b>(n = 211)</b>
Grade Average A	7.2%	8.0%	8.6%	9.0%	10.4%	10.9%
Grade Average B	24.7%	25.0%	28.8%	27.3%	31.8%	31.8%
Grade Average C	29.2%	34.8%	33.6%	34.0%	32.2%	28.9%
Grade Average D	10.0%	10.1%	9.7%	10.8%	8.7%	10.4%
Failing All or Most Classes	23.7%	17.8%	14.9%	14.2%	13.8%	10.9%
School Does Not Grade	3.5%	2.9%	4.0%	4.1%	2.8%	6.6%
Other	1.6%	1.3%	0.4%	0.6%	0.3%	0.5%

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Education Questionnaire (EQ), continued</b>						
<b>Type of Educational Placement<sup>c</sup></b>	<b>(n = 3,468)</b>	<b>(n = 2,123)</b>	<b>(n = 1,526)</b>	<b>(n = 1,059)</b>	<b>(n = 764)</b>	<b>(n = 502)</b>
Regular Public Day School	75.7%	72.1%	70.6%	69.4%	70.2%	69.9%
Regular Private or Boarding School	1.4%	1.0%	1.2%	1.2%	1.0%	1.2%
Home Schooling	1.3%	1.0%	0.7%	0.8%	0.5%	0.2%
Home-based Instruction	1.9%	1.3%	0.9%	1.3%	0.5%	1.2%
Combination Home Schooling/Home-based Instruction	0.3%	0.6%	0.5%	0.3%	0.4%	0.2%
Alternative/Special Day School	23.7%	24.1%	24.7%	24.8%	22.3%	25.5%
School in 24-Hour Hospital Setting	5.9%	3.5%	2.8%	3.0%	2.9%	1.6%
School in 24-Hour Juvenile Justice Facility	4.2%	2.7%	3.3%	4.2%	4.5%	2.8%
School in 24-Hour Residential Treatment Center	5.8%	6.4%	4.8%	5.0%	5.6%	5.4%
Other	2.5%	2.5%	2.7%	2.3%	2.1%	2.6%
<b>Disciplinary Actions in Past 6 Months</b>						
Detention	33.4% (n = 3,379)	28.6% (n = 1,995)	25.1% (n = 1,441)	22.6% (n = 1,000)	22.7% (n = 728)	20.0% (n = 480)
Suspension	45.7% (n = 3,422)	37.5% (n = 2,012)	36.0% (n = 1,454)	32.3% (n = 1,009)	30.4% (n = 734)	29.4% (n = 487)
Expulsion	7.3% (n = 3,435)	4.2% (n = 2,016)	4.0% (n = 1,449)	3.4% (n = 1,008)	2.7% (n = 736)	2.9% (n = 486)

<sup>c</sup> Because an individual may have more than one educational placement, the educational placement variable may add to more than 100%.

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Delinquency Survey (DS)</b>						
<b>Juvenile Delinquency in Past 6 Months</b>						
Accused of Breaking the Law	24.4% (n = 2,253)	17.7% (n = 1,345)	16.0% (n = 925)	14.7% (n = 647)	13.9% (n = 466)	14.2% (n = 318)
Arrested	23.3% (n = 2,257)	15.5% (n = 1,344)	13.9% (n = 922)	13.6% (n = 648)	11.4% (n = 466)	8.8% (n = 320)
Convicted of a Crime	13.9% (n = 2,255)	10.0% (n = 1,336)	8.4% (n = 929)	7.1% (n = 648)	5.1% (n = 467)	7.5% (n = 319)
On Probation	30.2% (n = 2,260)	30.4% (n = 1,346)	23.1% (n = 928)	21.4% (n = 646)	20.1% (n = 467)	15.0% (n = 319)
In Detention Center/Jail	21.2% (n = 2,218)	14.5% (n = 1,319)	12.6% (n = 916)	9.8% (n = 642)	10.4% (n = 461)	10.1% (n = 317)

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Substance Use Survey A (SUS-A)</b>						
<b>Have You Ever Used:</b>						
Cigarettes	51.1% (n = 2,268)	48.2% (n = 1,358)	49.8% (n = 939)	48.5% (n = 652)	49.8% (n = 466)	53.4% (n = 320)
Alcohol	45.0% (n = 2,269)	41.8% (n = 1,358)	44.0% (n = 940)	43.0% (n = 654)	44.0% (n = 466)	50.0% (n = 320)
Marijuana/Hashish	38.7% (n = 2,266)	35.3% (n = 1,358)	36.5% (n = 939)	36.3% (n = 653)	35.3% (n = 465)	40.6% (n = 320)
Cocaine in a Powder Form	5.8% (n = 2,265)	5.7% (n = 1,358)	5.3% (n = 938)	6.3% (n = 651)	7.5% (n = 464)	7.2% (n = 320)
LSD, Acid, PCP or Other Psychedelics	6.5% (n = 2,265)	5.4% (n = 1,358)	4.5% (n = 938)	6.0% (n = 652)	6.3% (n = 464)	4.4% (n = 320)
Non-Prescription or Over-the-Counter Drugs	7.2% (n = 2,260)	5.8% (n = 1,353)	5.0% (n = 937)	6.8% (n = 651)	5.2% (n = 464)	7.5% (n = 319)
Quaaludes (e.g., quads)	0.6% (n = 2,261)	0.7% (n = 1,358)	0.2% (n = 937)	0.8% (n = 651)	1.1% (n = 464)	0.0% (n = 320)
Heroin, Smack	1.7% (n = 2,265)	2.1% (n = 1,358)	1.5% (n = 937)	2.6% (n = 652)	1.5% (n = 464)	0.9% (n = 320)
Barbituates (e.g., downers)	2.5% (n = 2,263)	1.9% (n = 1,358)	1.9% (n = 938)	2.9% (n = 652)	1.7% (n = 464)	1.6% (n = 320)
Narcotics (e.g., morphine)	4.5% (n = 2,262)	2.9% (n = 1,358)	2.7% (n = 938)	4.9% (n = 652)	3.7% (n = 464)	3.8% (n = 320)
Crack or Rock in a Hard Chunk Form	2.9% (n = 2,266)	2.7% (n = 1,358)	2.1% (n = 937)	3.5% (n = 651)	3.4% (n = 464)	2.8% (n = 320)
Amphetamines	5.9% (n = 2,263)	5.1% (n = 1,357)	5.0% (n = 938)	5.4% (n = 652)	5.4% (n = 465)	4.7% (n = 320)

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Substance Use Survey A (SUS-A), continued</b>						
<b>Have You Ever Used: continued</b>						
Tranquilizers (e.g., Valium)	4.0% (n = 2,262)	3.9% (n = 1,358)	3.4% (n = 937)	4.0% (n = 653)	4.3% (n = 464)	3.1% (n = 320)
Inhalants (e.g., spray cans)	7.5% (n = 2,265)	5.0% (n = 1,358)	5.5% (n = 937)	5.1% (n = 652)	3.2% (n = 464)	5.9% (n = 320)
<b>Substance Use in Last 6 Months</b>						
Cigarettes	34.6% (n = 2,266)	31.3% (n = 1,357)	31.8% (n = 939)	30.9% (n = 653)	31.6% (n = 465)	36.4% (n = 319)
Alcohol	22.9% (n = 2,267)	18.9% (n = 1,358)	19.7% (n = 938)	20.5% (n = 653)	20.6% (n = 466)	25.7% (n = 319)
Marijuana/Hashish	19.3% (n = 2,266)	15.1% (n = 1,357)	15.8% (n = 939)	14.5% (n = 653)	17.4% (n = 465)	15.3% (n = 320)

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Multi-Sector Service Contacts (MSSC)</b>						
<b>Traditional Services Received in Last 6 Months</b>						
Individual Therapy	n/a	78.1% (n = 2,070)	75.0% (n = 1,429)	70.9% (n = 985)	71.2% (n = 685)	68.1% (n = 452)
Case Management	n/a	77.2% (n = 2,069)	71.6% (n = 1,428)	68.1% (n = 980)	63.6% (n = 687)	59.6% (n = 453)
Assessment or Evaluation	n/a	63.1% (n = 2,052)	56.8% (n = 1,420)	51.3% (n = 982)	51.8% (n = 683)	48.4% (n = 448)
Medication Treatment/Monitoring	n/a	69.5% (n = 2,074)	71.9% (n = 1,429)	71.0% (n = 985)	73.1% (n = 688)	73.3% (n = 453)
Family Therapy	n/a	38.5% (n = 2,072)	34.6% (n = 1,424)	29.4% (n = 980)	27.8% (n = 686)	26.9% (n = 454)
Group Therapy	n/a	38.2% (n = 2,071)	36.1% (n = 1,428)	33.5% (n = 980)	34.7% (n = 681)	35.2% (n = 452)
Crisis Stabilization	n/a	19.9% (n = 2,074)	15.1% (n = 1,426)	15.2% (n = 986)	11.8% (n = 686)	12.8% (n = 453)

**Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued**

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Multi-Sector Service Contacts (MSSC), continued</b>						
<b>Innovative Services Received in Last 6 Months</b>						
Recreational Activities	n/a	36.5% (n = 2,075)	37.2% (n = 1,427)	36.9% (n = 983)	36.1% (n = 684)	34.4% (n = 450)
Family Support	n/a	29.1% (n = 2,064)	25.4% (n = 1,419)	23.2% (n = 974)	22.0% (n = 683)	19.5% (n = 452)
Transportation	n/a	26.8% (n = 2,069)	26.5% (n = 1,429)	24.8% (n = 981)	24.2% (n = 686)	24.8% (n = 452)
Flexible Funds	n/a	24.7% (n = 2,057)	21.3% (n = 1,416)	18.9% (n = 978)	14.6% (n = 684)	14.8% (n = 453)
Behavioral/Therapeutic Aide	n/a	18.0% (n = 2,072)	17.8% (n = 1,426)	17.9% (n = 982)	17.5% (n = 686)	17.3% (n = 451)
Family Preservation	n/a	16.0% (n = 2,068)	11.6% (n = 1,422)	10.9% (n = 978)	7.9% (n = 684)	6.2% (n = 452)
Respite	n/a	17.0% (n = 2,075)	16.8% (n = 1,424)	15.9% (n = 981)	14.5% (n = 684)	15.5% (n = 452)
Transition	n/a	3.2% (n = 2,078)	3.2% (n = 1,428)	4.2% (n = 980)	3.9% (n = 685)	4.4% (n = 453)
Independent Living	n/a	3.3% (n = 2,079)	4.3% (n = 1,430)	4.5% (n = 984)	4.7% (n = 687)	7.1% (n = 452)
Afterschool Programs	n/a	13.3% (n = 2,070)	12.1% (n = 1,425)	12.1% (n = 979)	11.1% (n = 685)	12.6% (n = 452)

Table D-3 (Part 2). Child and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, and 30 Months, continued

	Grant Communities Funded in 1999 and 2000 Intake %	Grant Communities Funded in 1999 and 2000 6 Months %	Grant Communities Funded in 1999 and 2000 12 Months %	Grant Communities Funded in 1999 and 2000 18 Months %	Grant Communities Funded in 1999 and 2000 24 Months %	Grant Communities Funded in 1999 and 2000 30 Months %
<b>Multi-Sector Service Contacts (MSSC), continued</b>						
<b>Restrictive Services Received in Last 6 Months</b>						
Day Treatment	n/a	15.2% (n = 2,076)	15.4% (n = 1,432)	14.3% (n = 983)	13.3% (n = 686)	12.6% (n = 452)
Inpatient Hospitalization	n/a	12.5% (n = 2,081)	11.0% (n = 1,430)	10.8% (n = 985)	8.0% (n = 687)	8.6% (n = 453)
Residential Treatment Center	n/a	12.3% (n = 2,077)	12.0% (n = 1,432)	11.0% (n = 984)	11.7% (n = 686)	14.8% (n = 453)
Therapeutic Group Home	n/a	5.7% (n = 2,081)	5.8% (n = 1,429)	5.8% (n = 983)	6.0% (n = 687)	3.1% (n = 452)
Therapeutic Foster Care	n/a	5.0% (n = 2,073)	4.7% (n = 1,421)	4.4% (n = 982)	4.8% (n = 684)	3.4% (n = 446)
Residential Camp	n/a	5.0% (n = 2,074)	3.9% (n = 1,426)	3.6% (n = 984)	3.6% (n = 687)	4.0% (n = 452)
<b>Average Number of Service Types Received in Last 6 Months</b>	n/a	<b>6.2</b> (n = 2,084)	<b>5.8</b> (n = 1,436)	<b>5.5</b> (n = 987)	<b>5.3</b> (n = 688)	<b>5.2</b> (n = 454)



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