Comprehensive Community Mental Health Services for Children and Their Families Program

Evaluation Findings: Report to Congress

2011

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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

Evaluation Findings

Annual Report to Congress

2011

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

Pamela S. Hyde, J.D.
Administrator

Center for Mental Health Services

Paolo del Vecchio, M.S.W.
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

The Comprehensive Community Mental Health Services for Children and Their Families Program, Evaluation Findings—Annual Report to Congress (2011) was written by staff at ICF Macro pursuant to a contract (contract numbers 283-07-0702, 283-07-0708) under the direction of the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

PEP13-CMHI2011

Contents

Executive Summary i
Introduction 1
System of Care Philosophy and Goals 2
Characteristics of Communities Receiving CMHI Funding 3
The National Evaluation of the CMHI 5
Design and Methods of the National Evaluation 5
Description of Children, Youth, and Their Families Entering Services in CMHI-Funded Systems of Care 8
Demographics 8
Life Experiences of Children and Youth Entering Services in CMHI-Funded Systems of Care 9
Referrals to CMHI-Funded System of Care Services and School Attendance 9
Mental Health Status of Children and Youth at Intake 10
Physical Health Status of Children and Youth at Intake 11
Insurance Coverage of Participants at Intake 11
Outcomes of Children, Youth, and Their Families Served in the CMHI Communities 12
Mental Health Outcomes of Children and Youth 12
Improvement in Behavioral and Emotional Symptoms 12
Improvement in Functional Impairments 13
Improvement in Symptoms of Anxiety and Depression 13
Reduction in Suicidal Thoughts and Suicide Attempts 15
Additional Outcomes of Children and Youth 16
Improvement in Educational Outcomes 16
Improvement in Living Situations 16
Reduction in Law Enforcement Contacts 17
Improvement Among Youth with a History of Arrest 17
Improvement in Physical Health Outcomes 18
Improvement in Behavioral and Emotional Strengths 18
Reduction in Exposure to Potentially Traumatic Events 20
Caregiver Outcomes 21
Improvement in Caregiver Strain 21
Improvement in Caregiver Work Life 22
Improvement in Support Services Available to Families 23
Service Use by Children, Youth, and Families Served by CMHI Communities and Associated Costs 25
Involvement in Service Planning 25
Types of Services Received 25
Reduction in Community Service Costs in Six Communities 26
Reduction in Inpatient Service Costs 29
Reduction in Cost of Arrests 30

System Change and Sustainability 31
Implementation of the System of Care Approach 31
Sustainability of the System of Care Approach 33
Caregiver and Youth Assessment of System of Care Services 35
CMHI Alignment with SAMHSA Strategic Initiatives 38
Report Summary 40
References 42

Appendices

A. SAMHSA Strategic Initiatives
B. System of Care Communities of the Comprehensive Community Mental Health Services for Children and Their Families Program, 1993-2010
C. Glossary of Terms
D. Description of Study Components
E. Measures
F. Data Analysis Techniques Used in This Report
G. Descriptive, Outcomes, and Service Experience Data Tables
H. Performance Measurement

Executive Summary

The Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Children's Mental Health Initiative (CMHI), is a cooperative agreement program administered by the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. The CMHI was authorized by legislation (Public Law 102-321) and provides funds to public entities to promote the coordination of the multiple and often fragmented systems that serve children and youth from birth through age 21 diagnosed as having serious emotional disturbances[1] and their families. Because approximately one-half of all diagnosed mental health concerns found in adults started by age 14 and three fourths by age 24 (Kessler et al., 2005), it is critical that needed services and supports reach children with mental health needs and their families as early as possible.

CMHI funding is provided to develop and implement systems of care in states, local communities, U.S. territories, Indian tribes and tribal organizations, and other American Indian/Alaska Native communities. Children and youth with serious mental health conditions face challenges in many aspects of their daily lives. They are at greater risk for substance-related disorders (Hawkins, 2009; Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008; Wu et al., 2008) and negative encounters with the juvenile justice system (Cocozza, Skowyra, Burrell, Dollard, & Scales, 2008; Pullmann et al., 2006). Students with serious mental health conditions have lower grade point averages, miss more days of school, are less likely to be promoted to the next grade than students with other disabilities, and have higher dropout rates (Clark et al., 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research demonstrates poor long-term outcomes for these children and adolescents, indicating a significant relationship between childhood emotional disorders and problems in adulthood (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Services that exist to address these issues often are difficult to access because they frequently are provided by a variety of professionals who work in diverse, relatively independent, and loosely coordinated public and private settings, agencies, and systems. Therefore, families are challenged with obtaining services, and children and youth are left at risk for difficulties in school, in the home, and/or in the community.

The system of care approach, however, offers a clear pathway to better outcomes for children who have serious mental health conditions, including improved functioning at home, at school, and in the community. These improvements are based on a philosophy that services should be

- family driven;
- based on service plans that are individualized, strengths based, and evidence informed;
- youth guided;
- culturally and linguistically competent;
- provided in the least restrictive environment possible;
- community based;
- accessible;
- collaborative and coordinated through an interagency network.

Services and supports should be both comprehensive and coordinated among public and private providers across all child-serving agencies. CMHI-funded systems of care build on the individual strengths of participating children, youth, and families to address their service needs.

The program has grown since its inception in Fiscal Year (FY) 1993 from initial funding of $4.9 million to an accumulated total investment of nearly $1.62 billion as of FY 2011, awarding 173 grants and cooperative agreements to communities.

The legislation authorizing the CMHI also mandates a national evaluation to describe, monitor, and chronicle the initiative's progress. The national evaluation consists of multiple studies designed to examine several aspects of the CMHI at different levels (see Appendix D, Description of Study Components, for descriptions of all national evaluation studies). These include descriptive, longitudinal, system-level, cost, and special studies. Descriptive data are collected at service intake on all children and youth. Child, youth, and family service experience and outcomes data are collected at intake and every 6 months for up to 36 months. System-level data are collected every 18–24 months beginning in the second year of program funding, and cost data are obtained from management information systems.

The 2011 *Annual Report to Congress* describes

- the system of care approach used by the CMHI;
- the characteristics, outcomes, and service experiences of the children, youth, and families receiving services through the CMHI;
- the implementation of the system of care philosophy;
- the sustainability efforts of CMHI programs and services, once Federal funding is ended.

The 2011 *Annual Report to Congress* presents findings based on the national evaluation of 68 grantee communities, which represents children, youth and families who received services between 2006 and 2011. Descriptive data were collected from intake records for 14,431 children and youth enrolled in services. A subset of these youth were followed over time, and longitudinal data were collected from 5,821 caregivers and 3,004 youth aged 11 and older. A glossary of terms is included in Appendix C.

Description of Children, Youth, and Their Families at Intake into System of Care Services

CMHI-funded system of care communities serve a diverse group of children and youth who were more likely to be

- male (61.4 percent, compared to 51.2 percent nationally);
- in the custody of a parent or other relative (93.3 percent);
- living in single-parent/caregiver families—fewer than one third (30.6 percent) were in the legal custody of both biological parents, as compared to 69.4 percent in the U.S. population;
- living in poverty (56.0 percent), compared to 19 percent nationally.

Caregivers reported that, before intake into system of care services,

- 25.8 percent of children and youth had run away at least once,
- 22.3 percent had experienced physical abuse,
- 14.6 percent had experienced sexual abuse,
- 15.8 percent had a history of drug or alcohol problems,
- 10.0 percent had attempted suicide.

Over a quarter (27.4 percent) had experienced one of these risk factors; 15.7 percent had experienced two, and 9.5 percent had experienced three or more prior to intake.

Children and youth exhibited a range of behavioral and emotional symptoms at intake:

- Conduct- or delinquency-related problems (52.4 percent)
- Hyperactive and attention-related problems (40.6 percent)
- School performance problems (33.4 percent)
- Depression-related problems (31.7 percent)
- Anxiety-related problems (30.8 percent)
- Adjustment-related problems (29.0 percent)

In addition, children and youth served in CMHI-funded systems of care had a wide range of diagnoses assigned by professionals. The most common were

- mood disorders (37.2 percent),
- attention-deficit/hyperactivity disorder (37.1 percent),
- oppositional defiant disorder (23.4 percent),
- adjustment disorders (14.1 percent).

Outcomes of Children, Youth, and Families

Children, youth, and their families were followed from intake into system of care services, at 6-month intervals, for a period of 30 months. Within the first 6 months after intake:

- The percentage of children and youth reporting suicidal thoughts fell from 23.1 percent to 16.2 percent, for an overall reduction of 30 percent over baseline.[2]
- The percentage of children and youth attempting suicide fell from 6.1 percent to 3.6 percent, a reduction of 41 percent over baseline.[3]
- School suspension or expulsion fell from 37.0 percent to 29.0 percent, for a reduction of 22 percent over baseline.[4]
- Personal strengths, including social skills and anger management, improved for 29.2 percent of children and youth.

At 30 months after intake into system of care services:

- Clinically significant levels of emotional and behavioral problems fell from 78.1 percent of children and youth at intake to 56.0 percent, a reduction of 28 percent over baseline.[5]
- The proportion of children and youth exposed to potentially traumatizing events decreased from 62.4 percent at intake to 51.2 percent.[6]
- Over 47 percent of caregivers reported significantly less strain from caring for a child or youth with a serious mental health condition after 30 months of receiving services.[7]

Youth who previously had been arrested showed significant improvements on measures of behavioral and emotional problems, as well as school achievement.

- In the first 6 months after intake, 66.5 percent of youth avoided being re-arrested. Among those followed for 30 months, 90.9 percent continued to avoid arrest after 30 months.[8]
- The percentage of youth who were either suspended or expelled from school in the previous 6 months fell from 63.2 percent at intake into services to 48.2 percent after 6 months.[9] For those followed for 30 months, 64.4 percent had been suspended prior to entering services; this proportion fell to 46.6 percent after 30 months.[10]

- Six months after intake, 30.4 percent of these youth made clinically significant improvements in their behavioral and emotional symptoms. Among those followed for 30 months, 43.8 percent showed significant improvement after 30 months.[11]

Service Use by Children, Youth, and Families Served by CMHI Communities and Associated Costs

Children and youth, as well as their caregivers and families, received a wide array of services and supports to address their mental health needs, including assessment and evaluation services; medication monitoring; individual, group, and family therapy; care management; caregiver or family support; respite care; recreational activities; and transportation services. An analysis of six communities initially funded in 2005 revealed that the average length of time during which children and youth received services was 20 months. The estimated average monthly cost for services and supports per child or youth during their time in services in the six communities was less than $516, with a median cost of approximately $436. Medicaid, the major payer for services and supports, was responsible for 68.8 percent of total payments to providers. Payments for services provided in the six communities decreased over time; payments for services provided between 12 and 18 months after intake into services were roughly half of the total payments in the first 6 months of services. Continued improvements in outcomes over time combined with observed reductions in costs are indicative of increases in cost efficiencies of services provided to children and youth enrolled in systems of care.

Total estimated costs for inpatient hospital care and costs due to arrests decreased substantially.

The average charge per day for inpatient hospital care for all children and youth between 1 and 18 years old with a primary diagnosis of a mental health disorder is estimated to be $2,258 in 2011 dollars.[12] When this daily rate is multiplied by the average number of days of inpatient hospitalization of children and youth in a system of care, the average estimated total cost per child for the use of inpatient hospitalization in the 6 months prior to intake into a system of care was approximately $1,919. This cost decreased to an average estimated cost per child of $1,513 between 6 and 12 months after intake, representing a 21.1 percent reduction in average per-child inpatient hospitalization costs. This decrease in the use of inpatient hospitalization translates into an estimated total decrease in inpatient hospitalization costs of more than $4 million for every 10,000 children served.

Cost estimates of arrests were calculated as follows. The average number of arrests decreased slightly from 0.47 in the 6 months prior to intake to 0.32 in the 6 months prior to the 12-month interview. The estimated average cost per juvenile arrest was $5,458 in 2011 dollars.[13] When this cost per juvenile arrest is multiplied by the average number of arrests among youth in systems of care, the average estimated cost per youth due to arrest in the 6 months prior to intake into system of care services was approximately $2,565, decreasing to an average estimated cost per youth of $1,747 between 6 and 12 months after intake. This represents a 31.9 percent reduction in average per-child arrest costs. Within systems of care the decrease in juvenile arrests translates into an estimated total decrease in juvenile arrest costs of

$8,180,000 for every 10,000 youth 11 years or older served.

System Change and Sustainability

CMHI-funded communities must be able to implement system change with fidelity to system of care principles (see page i above for a list of principles; further information can be found in Table E-3 in Appendix E). They are also expected to sustain that change when their Federal funding ends.

The degree to which communities develop and implement changes to their infrastructure and service delivery according to system of care principles (fidelity) is assessed at the beginning, middle, and end of their funding period. This report focuses on the first assessment, or baseline, of communities initially funded in 2008. System of care community representatives rated the extent to which infrastructure and service delivery were transformed over the course of the cooperative agreement. Results demonstrate that higher overall ratings of adherence to system of care principles generally were achieved in the service delivery domain than in the infrastructure domain at the earliest stage of program implementation. Within the service delivery domain, communities generally received higher ratings in adhering to system of care principles in their processes for service intake, service planning, and service provision. Within the infrastructure domain, communities generally received higher ratings in adhering to system of care principles in their processes for governance, management and operations, and service array development. Communities tended to receive higher ratings in adhering to the family driven principle in infrastructure activities, and to community-based care in service delivery activities.

Community representatives also rated the extent to which factors affecting system of care sustainability were present in the community during the last year of CMHI funding. Strong interagency relationships and family organizations were cited among the most effective general strategies to ensure sustainability during the final year of funding, whereas making policy and regulatory changes that support the system of care approach was reported as being more challenging. In terms of financing strategies, fundraising and using in-kind space donations were rated most effective toward sustainability, whereas obtaining new or increased private or corporate funds and administrative claiming (i.e., using available child welfare and Medicaid funds to cover administrative costs) were identified as being least effective.

Caregiver and Youth Assessments of the Effectiveness of Systems of Care

Measuring the satisfaction of caregivers fulfills and responds to the authorizing legislation’s mandate to have caregivers assess the effectiveness of systems of care, and is consistent with the development of the *National Healthcare Quality Report*, 2011 (HHS, 2012). In general, caregivers and youth reported satisfaction with the services they received at their 6-month interviews. Caregivers indicated consistently that providers understood the family’s beliefs, culture, and needs; treated them and their cultural beliefs with respect; were willing to incorporate the family’s religious/spiritual beliefs into their child’s treatment; and either spoke their language or provided interpreters most or all of the time. Notably, caregivers receiving information about particular aspects of their child’s treatment and service outcomes were more satisfied with the services provided than caregivers not receiving the same information.[14]

Summary

Results from the national evaluation of the CMHI indicate that substantial gains were made by children, youth, and families. Data from the national evaluation demonstrate that CMHI-funded systems of care

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- expand the availability of effective supports and services;
- continue to implement and maintain fidelity to system of care principles as the system develops;
- save money by reducing treatment in residential-based settings, inpatient hospitals, and juvenile justice services;
- incorporate principles that have a positive impact on sustainability after Federal funding ends.

As in any system transformation effort, CMHI-funded communities face challenges in sustaining their efforts and effecting broad system-level changes once Federal funding ends. Such challenges include building a culturally and linguistically competent workforce; developing an efficient structure for multi-agency collaboration to address the service needs of children, youth, and families; and implementing multiple strategies for sustaining systems of care over time. CMHI-funded communities address these challenges in their efforts to develop and implement individualized services and supports yielding positive outcomes for children, youth, and families.

Introduction

The Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Children's Mental Health Initiative (CMHI), is a cooperative agreement program administered by the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. The CMHI was authorized by legislation (Public Law 102-321) and provides funds to public entities to promote the coordination of the multiple and often fragmented systems that serve children and youth from birth through age 21 diagnosed as having serious emotional disturbances [15] and their families. Because approximately one-half of all diagnosed mental health concerns found in adults started by age 14 and three fourths by age 24 (Kessler et al., 2005), it is critical that needed services and supports reach children with mental health needs and their families as early as possible.

CMHI funding is provided to develop and implement systems of care in states, local communities, U.S. territories, Indian tribes and tribal organizations, and other American Indian/Alaska Native communities. Children and youth with serious mental health conditions face challenges in many aspects of their daily lives. They are at greater risk for substance-related disorders (Hawkins, 2009; Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008; Wu et al., 2008) and negative encounters with the juvenile justice system (Cocozza, Skowyra, Burrell, Dollard, & Scales, 2008; Pullmann et al., 2006). Students with serious mental health conditions have lower grade point averages, miss more days of school, are less likely to be promoted to the next grade than students with other disabilities, and have higher dropout rates (Clark et al., 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research demonstrates poor long-term outcomes for these children and adolescents, indicating a significant relationship between childhood emotional disorders and problems in adulthood (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Services that exist to address these issues often are difficult to access because they frequently are provided by a variety of professionals who work in diverse, relatively independent, and loosely coordinated public and private settings, agencies, and systems. Therefore, families are challenged with obtaining services, and children and youth are left at risk for difficulties in school, in the home, and/or in the community.

The 2011 *Annual Report to Congress* provides an overview of the CMHI and the national evaluation, followed by descriptions of the individuals and families served by the funded communities, various outcomes for these individuals, and highlights from special studies. The Report also includes discussions of service use and service costs, as well as information on system change and sustainability of the system of care within the CMHI-funded communities. The Report concludes with a summary and recommendations for future efforts to continue to improve children's mental health services.

Since the CMHI was authorized by Public Law 102-321 in 1992, it has been one of the most comprehensive efforts to transform the mental health care system that serves children and youth diagnosed as having serious mental health conditions and their families.[16] Until Fiscal Year (FY) 2000, CMHI funds were provided through a grant mechanism; since then funds have been awarded to communities through cooperative agreements. To date, approximately $1.62 billion has been provided to support 173 grantees in 50 states, the District of Columbia, Puerto Rico, Guam, and 21 American Indian/Alaska Native tribal communities. As required in the authorizing legislation, funding of CMHI communities is allocated according to a local–Federal match over the life of the funding period, which is 6 years. During the first 3 years, the proportion of match is $3 of Federal funding for every $1 of local funding. In the fourth year, the match proportion is dollar for dollar. During the fifth and sixth years, the Federal contribution is $1 for every $2 in local funds. Funding cycles have ended for communities initially funded between FY 1993 and FY 2004. Funding ended at the close of FY 2011 for communities initially funded in 2005. Funding continues for communities initially funded in FY 2006, FY 2008, FY 2009, and FY 2010.[17]

During FY 2011, 76 6-year cooperative agreements were funded. These included 24 of 25 communities initially funded in 2005 (1 was discontinued), 5 communities initially funded in 2006, 18 initially funded in 2008, 20 initially funded in 2009, and 9 initially funded in 2010. In addition to these 6-year cooperative agreements, 1-year planning cooperative agreements were funded to 25 communities.

System of Care Philosophy and Goals

The CMHI was shaped by several Federal and state initiatives, beginning in 1984 with the Child and Adolescent Service System Program (CASSP). CASSP was a national effort designed to help states and communities build comprehensive, community-based systems of care that were youth guided and family focused. This approach has since become the cornerstone of many mental health service delivery programs within communities across the country and in its territories. Stroul & Friedman (1994) provide a more comprehensive discussion of the program’s background and the system of care approach.

The system of care approach is a theoretical framework that calls for a comprehensive spectrum of mental health services and supports that are guided by a specific set of principles. This approach requires involvement and collaboration across agencies, families, and youth for the purpose of improving support systems, providing access to services that are culturally and linguistically competent, and expanding the array of coordinated community-based care for children and youth with serious mental health conditions and their families. Fundamentally, the system of care philosophy is grounded in the belief that services should be both comprehensive and coordinated among public and private providers; children, youth, and families; and other child-serving agencies. The system of care philosophy states that services should be

- family driven;
- based on service plans that are individualized, strengths based, and evidence informed;
- youth guided;
- culturally and linguistically competent;
- provided in the least restrictive environment possible;
- community based;
- accessible;
- collaborative and coordinated across an interagency network.

The CMHI is aligned with two of SAMHSA’s strategic initiatives as outlined in *Leading Change: A Plan for SAMHSA's*

Roles and Actions 2011–2014 (see Appendix A), the Trauma and Justice Initiative and the Recovery Support Initiative.

SAMHSA Strategic Initiative on Trauma and Justice

Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

SAMHSA Strategic Initiative on Recovery Support

Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

Goals of the CMHI include the following elements:

- Continuously expand community capacity to serve children and youth with serious mental health conditions and their families.
- Provide a broad array of accessible, clinically effective, and fiscally accountable services, treatments, and supports.
- Promote broad-based, sustainable systems change, including policy reform and service delivery and infrastructure development, across the United States, U.S. territories, and tribal organizations.
- Create care management teams to implement an individualized service plan for each child.
- Address each child and family's unique physical, emotional, social, cultural, intellectual, and language needs by delivering services that recognize diversity in race, ethnicity, sexual orientation, and language.
- Acknowledge and address the needs of underrepresented, underserved, or "invisible" cultural groups.
- Encourage and facilitate the full participation of children, youth, and families in planning, evaluation, and sustainability of local services and supports, and in overall system change activities.

Characteristics of Communities Receiving CMHI Funding

The extensive network of system of care communities provides a foundation from which to develop and refine emerging strategies to improve the lives of children with serious mental health conditions and their families. These communities provide an opportunity to examine evidence-based interventions in diverse populations and community-based settings, and approaches to address racial, ethnic, gender, and socioeconomic disparities. They also provide opportunities to learn about strategies for training providers, integrating behavioral and emotional health into the broader child-serving systems (e.g., schools, child welfare, juvenile justice), and sustaining systems of care. Finally, these communities have become a resource to identify unique and creative service practices. A complete list of all the communities that are funded by the CMHI is provided in Appendix B.

The CMHI-funded system of care communities vary by geographic location and their diverse populations of focus. Some CMHI recipients are state-level agencies that intend to develop system of care programs in various catchment areas (counties or regions) across their state or the state as a whole. States such as Vermont, Pennsylvania, Oklahoma, Mississippi, and New Mexico are using this approach to develop the system of care approach in multiple service areas in their states. Other CMHI recipients are county or city agencies that serve large urban areas such as Boston, Massachusetts; Miami-Dade County, Florida; Baltimore, Maryland; and Hamilton County (Cincinnati), Ohio. Some CMHI recipients are county agencies that serve rural areas such as southeastern Illinois and south-central Alabama. Guam's program serves children and families in both the capital city and rural villages; Puerto Rico is implementing its program in two small island communities adjacent to the main island.

CMHI recipients serve various populations. For example, the program in northwestern Tennessee that borders Ft. Campbell, Kentucky, focuses on serving children and families of military service members. Programs in Los Angeles, California; Alamance County, North Carolina; and the counties around Ft. Worth, Texas, focus on serving children and families involved in child welfare. Programs in Multnomah County (Portland), Oregon; Muscogee (Creek) Nation; and San Francisco, California, serve American Indian/Alaska Native children, youth, and families who live in those urban areas. The program in Honolulu, Hawaii, specifically serves girls aged 11–18 who are involved in the juvenile justice system.

Several communities had established components of systems of care prior to receiving CMHI funding and have used their funds to expand services to specific populations, such as children aged birth to 8 or transition-age youth aged 16–21; or to focus more specifically on the mental health needs of children and youth involved with juvenile justice or child welfare, or who have co-occurring mental health and substance-related disorders. CMHI-funded programs have implemented and improved access to services for underrepresented or underserved populations such as African Americans; American Indians/Alaska Natives; Hispanics/Latinos; or individuals who identify as lesbian, gay, bisexual, transgender, questioning, intersex, and Two-Spirit (LGBTQI2-S) and their families; and recent immigrant populations that have been displaced by war or natural disaster. Some of the languages spoken within the CMHI-funded communities include Cambodian, Creole, Cantonese, French, Hmong, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese, and a variety of American Indian/Alaska Native languages.

The National Evaluation of the CMHI

Mandated by Public Law 102–321, Section 565 of the Public Health Service Act, the annual national evaluation of the CMHI is required to describe, monitor, and document the progress of the program. The national evaluation assesses the outcomes for children, youth, and families in funded communities and provides data that are useful for decision making at all levels of government and for all providers across the range of child-serving agencies. Information also is provided that will help with the implementation and sustainability of existing systems of care and identify the critical and emerging issues in children's mental health. Findings from the national evaluation have informed treatment planning, service delivery, and program funding decisions, and have resulted in modifications to existing health policy related to children and youth nationally.

Authorizing Legislation of the National Evaluation of the CMHI

The evaluations shall assess the effectiveness of the systems of care operated pursuant to such section, including longitudinal studies of outcomes of services provided by such systems, other studies regarding such outcomes, the effect of activities under this subpart on the utilization of hospital and other institutional settings, the barriers to and achievements resulting from inter-agency collaboration in providing community-based services to children with a serious emotional disturbance, and assessments by parents of the effectiveness of the systems of care.

Design and Methods of the National Evaluation

The 2011 *Annual Report to Congress* highlights noteworthy findings from the national evaluation of the 68 communities initially awarded funding from 2005 to 2009, which represents children, youth, and families who received services between 2006 and 2011. Outcome data are not yet available for the nine communities recently funded in 2010; therefore, only descriptive information for these communities is presented in this report. Information is presented in regard to children's and youths' changes in mental health and functioning in the home, school, and community; changes experienced by caregivers and families; services received and service costs; and system of care implementation and sustainability. Each community is funded for a 6-year period, with children, youth, and families being continuously enrolled into services and into the evaluation after the first year, which is dedicated to planning. For the national evaluation, enrollment continues only until the fifth year so to ensure that follow-up interviews can be conducted before funding ends. Table 1 describes the data collection schedule for the national evaluation.

Cooperative Agreements Funded During FY 2011

76 Communities

24 of 25 initially funded in 2005
(1 discontinued)
5 initially funded in 2006
18 initially funded in 2008
20 initially funded in 2009
9 initially funded in 2010

Table 1. National Evaluation Data Collection Schedule[a]

Longitudinal Data Collection Year	Initial Year of Funding				
	FY 2005	FY 2006[b]	FY 2008[b]	FY 2009	FY 2010
FY 2006					
FY 2007	x				
FY 2008	x	x			
FY 2009	x	x			
FY 2010	x	x	x		
FY 2011	x	x	x	x	
FY 2012			x	x	x
FY 2013			x	x	x
FY 2014				x	x
FY 2015				x	x
FY 2016					x

[a] Shaded cells indicate communities and years represented in this report.
[b] The evaluation was funded to be conducted during years 2–5 of program funding.

A glossary of terms is included in Appendix C. The national evaluation study components analyzed for this report are described in Appendix D. Findings describe data obtained from youth aged 11 and older or caregivers who completed the follow-up interviews,[18] which could result in variation of the sample sizes across analyses. Caregivers reported information about their children and their families' experiences in systems of care; youth responded for themselves, where feasible. Outcome findings are based on interviews conducted at 6-month intervals (i.e., at intake and at 6, 12, 18, 24, and 30 months after intake; for participants receiving services at sites funded in 2008 and 2009, data were only collected to 24 months).[19] Denominators for the analyses may vary, because not all respondents completed all interview items. Findings based only on intake data will be noted in the text, tables, and figures.

Both descriptive and longitudinal information are provided in this report. The instruments used to collect information are described in Appendix E. Data for this report include the following:

- Descriptive data (e.g., demographic information, diagnosis, child and family history, potentially traumatic events, functional characteristics, and referral sources) obtained at the time children and youth entered system of care services (i.e., intake) across the grant funding period. Descriptive data were collected from the records of 14,431 children and youth enrolled in systems of care in these communities between 2006 and 2011.
- Child, youth, and family outcomes data collected on selected groups of children and youth who were assessed at intake, 6 months, 12 months, 18 months, and 30 months, with assessments continuing for up to 36 months. Data collected at these intervals focus on the child's or youth's clinical and social functioning, behavioral and emotional strengths, educational performance, unlawful activities and engagement with law enforcement, use of substances, and the stability of their living arrangements. Data also were collected on the strain felt by family caregivers when caring for children and youth who experience serious mental health conditions. These longitudinal data were collected from a sample of 5,821 caregivers and 3,004 youth who participated in the Longitudinal Child and Family Outcome Study.
- Data related to the provision of services; the experience children, youth, and families have with their service providers and the services they receive; the cultural and linguistic competence of service delivery; and their satisfaction with services.

- Data related to the cost of services that were made available by service agencies from their management information systems.
- Data related to system-level activities collected through comprehensive site visits to communities initially funded in 2008 that were conducted in their second year of funding.
- Data related to program sustainability obtained by surveying key individuals in systems of care.

Findings discussed in this report were statistically significant at least at the $p < .05$ level. Appendix F provides a description of the statistical methods used in these analyses. Data are derived from intake records, interviews with caregivers and youth, and from interviews with community staff. Findings of change over time are reported as the change occurring from the time of intake into services to subsequent data collection points. Short-term outcome findings are provided for intake and the 6-month follow-up interview. Long-term clinical and program findings are reported for children and youth and their families who continued in the Longitudinal Child and Family Outcome Study from intake through the 30-month follow-up interview. Detailed findings across various outcome measures for the entire cohort samples can be found in Appendix G.

SAMHSA Strategic Initiative on Data, Outcomes, and Quality

SAMHSA has highlighted the importance of supporting programmatic decisions with high-quality data and of transparency in these decisions by making data readily available to the public. The national evaluation is designed to provide high-quality data that will help to improve the quality of programs and service delivery, and to improve the quality and accessibility of evaluation information for staff, constituencies, funders, and policymakers.

Developed by the national evaluation to assist local communities to do the same, the *Continuous Quality Improvement (CQI) Progress Report* (see Appendix H) is designed to

- help them document program-specific performance at the community level;
- support communities in conducting program assessments that result in data-driven decisions related to program quality and improvement;
- present program-specific performance data in five domains: (1) system-level outcomes, (2) child and family outcomes, (3) satisfaction with services, (4) family and youth involvement, and (5) cultural and linguistic competence.

Description of Children, Youth, and Their Families Entering Services in CMHI-Funded Systems of Care

Demographics

The demographic characteristics of children and youth at intake into services in CMHI-funded systems of care differed from those of the general population in the United States (see Table 2).[20] These characteristics include gender, age and race/ethnicity. In comparison to the national population, children and youth were more likely to be male (61.4 percent in CMHI communities compared to 51.2 percent of the general population in the U.S.). The CMHI also has been successful in providing services and supports to some populations where health disparities exist, for example, there are greater proportions of children and youth who are American Indian or Alaska Native, Black or African American, Native Hawaiian or Pacific Islander, and multi-racial in the CMHI population than reported in the general U.S. population. Appendix G provides percentages and sample sizes for additional items.

Table 2. Gender, Age, and Race/Ethnicity Frequencies: CMHI Population Compared to the U.S. Population

	CMHI Communities Funded in 2005–2009	U.S. Population 2008[a]
Gender	***n* = 14,283**	
Male	61.4%	51.2%
Female	38.3%	48.8%
Other	0.3%	***
Age	***n* = 14,153**	
0–5 years	18.4%	26.3%
6–11 years	28.0%	25.1%
12–15 years	33.2%	17.1%
16–21 years	20.4%	31.5%
Race/Ethnicity	***n* = 14,091**	
American Indian or Alaska Native	5.3%	0.9%
Asian	1.0%	4.1%
Black or African American	20.6%	14.3%
Native Hawaiian or Pacific Islander	0.4%	0.2%
White	49.5%	57.0%
Hispanic/Latino	16.6%	21.0%
Two or More Races	6.4%	2.6%
Other	0.1%	–

[a] These estimates correspond with the midpoint of 2005–2011, the years that communities are receiving funding.

Nearly all children and youth served in CMHI-funded communities (93.3 percent) were in the custody of a parent or other relative. However, only 35.6 percent were in the legal custody of both biological parents, as compared to 69.4 percent in the U.S. population.[21] Nearly one half (46.0 percent) were in the care of their biological mothers only, and 4.3 percent were in the custody of their biological fathers only. Of the 14.1 percent of children and youth not in the custody of their biological parents, most were in the custody of other family members (e.g., grandparents, siblings), adoptive parents, or friends, or were wards of the state. More than one-half of the children and youth (56.0 percent) were living in poverty.[22] A large proportion of caregivers (45.0 percent) reported that they had not been employed during the 6 months prior to their child's intake into services[23] (see Table 3).

Table 3. Custody, Family Poverty, and Employment Status at Intake, Communities Initially Funded in 2005-2009

Custody Status at Intake	*n* = 5,551
Two Biological Parents or One Biological Parent and One Step or Adoptive Parent	35.6%
Biological Mother	46.0%
Biological Father	4.3%
Grandparent(s)	5.8%
Aunt and/or Uncle	1.5%
Sibling(s)	0.2%
Ward of the State	4.4%
Adult Friend	0.2%
Other	2.1%
Family Poverty Status Prior to Intake	***n* = 4,947**
Below Poverty Threshold	56.0%
At or Near Poverty Threshold (101–150% of Poverty Threshold)	15.8%
Above Poverty Threshold (150% of Poverty Threshold and Above)	28.2%
Employment Status in the 6 Months Prior to Intake	***n* = 5,475**
Caregiver Employed	55.0%

Life Experiences of Children and Youth Entering Services in CMHI-Funded Systems of Care

Caregivers reported that, before intake into systems of care, 22.3 percent of children and youth had experienced physical abuse, 14.6 percent had been sexually abused, 25.8 percent had run away at least once, 10.0 percent had attempted suicide, and 15.8 percent had a history of drug or alcohol problems. More than one-half (52.6 percent) of children and youth experienced one or more of these risk factors prior to intake. Over a quarter (27.4 percent) had experienced one of these risk factors, while 15.7 percent had experienced two of them, and 9.5 percent had experienced three or more.

According to caregivers, almost one-half (44.6 percent) of children and youth had been exposed to domestic violence, and just over one-third (34.5 percent) had ever lived in a household where someone had been convicted of a crime. Caregivers also reported that many children and youth had lived with a person who had depression or some other type of mental health concern: 66.7 percent were reported to have lived with someone who had clinical depression, and 37.7 percent had lived with someone who had another type of mental health concern. In addition, caregivers reported that 45.0 percent of children and youth had lived with a household member who had a drinking or drug problem.

Over a quarter of youth (27.9 percent) reported seeing violent crimes in their neighborhood, and 10 percent reported being the victim of a violent crime in the 6 months prior to beginning services.

Referrals to CMHI-Funded System of Care Services and School Attendance

Approximately one-third (33.9 percent) of the referrals to CMHI-funded systems of care were made by mental health agencies. All other referrals were made by caregivers or youth as self-referrals (15.0 percent), schools (14.0 percent), the child welfare system and family courts (12.2 percent), the juvenile justice system (10.2 percent), and various other sources (14.8 percent).

Most children and youth (89.7 percent) receiving services in systems of care were in school or preschool in the 6 months before intake. Of these children and youth, most (83.9 percent) attended school regularly (at least 80 percent of school days).

Mental Health Status of Children and Youth at Intake

Children and youth entered system of care services with a range of behavioral and emotional symptoms, and met the criteria for a range of clinical diagnoses assigned by professionals, as defined by the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM–IV–TR*; American Psychiatric Association, 2000). Appendix G provides detailed tables on symptoms and diagnoses of children and youth at intake.

Presenting Problems

At intake into services, children and youth were diagnosed as having conduct/delinquency-related problems (52.4 percent), followed by hyperactive and attention-related problems (40.6 percent), school performance problems (33.4 percent), depression-related problems (31.7 percent), anxiety-related problems (30.8 percent), and adjustment-related problems (29.0 percent).

Formal Diagnoses

Diagnoses were assigned by mental health clinicians using two instruments. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (DC:0–3R; ZERO TO THREE, 2005) is intended to be used to provide diagnoses for children between the ages of 0 and 3 years; the *DSM–IV–TR* can be used for children and youth of all ages.

The most common DC:0–3R diagnoses for children aged 0–3 were adjustment disorders (22.2 percent), sensory stimulation-seeking/impulsive disorder (13.3 percent), anxiety disorders (10.3 percent), and hypersensitivity (9.4 percent).[24] The most common *DSM–IV–TR* diagnoses for all ages were mood disorders (37.2 percent), attention-deficit/hyperactivity disorder (37.1 percent), oppositional defiant disorder (23.4 percent), and adjustment disorders (14.1 percent).[25]

Among participants who were aged between 0 and 3 years, the most common diagnoses reported were adjustment disorders (29.4 percent), disruptive behavior disorder (25.2 percent), and attention-deficit/hyperactivity disorder (12.9 percent). Among those participants aged between 4 and 6 years, the most common diagnoses given were attention-deficit/hyperactivity disorder (32.2 percent), disruptive behavior disorder (26.5 percent), and adjustment disorder (25.8 percent). Among participants who were aged between 7 and 11 years, the most common diagnoses were attention-deficit/hyperactivity disorder (50.1 percent), mood disorders (36.2 percent), and oppositional defiant disorder (25.7 percent). Among those participants aged between 12 and 14 years, the most common diagnoses were mood disorders (46.4 percent), attention-deficit/hyperactivity disorder (41.9 percent), and oppositional defiant disorder (27.6 percent). Among those participants aged between 15 to 18 years, the most common diagnoses were mood disorders (58.5 percent), attention-deficit/hyperactivity disorder (29.2 percent), and PTSD or acute stress disorder (12.7 percent). Among those participants aged 19 to 21 years, the most common diagnoses were mood disorders (55.9 percent), attention-deficit/hyperactivity disorder (24.8 percent), and substance use disorders (23.4 percent).

Physical Health Status of Children and Youth at Intake

In addition to behavioral and emotional symptoms, many children and youth had chronic physical health problems affecting their daily lives. Caregivers were asked to describe their child's recurring health problems (such as allergies, asthma, migraines, headaches, and epilepsy) if any were present. Among all children and youth with intake data on health issues in the Longitudinal Outcome Study, 41.2 percent were reported to have some sort of chronic health condition. This rate remained fairly consistent across all time points. The most frequently reported health problems were asthma (13.6 percent), allergies (11.6 percent), and headache/migraine (4.6 percent) (see Table 4).

Table 4. Percentage of Children and Youth with a Recurring Health Problem at Intake

Health Problem	*n* = 5,936
Asthma	13.6%
Allergies	11.6%
Headache/Migraine	4.6%
Neurological Disorders/Epilepsy	1.4%
Heart Problems	0.8%
Other Health Problems	9.2%
No recurring health problems reported	58.8%

Insurance Coverage of Participants at Intake

A review of records showed that the majority of participants were enrolled either in Medicaid or in the Children's Health Insurance Program (CHIP). Among all participants, 74.9 percent were already recipients of services funded by Medicaid or CHIP at entry into services. Enrollment in these plans varied somewhat by age. Among those aged 0 to 5 years, 80.5 percent had received services funded by Medicaid or CHIP, and 75.8 percent of participants aged 6 to 11 years had received similarly funded services. The proportion of those aged 12 to 15 years who received services funded by Medicaid or CHIP was 74.3 percent, while 69.8 percent of those aged 16 to 22 years had received services funded through either program.

Summary of Characteristics of Children and Youth Served

- The majority of children and youth were male, came from ethnically diverse backgrounds, and came from families that were more likely to live at or below the poverty threshold than above the poverty threshold.
- More than one-half of the children served were reported to have been exposed to one or more potentially traumatizing experiences, such as interpersonal violence, that are associated with greater risk for mental health challenges.
- More than one-half of the children and youth exhibited conduct- or delinquency-related problems at intake into CMHI-funded systems of care.
- The most common clinical diagnoses assigned to children and youth entering CMHI-funded systems of care were mood disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and adjustment disorders.

Outcomes of Children, Youth, and Their Families Served in the CMHI Communities

Mental Health Outcomes of Children and Youth

Systems of care help families and youth navigate service systems and get the services they need so that children and youth can function better at home, in school, and in the community. Improvements achieved during and after participation in system of care services are described in this section. Information is provided based on both short- and long-term outcomes of system of care involvement. Short-term outcomes are reported for children and youth in communities initially funded in 2005–2009 with both an intake and a 6-month follow-up assessment. Long-term outcomes are reported for children and youth with completed intake assessments, and follow-up assessments at 6, 12, 18, 24, and 30 months after intake in communities initially funded in 2005–2006.[26]

Improvement in Behavioral and Emotional Symptoms

For children and youth aged 1½ years to 18 years, behavioral and emotional symptoms were assessed using the Child Behavior Checklist (CBCL 1½–5; Achenbach & Rescorla, 2000; CBCL 6–18; Achenbach & Rescorla, 2001). The measure is completed by caregivers and has two scales that assess internalizing symptoms, such as depression or anxiety, and externalizing symptoms, such as rule-breaking behavior or aggression toward others. Additionally, there is a Total Problems Scale that gives an overall picture of behavioral and emotional symptoms.

Six months after intake, 27.4 percent of children and youth showed a significant reduction in their overall symptoms. Among children and youth followed for up to 30 months after intake, 24.2 percent improved significantly at 6 months; 37.1 percent improved significantly at 18 months, and 45.8 percent improved significantly at 30 months.[27]

As shown in Figure 1, children and youth with a clinically significant level of behavioral and emotional problems on the Total Problems Scale (i.e., a T-score of 64 or above) fell from 74.2 percent at intake to 63.9 percent within the first 6 months after intake.[28] Among those children and youth followed for up to 30 months after intake, 78.1 percent entered services with a clinically significant level of behavioral and emotional problems; this percentage fell to 68.3 percent after 6 months, and to 56.0 percent within 30 months after intake[29] (see Figure 1).

As shown in Figure 1, the percentage of youth with internalizing symptoms, such as depression or anxiety, in the clinical range fell from 59.4 percent at intake to 48.7 percent within the first 6 months in systems of care.[30] For children and youth followed for 30 months, the percentage in the clinical range fell from 65.1 percent at intake to 53.3 percent within 6 months, and to 39.2 percent within 30 months after intake.[31]

The percentage of children and youth who displayed clinical levels of externalizing symptoms fell from 73.9 percent to 63.5 percent after 6 months in systems of care[32] (see Figure 1). For those children and youth followed for 30 months, the percentage in the clinical range fell from 76.1 percent at intake to 66.5 percent after 6 months and to 54.5 percent after 30 months.[33]

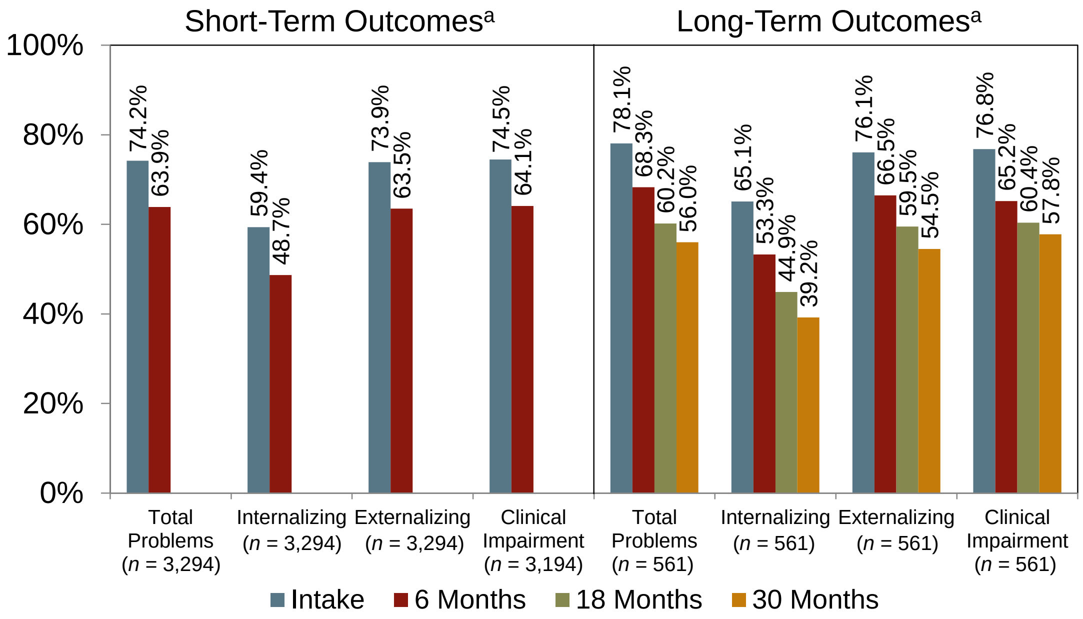
Improvement in Functional Impairments

The overall level of impairment children and youth experience with their functioning at home, in school, and in their communities was assessed using the Columbia Impairment Scale (CIS; Bird et al., 1993). The CIS is a measure of basic areas of functioning for children and youth, and includes scales measuring interpersonal relationships, behavioral problems, and emotional problems.

Within 6 months after intake into CMHI-funded systems of care, 14.8 percent of children and youth showed clinically significant improvement in functioning. Among those followed for up to 30 months, 12.5 percent of children and youth showed significant improvement in functioning within the first 6 months. By 30 months, this number increased to 24.1 percent.[34]

Figure 1 also shows that the percentage of children and youth with significantly impaired functioning fell from 74.5 percent at intake to 64.1 percent 6 months after entering system of care services.[35] Among the children and youth followed for 30 months, impairment in functioning fell from 76.8 percent at intake to 57.8 percent at 30 months.[36]

Figure 1. Percentage of Children and Youth with Clinical Levels of Behavioral and Emotional Problems and Functional Impairment



[a] Total Problems, Internalizing, and Externalizing are measured by the Child Behavior Checklist. Clinical Impairment is measured by the Columbia Impairment Scale.

$p < .001$

Improvement in Symptoms of Anxiety and Depression

Youth aged 11 years and older were interviewed about their symptoms of anxiety and depression by using the Revised Children's Manifest Anxiety Scale: Second Edition (Reynolds & Richmond, 2008), a standardized measure of anxiety symptoms, and the Reynolds Adolescent Depression Scale, Second Edition (Reynolds, 1986), a standardized measure of depression symptoms.

Anxiety

Figure 2 shows that at intake into services, 31.0 percent of youth reported clinically significant symptoms of anxiety, indicating a need for clinical services. Six months after intake, only 25.0 percent of these youth reported symptoms of anxiety above clinical levels.[37] Among youth followed for 30 months, 33.2 percent had scores indicating a need for clinical services for anxiety at intake. After 6 months, only 26.7 percent scored in the clinical range, and after 30 months, this number fell to 22.3 percent.[38]

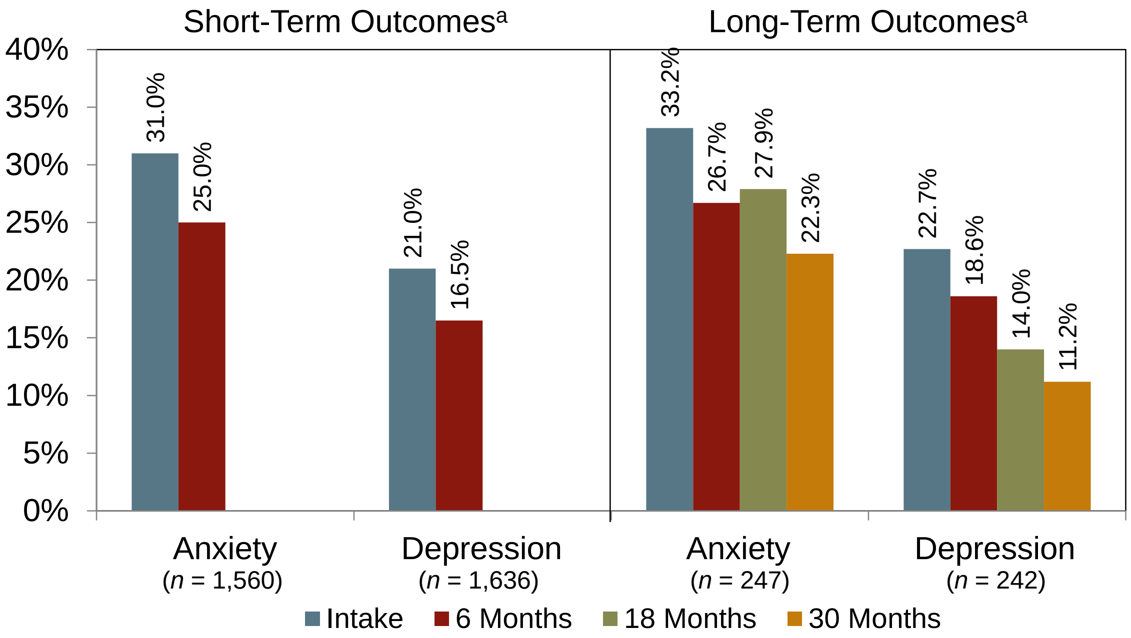
Six months after intake, 15.8 percent of youth showed significant decreases in their levels of anxiety. Among youth followed for 30 months, 14.6 percent improved significantly on their level of anxiety in the first 6 months. By 18 months, this increased to 21.1 percent of youth, and by 30 months to 28.3 percent.[39]

Depression

There were similar results related to symptoms of depression. In the short term, at intake, 21.0 percent of youth reported symptoms of depression in the clinical range. Within 6 months, only 16.5 percent reported depression symptoms in the clinical range[40] (see Figure 2). Among those youth followed for 30 months, 22.7 percent reported depression-related symptoms in the clinical range at intake. At 30 months only 11.2 percent reported this level of depression symptoms.[41]

Six months after intake, 12.6 percent of youth improved significantly in their symptoms of depression. Among those followed for 30 months, 9.1 percent reported significant improvement in symptoms of depression at 6 months, and continued to improve; at 18 months and 30 months after intake, 19.4 and 25.6 percent showed significant improvement, respectively.[42]

Figure 2. Percentage of Youth with Clinically Elevated Levels of Anxiety and Depression



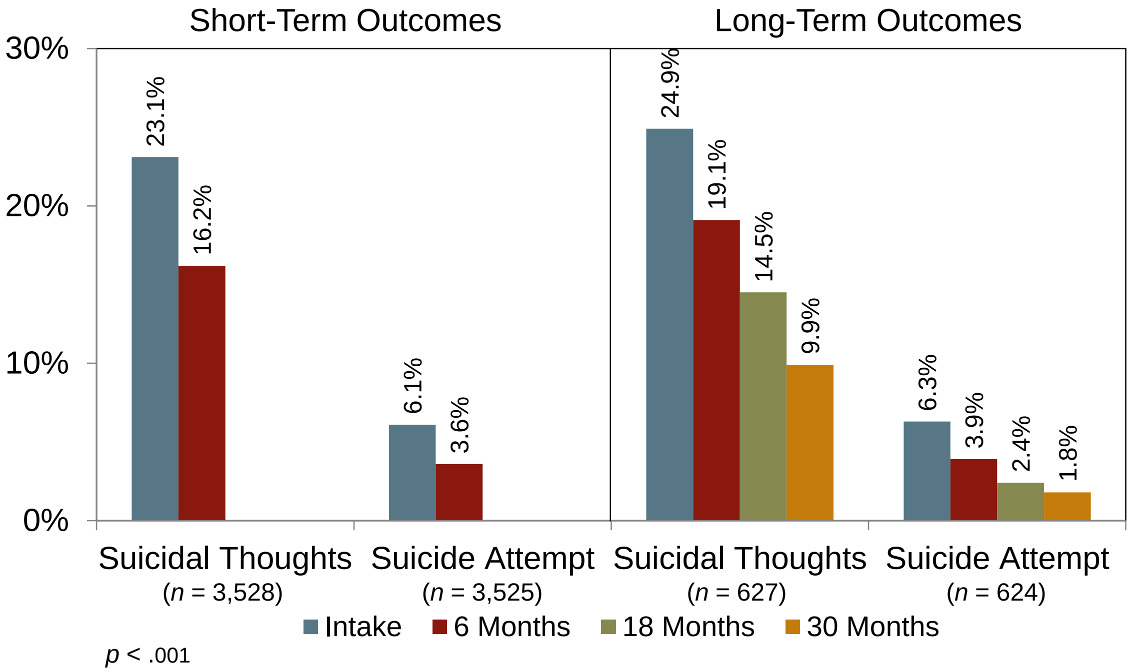
Anxiety is measured by the Revised Children’s Manifest Anxiety Scale—2nd edition. Depression is measured by the Reynolds Adolescent Depression Scale—2nd edition.
p < .001

Reduction in Suicidal Thoughts and Suicide Attempts

At intake, caregivers of children and youth, as well as youth aged 11 years or older, were asked whether the child or youth had thoughts of committing suicide or if they had made a suicide attempt within the past 6 months. Figure 3 shows that the percentage of children and youth who were reported to have had thoughts of suicide in the previous 6 months fell from 23.1 percent at intake to 16.2 percent at 6 months after intake into a system of care.[43] Among children and youth followed for 30 months, those who had thoughts of committing suicide fell from 24.9 percent at intake to 19.1 percent at 6 months (see Figure 3). After 30 months, only 9.9 percent of children and youth reported thoughts of committing suicide, a 60 percent reduction in children and youth with these thoughts.[44]

The percentage of children and youth who made a suicide attempt in the previous 6 months fell by nearly half from 6.1 percent at intake to 3.6 percent after 6 months in system of care services.[45] Children and youth followed for 30 months made similar improvements and continued to improve significantly. Among these children and youth, suicide attempts fell by 37 percent from 6.3 percent in the 6 months prior to intake to 3.9 percent after 6 months in system of care services. At the 30-month assessment, suicide attempt was reported for only 1.8 percent of children and youth during the previous 6 months, a 71 percent reduction in suicide attempt from intake to 30 months.[46]

Figure 3. Percentage of Children and Youth Experiencing Suicidal Thoughts and Suicide Attempts



Additional Outcomes of Children and Youth

Improvement in Educational Outcomes

At each assessment, caregivers provide information about their child's school attendance, academic performance, and school discipline record, as well as which services were provided by the school.

At intake, more than half (53.5 percent) of the children and youth had an individualized education plan (IEP) or a Section 504 plan in place, 44.7 percent of children and youth were receiving special education services, and 24.4 percent were receiving services from a one-on-one classroom aide. IEP and Section 504 plans were established for an additional 4.0 percent of children and youth during the first 6 months in services, for a total of 57.5 percent.[47] Among children and youth followed for 30 months, 57.5 percent had an IEP or Section 504 Plan at intake; this percentage increased to 60.3 percent within the first 6 months in systems of care, and further increased to 63.9 percent after 18 months. At 30 months, the number of children and youth with these plans decreased to 61.8 percent. The overall trend toward increase in IEPs was significant;[48] the decrease from 18 months to 30 months was not significant.

Among children and youth receiving system of care services, the percentage who attended school regularly, defined as attending 80 percent of school days or more, rose from 86.3 percent at intake to 90.4 percent within 6 months after intake.[49] Children and youth who were followed for 30 months also showed improvements; 89.3 percent attended school regularly in the 6 months before intake, and 94.2 percent attended school regularly in the first 6 months. At 18 months after intake this number increased to 95.6 percent, and at 30 months, 93.4 percent of children and youth attended school regularly.[50]

In addition to attendance, school performance improved. At intake, 65.8 percent of children and youth had a C average or better. After 6 months, 72.3 percent of children and youth had average grades of C or better.[51] Among those children and youth followed for 30 months, school performance also improved. The percentage of those with a C average or better increased from 70.8 percent at intake to 73.3 percent at 6 months. Eighteen months after intake, the percentage increased to 79.5 percent, and after 30 months 80.0 percent of children and youth had a C average or better.[52]

Children and youth were less likely to be suspended or expelled within 6 months after intake into system of care services. At intake, 37.0 percent of children and youth had been suspended or expelled from a school in the previous 6 months. Six months after intake, this percentage fell to 29.0 percent.[53] Similar improvements were reported among those followed for 30 months, with 31.3 percent having been suspended or expelled at intake and 25.6 percent at 6 months. At 18 months, 23.4 percent of children and youth had been either suspended or expelled in the previous 6 months. By 30 months, the percentage decreased to 20.6 percent.[54]

Improvement in Living Situations

Children and youth achieved greater stability in their living situations after receiving system of care services. (Children and youth who lived in two or more settings, but consistently lived with relatives, were considered to be consistently living at home.) In the 6 months prior to intake, 18.3 percent of children and youth lived in a setting that was not their home, such as a foster home, jail or prison, or hospital. After 6 months, this percentage fell to 16.0 percent.[55] Among children and youth followed for 30 months, 18.6 percent had recently lived somewhere other than their home at intake. That number fell to 13.3 percent at 6 months, and to 10.0 percent at 18 months. At 30 months, only 9.3 percent of children and youth had lived for at least a part of the previous 6 months in a setting that was not their home.[56]

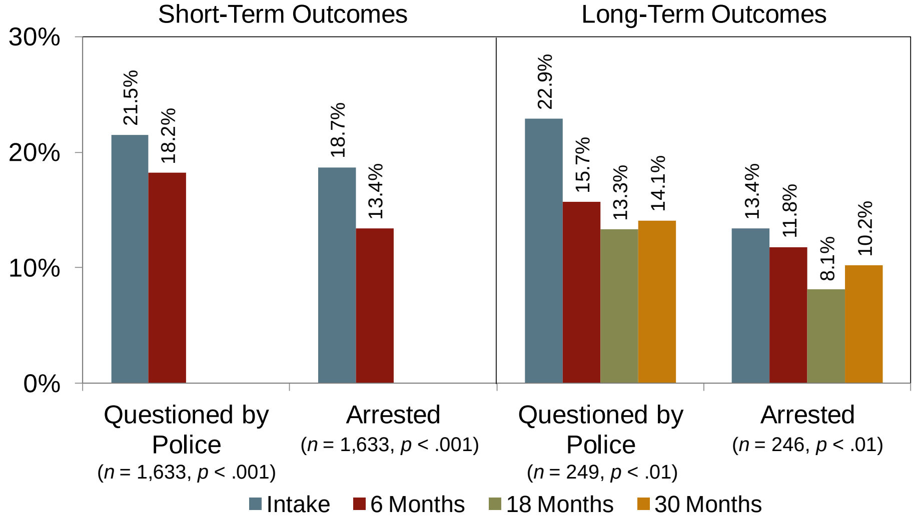
Reduction in Law Enforcement Contacts

Youth who were 11 years or older were asked how often they engaged in unlawful behaviors, such as taking items from a store without paying, destroying property, selling drugs, or taking things from another person by force. They also were asked about their involvement with the juvenile and adult criminal justice systems.

At intake, 73.2 percent of youth stated that they had engaged in at least 1 of the 22 unlawful behaviors assessed. After 6 months, the percentage had fallen to 56.1 percent engaging in at least one behavior in the previous 6 months.[57] For youth followed for 30 months, 74.9 percent stated at intake that they had engaged in unlawful behavior during the previous 6 months. The percentage fell to 58.0 percent at 6 months, 43.1 percent at 18 months, and 35.7 percent at 30 months.[58]

Figure 4 shows the progress made over time. At intake, 21.5 percent of youth had been questioned by the police in the previous 6 months, and 18.7 percent had been arrested. At 6 months, these numbers had fallen to 18.2 percent and 13.4 percent, respectively.[59] Among youth followed for 30 months, at intake 22.9 percent of participants had been questioned by the police within the previous 6 months, and 13.4 had been arrested. At 30 months, the percentage had fallen to 14.1 percent and 10.2 percent, respectively.[60]

Figure 4. Percentage of Youth Involved with Law Enforcement in the Previous 6 Months



Improvement Among Youth with a History of Arrest

Youth who had a history of arrest before intake into system of care services improved on several key indicators. In the first 6 months after intake, 66.5 percent of youth avoided being re-arrested. Among those followed for 30 months, after 6 months, 57.6

percent avoided re-arrest. By 18 months, 83.3 percent of youth with an arrest history at intake had no arrests within the previous 6 months, and 90.9 percent continued to avoid arrest after 30 months.[61]

These youth also had fewer disciplinary problems in school and had fewer behavioral and emotional problems. The percentage of youth who were either suspended or expelled from school in the previous 6 months fell from 63.2 percent at intake into services to 48.2 percent after 6 months.[62] For those followed for 30 months, 64.4 percent had been suspended prior to entering services; this proportion fell to 63.0 percent after 6 months, and to 42.5 percent after 18 months, before rising slightly to 46.6 percent after 30 months.[63]

Six months after intake, 30.4 percent of youth with a history of arrest made clinically significant improvements in their behavioral and emotional symptoms as shown on the CBCL Total Problems Scale. For those followed to 30 months, 25.0 percent showed significant improvement after 6 months, 40.6 percent showed improvement after 18 months, and 43.8 percent improved after 30 months.[64]

Improvement in Physical Health Outcomes

At intake, caregivers reported that the regular activities of 41.0 percent of children and youth were disrupted due to their health problems. By 6 months after intake, only 35.5 percent of caregivers reported disruptions in their child's activities due to recurring health problems.[65] Caregivers of 43.3 percent of children and youth followed for 30 months reported at intake that their children's regular activities were disrupted due to health problems. This percentage declined to 30.9 percent at 18 months, but rose to 45.4 percent at 30 months.

Improvement in Behavioral and Emotional Strengths

The national evaluation examined several factors contributing to the overall well-being of children and youth.

Strengths were measured using the Behavioral and Emotional Rating Scale–2 (BERS–2; Epstein, 2004). This scale focuses on strengths and resiliency, identifying behavioral and emotional strengths of children and youth in key areas related to school, family, relationships, and personal competence. There are two versions of this scale: one completed by caregivers and one completed by youth. Data from both the youth and their caregivers were analyzed for the results presented here.

Caregivers reported an increase in their child's strengths over the first 6 months of services, with 29.2 percent reporting their child had improved in their behavioral and emotional strengths. Caregivers of children and youth followed for 30 months reported that 25.0 percent had improved in their behavioral and emotional strengths 6 months after beginning system of care services. By 30 months after intake, 40.0 percent exhibited improvement[66] (see Figure 5).

Youth perceived improvement in their own strengths to be lower than their caregivers did at intake into services. At 6 months after intake, 23.2 percent of the youth reported improvement in their behavioral and emotional strengths. Among youth followed for 30 months, 22.5 percent reported improved strengths after 6 months. At 30 months after intake, 38.2 percent reported improved strengths[67] (see Figure 6).

Figure 5. Caregiver Report of Change in Children's and Youths' Behavioral and Emotional Strengths from Intake to 6 Months, Intake to 18 Months, and Intake to 30 Months

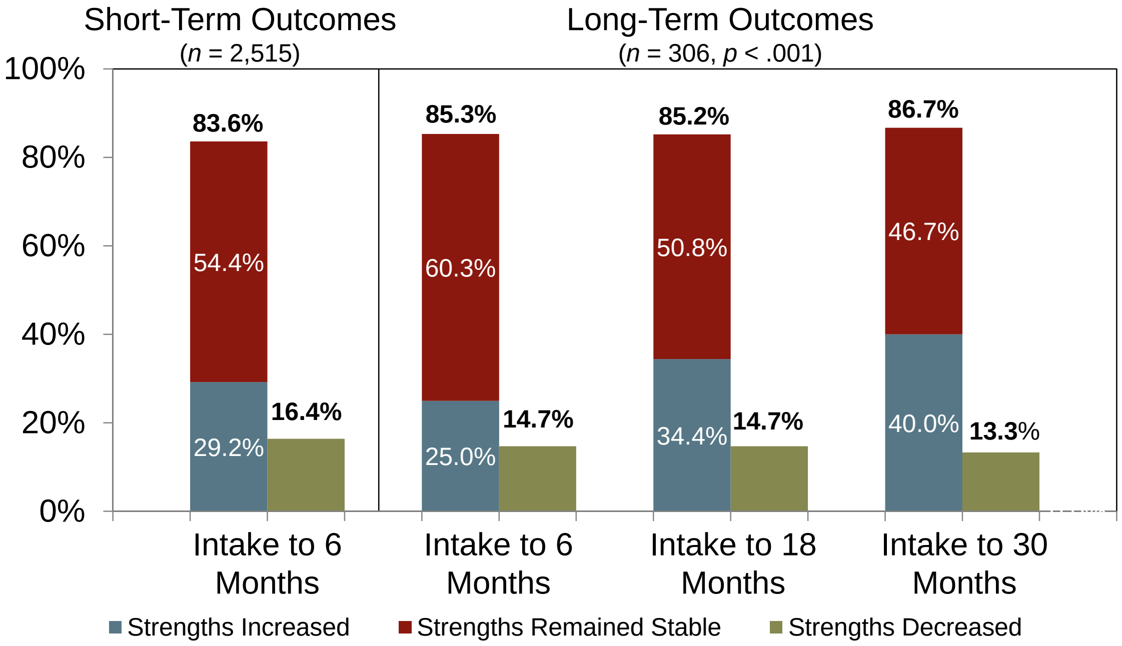
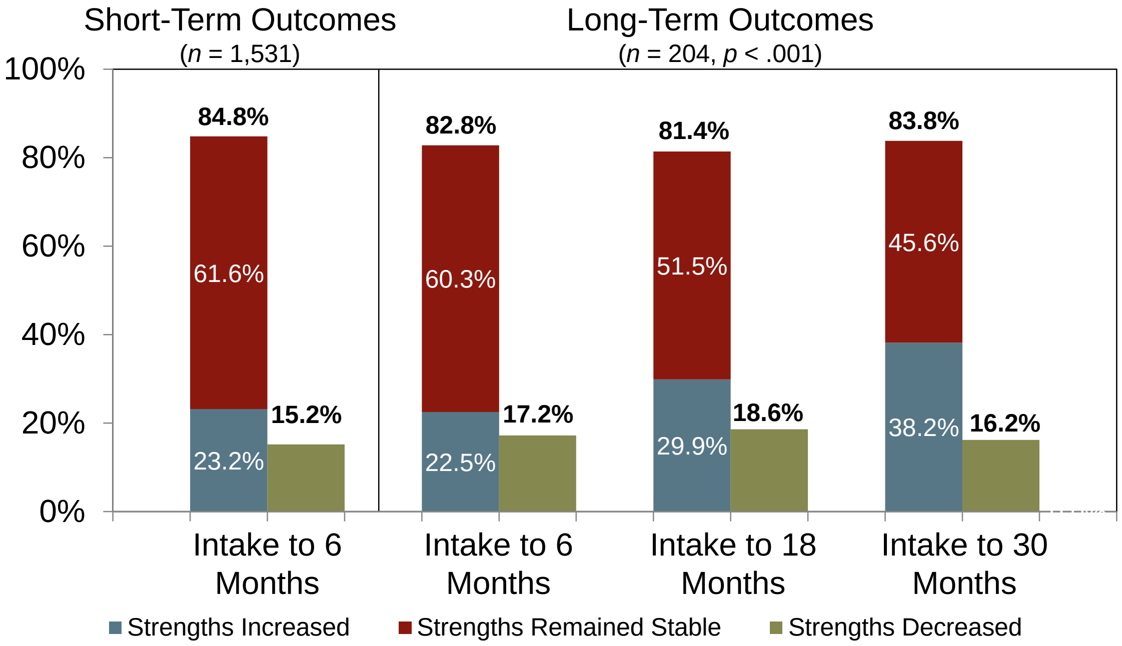


Figure 6. Youth Report of Change in Their Behavioral and Emotional Strengths from Intake to 6 Months, Intake to 18 Months, and Intake to 30 Months



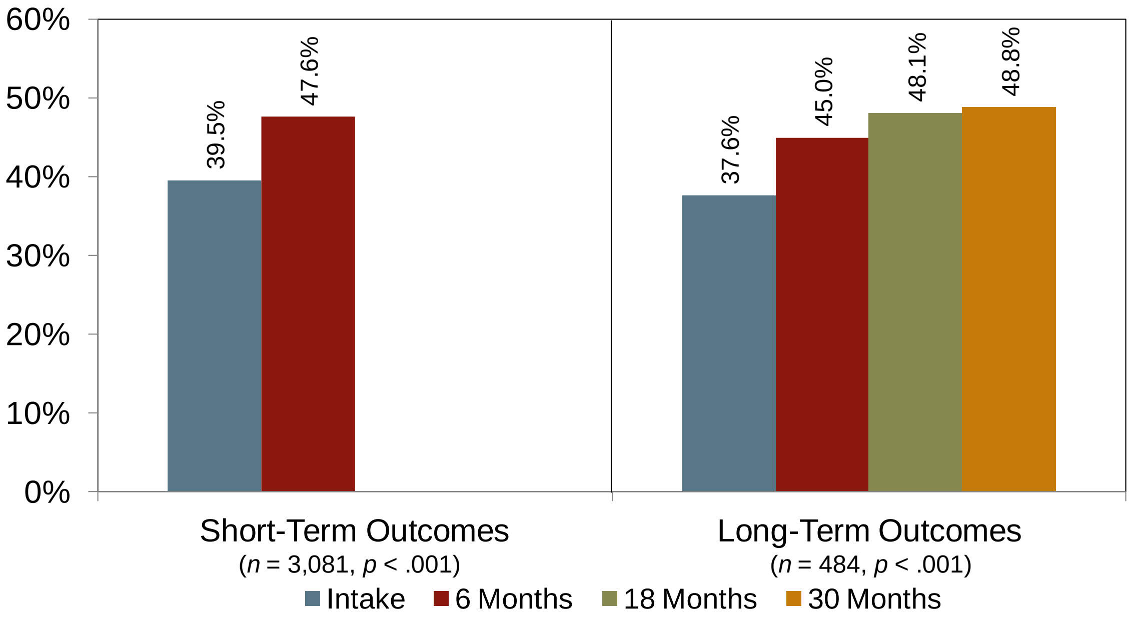
Reduction in Exposure to Potentially Traumatic Events

Caregivers were asked whether their child or youth had ever been exposed to six potentially traumatic events: physical abuse, sexual abuse, witnessing domestic violence, living with someone who has a drug or alcohol problem, living with someone who has a mental health concern, and living with a person who has a previous felony conviction. Based on caregiver report, children and youth had been exposed to fewer potentially traumatic events after intake into system of care services.

The greatest reduction in exposure to potentially traumatic events occurred within the first 6 months in system of care services, with smaller changes reported at 18 and 30 months after intake. This suggests that systems of care are successful in reducing exposure to potentially traumatic events and that these gains are maintained over time.

The percentage of children and youth who were not exposed to potentially traumatic events increased over time. At intake, 39.5 percent of children and youth with 6-month outcome data had not been exposed to any events in the previous 6 months. At 6 months after intake, 47.6 percent of these children and youth had not been exposed to any events in the previous 6 months.[68] This represents a 21 percent increase in the number of children and youth who were not exposed to a potentially traumatic event. For those children and youth followed for 30 months, 37.6 percent had not been exposed to any events in the 6 months prior to intake, whereas 45.0 percent were not exposed to any events in the first 6 months after intake, and 48.8 percent were not exposed to any events at 30 months after intake[69] (see Figure 7), which is a 30 percent increase in the number of children and youth who were not exposed to a potentially traumatic event.

Figure 7. Percentage of Children and Youth without Exposure to Potentially Traumatic Events



At intake, nearly 9 percent of caregivers reported that children and youth had been exposed to domestic violence within the 6 months prior to intake; this percentage fell by half to 4.6 percent within the first 6 months in system of care services.[70] For children and youth followed for 30 months, 11 percent had been exposed to domestic violence during the 6 months prior to intake; this percentage fell by more than half to 5.1 percent during the first 6 months after intake. This reduction in exposure to domestic violence remained low and showed further, although insignificant, reductions at 18 months (4.5 percent) and 30 months (4.4. percent).[71]

Similarly, caregiver reports of child exposure to physical abuse fell to levels about half those reported at intake into services (3.7 percent) within the first 6 months in services (1.9 percent). For children and youth followed for 30 months, similar reductions in exposure to physical abuse were found after 6 months in services. Caregivers reported 4.4 percent of children and youth had been exposed to physical abuse at intake, with a decrease to 2.2 percent at 6 months. However, exposure to physical abuse increased within 18 months to 3.2 percent, and then decreased to 2.0 percent at 30 months.[72]

With respect to behavioral health concerns, at intake, 8.6 percent of caregivers reported that their child had lived with someone who had a drinking or drug problem in the 6 months prior to intake. At 6 months after intake, this number decreased to 7.9 percent.[73] About 10 percent of children and youth followed for 30 months had lived with someone with a drinking or drug problem in the 6 months prior to intake. This percentage decreased to 7.7 percent in the 6 months after intake, and remained at this level 18 and 30 months after intake (7.7 percent and 7.4 percent, respectively). For children and youth followed for 30 months, the likelihood that they lived with someone who previously had been convicted of a crime showed a similar pattern, dropping from 6.8 percent in the 6 months prior to intake to 3.3 percent after 18 months, and to 4.2 percent after 30 months.[74] The rate at which children and youth were reported to have lived with a person with a significant mental health concern in the previous 6 months fell from 58.5 percent at intake to 54.2 percent after 18 months and to 52.5 percent after 30 months.[75]

Caregiver Outcomes

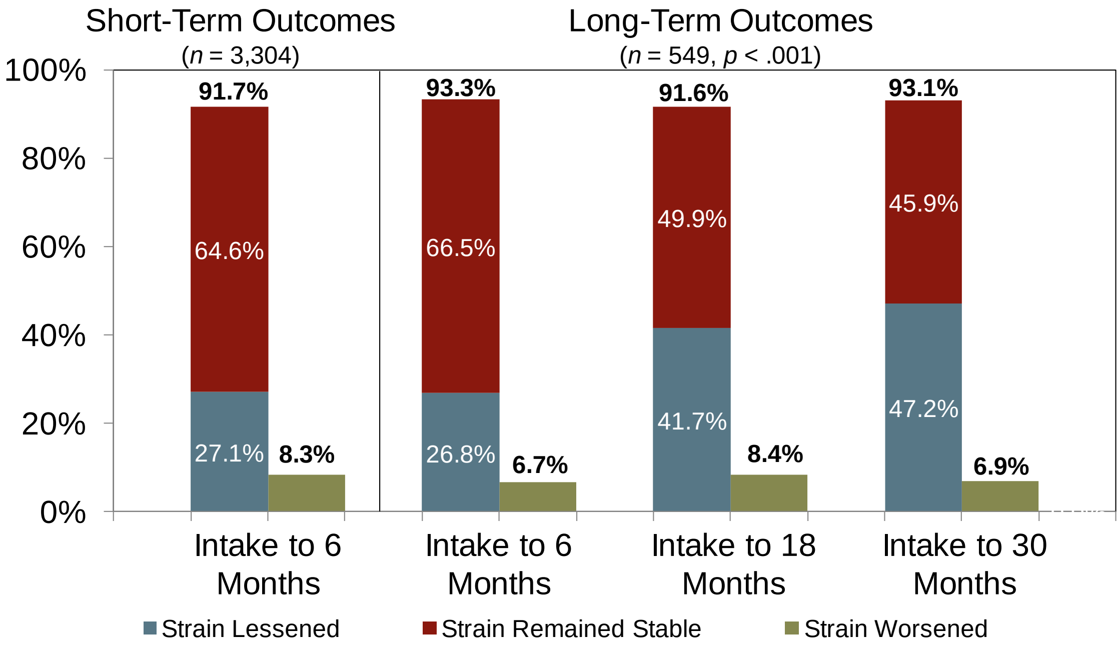
Caregivers and families of children and youth who have mental health challenges may experience stress that can impact their own functioning. Factors that may contribute to improved caregiver functioning, including reductions in the strain associated with caring for a child with serious mental health conditions, increased or stabilized employment, and improved family resources, are discussed below.

Improvement in Caregiver Strain

Caregivers reported on their level of strain associated with caring for a child with serious mental health conditions by responding to the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1998). This scale is comprised of three related dimensions of caregiver strain: subjective externalizing strain (e.g., feeling anger or resentment towards one’s child), subjective internalizing strain (e.g., feeling worry or guilt), and objective strain (e.g., observable disruptions in family life such as lost work time).

More than one-fourth (27.1 percent) of caregivers reported significant reductions in global strain from intake to 6 months. Among caregivers followed for 30 months, 26.8 percent reported significant reduction in global strain from intake to 6 months, with continued significant improvement to 47.2 percent after 30 months[76] (see Figure 8).

Figure 8. Change in Caregiver Global Strain from Intake to 6 Months, Intake to 18 Months, and Intake to 30 Months



Between intake and 6 months, 7.6 percent of caregivers reported reduced subjective externalizing strain and 15.9 percent reported reduced subjective internalizing strain. For those followed for 30 months, 8.5 percent and 15.4 percent, respectively, reported significant reductions in subjective externalizing and subjective internalizing strain from intake to 6 months. These percentages increased to 15.9 percent and 28.3 percent, respectively, at 18 months after intake. At 30 months, 16.9 percent and 33.3 percent, respectively, of caregivers reported significant reductions in subjective externalizing and subjective internalizing strain since intake.[77]

Caregivers also reported reduced objective strain from intake to 6 months (22.9 percent). For those followed for 30 months, 22.7 percent reported significant reductions in objective strain between intake and 6 months, 33.2 percent reported reductions between intake and 18 months, and 40.8 percent reported reductions in objective strain between intake and 30 months.[78]

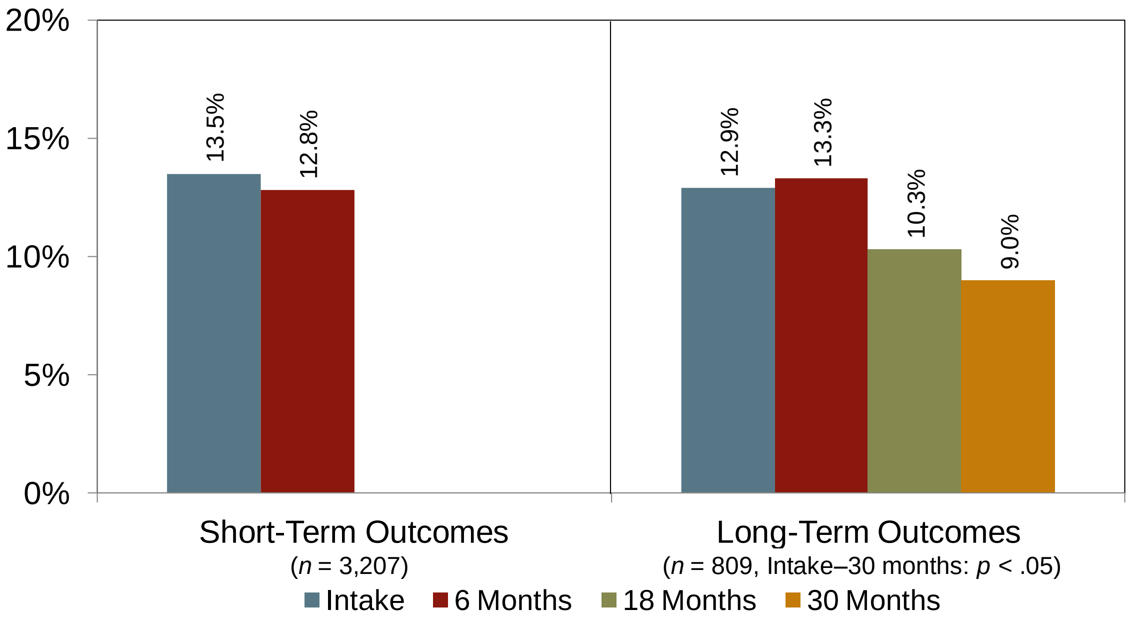
Beginning with communities initially funded in 2008, parenting stress is being assessed using the Parenting Stress Index-Short Form (PSI/SF; Abidin, 1995). At intake, 82.1 percent of the caregivers reported levels of parenting stress, which placed the parents in the "severe" range. This decreased to 73.5 percent at 6 months.[79]

Improvement in Caregiver Work Life

Caregivers who were employed at intake (53.9 percent) reported missing an average of 4.8 days of work in the previous 6 months due to their child's behavioral or emotional problems. This decreased to 3.5 days after 6 months.[80] Caregivers followed for 30 months reported at intake that they missed an average of 4.5 days of work due to their child's behavioral or emotional problems. At 6 months, caregivers reported missing an average of 3.6 days of work. After 18 months, missed days of work had decreased significantly to an average of 2.1 days and further reduced to 1.6 days after 30 months.[81]

A child's or youth's behavioral or emotional concerns may impact caregiver employment and the financial stability of the family. At intake, 13.5 percent of caregivers reported that they were unemployed but thought they would be employed if their child did not have behavioral or emotional problems. This percentage decreased slightly to 12.8 percent at 6 months after intake. Among caregivers of children and youth followed for 30 months, 12.9 percent reported that they were unemployed at intake but thought they would be employed if their child did not have behavioral or emotional problems. This percentage fell to 9 percent after 30 months[82] (see Figure 9).

Figure 9. Percentage of Caregivers Who Reported They Were Unemployed Due to Child's Behavioral or Emotional Problems



Improvement in Support Services Available to Families

Beginning with communities initially funded in 2008, caregivers were asked about their experiences in working with a specific family advocate, parent partner, or family liaison, who is an additional member of a services team, often a parent whose children have received services and who is tasked with responding specifically to the needs of parents. These family support partners often assist families by providing information about or making referrals to community resources and helping them to navigate the service system. At intake, 62.4 percent of caregivers reported having a family support partner assigned to work with them; of this group, 45.1 percent reported at intake that they had received services from their family support partner to help them develop their parenting skills, a percentage that increased to 57.5 percent at 6 months.[83]

Summary of Outcomes of Children, Youth, and Families

- The number of children who displayed clinically significant levels of impairment fell from 74.5 percent to 64.1 percent within the first 6 months of receiving services, a difference of 13 percent over intake.
- After 30 months, the percentage of children and youth who displayed clinically significant levels of behavioral and emotional problems fell by 28 percent over baseline.
- Self-reported rates of anxiety and depression fell significantly over time: 33.2 percent of youth reported clinically significant levels of anxiety at intake and only 22.3 percent reported similar levels of anxiety after 30 months, representing a reduction of 33 percent over intake. The proportion with clinically significant symptoms of depression fell from 22.7 percent at intake to 11.2 percent after 30 months, representing a reduction of 51 percent over intake.
- Within the first 6 months of receiving services, rates of suicidal thoughts fell by 30 percent over baseline. Rates of suicide attempts fell by 41 percent over baseline.
- After 6 months of receiving services, children and youth were less likely to be suspended or expelled from school, with a reduction of 22 percent over baseline. Additionally, the number of children and youth receiving passing grades improved, as did the number attending school regularly.
- The proportion of children and youth living in a setting other than their home was reduced from 18.6 percent in the 6 months prior to intake to 9.3 percent after 30 months in services, representing a 50 percent reduction over intake.
- The proportion of youth who were arrested fell over time, including among those who entered system of care services with a history of having been arrested.
- Caregivers reported that, 6 months after beginning services, 29.2 percent of children and youth showed significant improvements in their personal strengths, including social skills and anger management.
- The percentage of caregivers reporting that their child's activities were impacted by long-lasting health problems fell significantly.
- Fewer children and youth were exposed to potentially traumatic events after receiving services within a system of care.
- Nearly one half (47.2 percent) of caregivers reported significantly less strain from caring for a young person with a serious mental health condition after 30 months of receiving services.
- Caregivers reported that they missed an average of 4.5 days of work in the previous 6 months due to their child's behavioral and emotional problems. This number was reduced to 1.6 days after 30 months.

Service Use by Children, Youth, and Families Served by CMHI Communities and Associated Costs

Involvement in Service Planning

The system of care approach promotes family-driven, youth-guided, and individualized service planning. Coordinating services in systems of care includes holding service planning meetings at intake into systems of care with the range of parties, including families, youth, and others important to determining the full array of services and supports needed by each unique child or youth and family. For almost all children and youth, caregivers were involved in planning services (95 percent), and the majority of youth (77.1 percent) reported participating in their own service planning; 74.7 percent of service planning meetings included a care manager, and 65.3 percent included a mental health staff member (therapist, behavioral aide, respite worker, or others). Family advocates participated in nearly one-fourth (23.8 percent) of the meetings. Other child- and youth-serving agency representatives from education (16.7 percent), child welfare (10.0 percent), and juvenile justice (7.6 percent) participated in smaller numbers.

Types of Services Received

Caregivers reported on services used during the first 6 months after intake into system of care services. Caregivers also reported on the locations in which the services were received. This section summarizes caregiver-reported services received in the 6 months following intake.[84]

Ninety-two percent of caregivers reported that their child received at least one type of service during the first 6 months in system of care services, and they received an average of 4.9 (*SD* = 2.7) different types of services during that period. Among those who did not receive any services, the most commonly given reasons by caregivers were not needing services (28.0 percent), completing services or being discharged (15.1 percent), and deciding not to continue services (14.7 percent). The most frequently used services and supports in the first 6 months of services were individual therapy (66.6 percent), care management (60.4 percent), and assessment or evaluation (53.8 percent) (see Table 5).

Table 5. Types of Services and Supports Received by Children, Youth, and Their Families from Intake to 6 Months, Communities Initially Funded in 2005-2008

Mental Health Services	
Individual therapy (*n* = 3,144)	66.6%
Care management (*n* = 3,129)	60.4%
Assessment or evaluation (*n* = 3,121)	53.8%
Medication treatment monitoring (*n* = 3,133)	42.4%
Informal supports (*n* = 3,131)	41.3%
Family therapy (*n* = 3,132)	27.5%
Recreational activities (*n* = 3,134)	26.8%
Caregiver or family support (*n* = 3,131)	25.6%
Transportation (*n* = 3,139)	21.1%
Group therapy (*n* = 3,129)	20.6%
Receipt of flexible funds for expenses (*n* = 3,132)	18.6%
Behavioral/therapeutic aide (*n* = 3,131)	15.9%
Afterschool programs or child care (*n* = 3,128)	14.4%
Crisis stabilization (*n* = 3,132)	10.8%
Respite care (*n* = 3,137)	9.2%
Family preservation (*n* = 3,122)	7.0%
Inpatient hospitalization (*n* = 3,137)	6.4%
Day treatment (*n* = 3,132)	5.7%
Residential treatment center (*n* = 3,135)	5.5%
Youth transition (*n* = 3,125)	2.6%
Therapeutic foster care (*n* = 3,132)	2.3%
Therapeutic group home (*n* = 3,132)	2.0%
Vocational training (*n* = 3,125)	2.0%
Residential therapeutic camp or wilderness program (*n* = 3,137)	1.7%
Independent living (*n* = 3,128)	1.6%

Caregivers reported that the most common places where services were received were mental health settings (77.3 percent) and schools (69.4 percent). However, nearly two-thirds of caregivers (63.9 percent) reported that services were provided to them in their homes (see Table 6). In addition, a substantial proportion of the services were received in social services or child welfare offices and in community settings. Services also were reported as being received in medical or psychiatric hospital settings (20.5 percent and 10.2 percent, respectively) or settings such as juvenile courts or detention centers (26.1 percent).

Table 6. Locations in Which Children, Youth, and Their Families Received Services

Location	
Mental health clinic or private practice (*n* = 3,145)	77.3%
School (*n* = 3,130)	69.4%
Home (*n* = 3,135)	63.9%
Social services or child welfare offices (*n* = 3,084)	32.7%
Community location or service center (*n* = 3,089)	25.0%
Medical hospital (*n* = 3,094)	20.5%
Juvenile court/Probation (*n* = 3,038)	19.0%
Psychiatric hospital/unit (*n* = 3,076)	10.2%
Non-hospital residential setting (*n* = 3,060)	7.7%
Jail/Youth detention (*n* = 3,056)	7.1%
Other setting (*n* = 2,718)	6.8%

Reduction in Community Service Costs in Six Communities

The following analyses are based on data drawn from the management information systems of six CMHI-funded communities (in four states) initially funded in 2005.[85] The data detail services and supports received by 695 children and youth following intake into CMHI-funded systems of care between November 2005 and June 2011. Community-based, non-residential services and supports delivered to children, youth, and families in CMHI-funded systems of care and their costs were examined based on 52,694 community-based support[86] and community-based mental health service events.[87]

The average length of time during which children and youth received services was 20.0 months (median = 17.8 months). The average cost associated with the services was $6,378.50 per child or youth (median = $3,334.80), or $515.70 per child or youth per month (median = $436.20). Children and youth received an average of 6.77 community-based mental health service or support events.

Among children and youth served in these six systems of care, 98.4 percent received community-based services and supports. The average number of community-based mental health service events received by children in this group was 5.55. The most commonly provided types of services received by these children and youth were individual therapy (76.4 percent), care management/clinical coordination (68.4 percent), and intake/screening/diagnosis/assessment (67.8 percent).

Among these children and youth, 52.3 percent received community-based support services. The average number of community-based support service events received by these children and youth was 2.48. The most common services of this kind were caregiver support/family support (received by 26.5 percent of children and youth), vocational/life skills training/independent living skills/youth transition (21.3 percent), and training/tutoring/education/mentoring (17.3 percent).

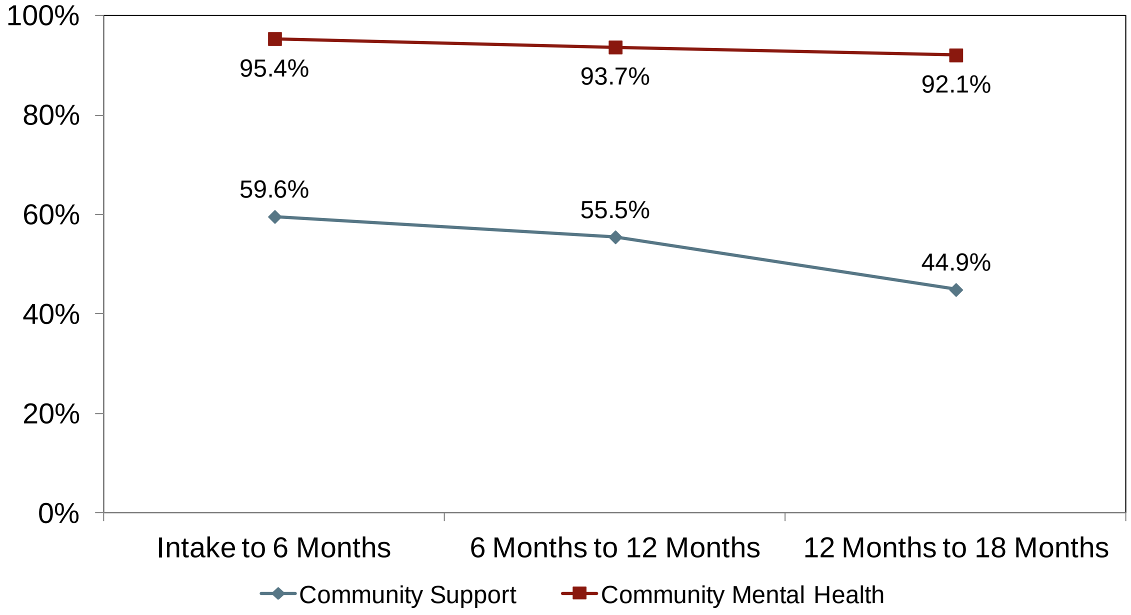
Table 7 displays amounts paid to providers by source of payment. The total amount paid for services was $4,377,419 (based on 48,577 services with payment data). Medicaid, the major payer for these services in these six communities, was responsible for 68.8 percent of total payments. CMHI funding, the second largest source of payment, was responsible for 19.7 percent of total payments, followed by the mental health agency, client out-of-pocket payment, private insurance, and child welfare. Other sources of payment accounted for 10.4 percent of total payments

Table 7. Amounts Paid by Source of Payment in Six Communities

Payment Source	
Medicaid	68.8%
CMHI Grant	19.7%
Other Payer	10.4%
Mental Health Agency	0.6%
Client Out-of-Pocket	0.2%
Private Insurance	0.1%
Child Welfare Agency	0.1%

Figure 10 displays the percentage of children and youth who received community mental health services and community supports during the time they received services in CMHI-funded systems of care. This figure is based on the subset of children and youth for whom data are available throughout three 6-month periods (*n* = 423). The percentages for each period are calculated based on the number of children and youth receiving at least one service event. In the first 6 months after intake, 95.4 percent of the children and youth received at least one community mental health service, and 59.6 percent received at least one community support service. For both categories of services, the percentage of children and youth receiving services decreased over time, which is consistent with the improvements in clinical and functional outcomes documented in previous sections of this Report, potentially resulting in a decreased need for service use and supports.

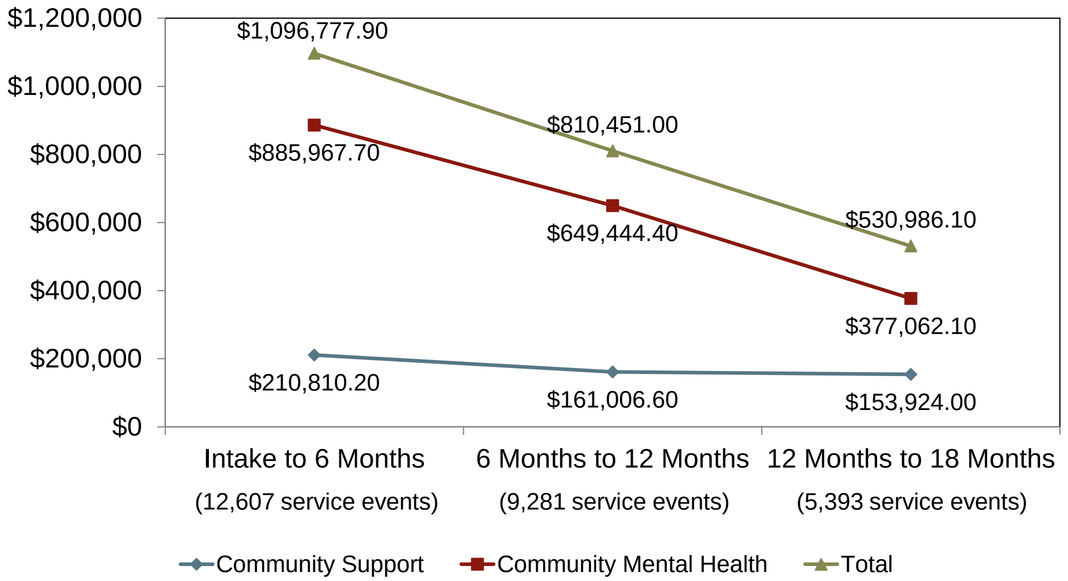
Figure 10. Percentage of Children and Youth Receiving Community Support and Mental Health Services by Service Category over Time in Six Communities



(*n* = 423)

Figure 11 displays total payments by service category over time for the same subset of children and youth (*n* = 423). Total payments follow a steady and pronounced decreasing trend.[88] Total payments incurred for services provided between 12 and 18 months after intake into system of care services were about half as much as the total payments in the first 6 months. Figure 11 also shows that payments for community mental health services were the main driver of this decreasing trend in total payments. Payments incurred for community support services decrease at a much lower rate and represent a relatively small proportion of total payments. Continued improvements in outcomes over time combined with observed reductions in costs are indicative of increases in cost efficiencies of services provided to children and youth enrolled in systems of care.

Figure 11. Total Payments by Community Support and Community Mental Health Service Category and Total Payments over Time in Six Communities



Reduction in Inpatient Service Costs

One of the intended outcomes of systems of care for children's mental health is to reduce the use of restrictive, high-cost inpatient services in favor of community-based services.

In systems of care initially funded in 2005–2008, the average number of days spent in inpatient hospital care decreased from 0.85 days in the 6 months prior to intake to 0.67 days in the 6 months prior to the 12-month interview. The average number of days of inpatient care is based on data for all 2,221 children and youth whose caregivers provided information during both their intake and 12-month interviews about whether their children received any inpatient hospitalization and, if so, for how many days.

The average charge per day for inpatient hospital care for patients between 1 and 18 years old with a primary diagnosis of a mental health disorder is estimated to be $2,258 in 2011 dollars.[89] When this daily rate is multiplied by the average number of days of inpatient hospitalization of children and youth in a system of care, the average estimated total cost per child for the use of inpatient hospitalization in the 6 months prior to intake into a system of care was approximately $1,919. This cost decreased to an average estimated cost per child of $1,513 between 6 and 12 months after intake, representing a 21.1 percent reduction in average per-child inpatient hospitalization costs. This decrease in the use of inpatient hospitalization translates into an estimated total decrease in inpatient hospitalization costs of $4,060,000 for every 10,000 children served.

Sub-group analyses indicated that the patterns in the use of inpatient hospitalization differed among age groups. For children younger than 11 at baseline, the average number of days spent in inpatient hospital care increased slightly from 0.41 days in the 6 months prior to intake to 0.44 days in the 6 months prior to the 12-month interview. For children and youth 11 or older, the average number of days spent in inpatient hospital care decreased from 1.11 days in the 6 months prior to intake to 0.86 days in the 6 months prior to the 12-month interview. Consequently, average inpatient cost per child increased by $68 per child among children younger than 11, and decreased by $565 per child among children 11 or older.

Reduction in Cost of Arrests

The average number of arrests decreased slightly from 0.47 in the 6 months prior to intake to 0.32 in the 6 months prior to the 12-month interview. The average number of arrests was calculated on data collected from 1,193 youth aged 11 and older who provided information at intake and the 12-month interview .

The estimated average cost per juvenile arrest is $5,458 in 2011 dollars.[90] When this cost per juvenile arrest is multiplied by the average number of arrests, the average estimated cost per youth arrest in the 6 months prior to intake was approximately $2,565. This cost decreased to an average estimated cost per youth of $1,747 between 6 and 12 months after intake. This represents a 31.9 percent reduction in average per-child arrest costs. This decrease in juvenile arrests translates into an estimated total decrease in juvenile arrest costs of $8,180,000 for every 10,000 youth 11 years or older served.

Summary of Services and Costs

- The most commonly used services received in the 6 months following intake were individual therapy, care management, assessment or evaluation, and medication.
- Most services were provided in mental health settings, in schools, or at home.
- Average cost per child or youth per month during time in services is $515.70, and the median cost was $436.20.
- Medicaid, the major payer, was responsible for 68.8 percent of total payments.
- Payments for services decreased over time; payments incurred for services provided between 12 and 18 months after intake were roughly half of the total payments incurred in the first 6 months.
- There are substantial estimated total decreases in inpatient hospital care costs and costs due to arrests.
- The results may not be generalizable to all communities, since data were available for only a subset of communities.

System Change and Sustainability

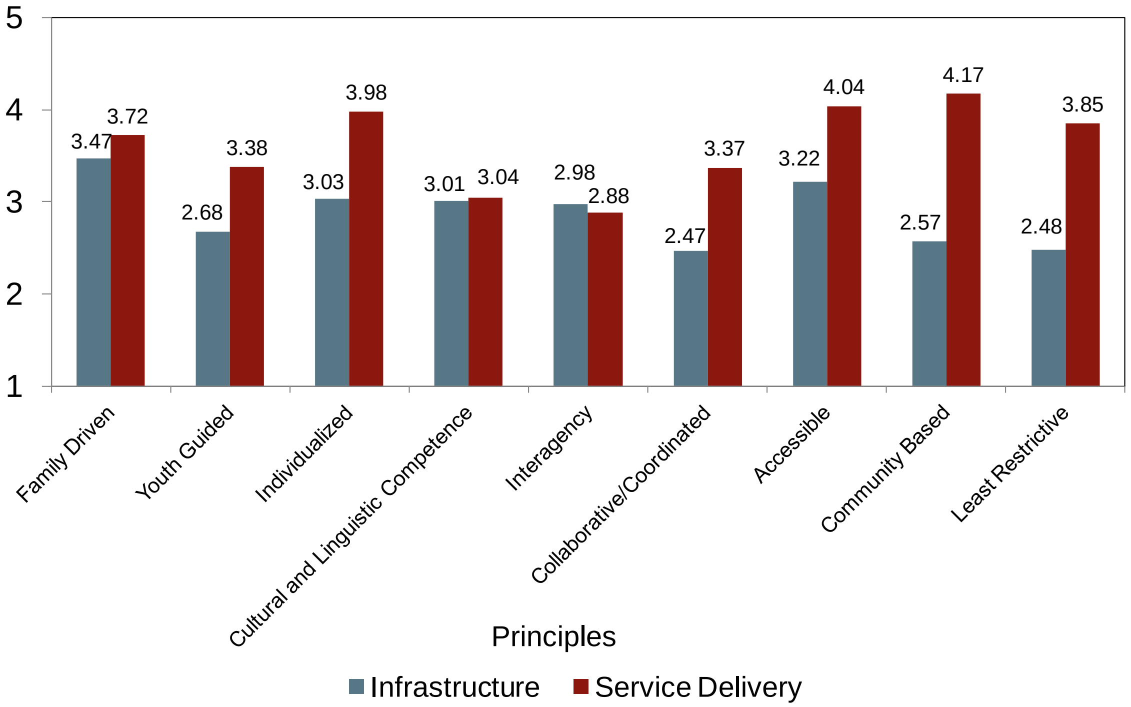
Implementation of the System of Care Approach

The CMHI System of Care Assessment examines whether programs are implemented in accordance with system of care principles and documents how systems develop over time to meet the needs of the children and families they serve. Of particular interest are whether services are delivered in a family-driven, youth-guided, coordinated, and culturally and linguistically competent manner, and the degree to which the system involved multiple child-serving agencies in infrastructure and service delivery. The implementation of these system of care principles is measured across two domains: infrastructure and service delivery. The infrastructure domain is comprised of four components that address governance, management and operations, service array, and program evaluation. The service delivery domain is comprised of four components that address intake into services, service planning, service provision, and care review.

Site visits are conducted every 18 to 24 months over the funding period for the cooperative agreements, beginning in the second year of funding. Information is collected through a combination of document and randomly selected case record reviews, semistructured interviews, observations made on site, and follow-up telephone interviews to clarify information. Respondents include project directors, core agency representatives, direct service providers, care coordinators, youth coordinators, family organization representatives, individual youth and family members who receive services, program evaluators, cultural competence coordinators, and social marketers. This section focuses on the first, or baseline, assessment of communities initially funded in 2008, which was conducted in FY 2010. These communities will be assessed a second time during their funding period. Previous Reports to Congress provide additional findings from communities that were initially funded from 1993 through 2006.

As Figure 12 shows, higher overall ratings generally were achieved in the service delivery domain than in the infrastructure domain at this early stage of program implementation. Within the service delivery domain, communities generally received higher ratings in adhering to system of care principles in their intake into services, service planning and service provision processes. Within the infrastructure domain, communities generally received higher ratings in adhering to system of care principles in their governance, management and operations, and development of a service array. Within these domains and across system of care principles, communities tended to receive higher ratings in adhering to the family driven principle in infrastructure activities, and to community-based care in service delivery activities.

Figure 12. Overall Infrastructure and Service Delivery Ratings for System of Care Communities Initially Funded in 2008, Assessment Point 1



(*n* = 18)

At the infrastructure level, almost all communities had developed governing bodies that had cross-agency membership and engagement in program governance, but not in management and operations of the grant program or in program evaluation activities. Communities had not yet had time to develop or implement shared administrative processes such as cross-agency forms (e.g., single referral or intake form, single care plan) or integrated management information systems; did not have pooled or blended funding across agencies at either the system or case levels; and had not developed cross-agency program evaluation efforts or collected data to track the extent to which there was interagency involvement in the system of care program efforts.

Communities demonstrated family-driven care by including family members in governance bodies and by involving families in daily program management and program staff training. Many communities succeeded at bringing families onto governance committees, in part by scheduling meetings at convenient locations and times, and by providing childcare and transportation stipends. Family representatives were very active in the governance of some programs, providing valuable input and leadership. Communities also provided cross-system training on family-driven care and some communities hired family members for staff positions, included family members in hiring decisions, and provided family advocacy and support services.

At this early stage of program development, as is typical, not all communities had developed their program evaluation plans or begun to collect data. Those communities that collected data had not yet had an opportunity to analyze the data and make use of it for system improvements. Some communities had included families and youth in their evaluation preparation activities and had prepared for data collection efforts to be culturally and linguistically competent (e.g., Spanish-language instruments). Other communities were less successful in engaging youth and families and had not begun collecting data, which resulted in lower ratings across system of care principles for the program evaluation element in the infrastructure domain, thus affecting overall infrastructure ratings.

At the service delivery level, almost all communities had begun or had plans to develop child and family teams that included representatives from all agencies involved with a particular child, youth, or family to participate in service planning. It was common for communities to receive or have plans to receive referrals from many of the core child-serving agencies relevant to the designated population of focus (e.g., early childhood, transition-age youth) but less common for the intake process to be completed by any agency other than mental health. Interagency care review structures had not been developed or implemented in most funded communities.

Communities demonstrated community-based care by providing or arranging for a broad array of services in the home communities of the children, youth, and families served, and by using a formal care review structure to explore community-based service options to prevent children, youth, and families from having to travel outside their home communities to receive services. Most communities used internal agency structures to conduct care review, which did not include other child-serving agencies or children, youth, or families. This practice resulted in lower ratings across system of care principles in the care review element of the service delivery domain, thus affecting overall service delivery ratings.

Sustainability of the System of Care Approach

The national evaluation examines the extent to which CMHI-funded communities are able to maintain their programs after CMHI funding ends, and assesses the strengths and weaknesses of strategies for sustainability and the goals achieved by communities. Data were gathered through a Web-based survey of four key constituents in each community: the 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 findings below are based on the survey completed during the final year of funding (FY 2011) by the communities initially funded in 2005. The survey covers both general strategies and financing strategies used by communities.

Table 8 depicts the most effective and least effective general strategies and financing strategies reported to be used for sustainability in communities in their sixth and final year of funding. Strong interagency relationships and family organizations were cited among the most effective general strategies, whereas making policy and regulatory changes that support the system of care approach was reported as being relatively ineffective. In terms of financing strategies, fundraising and using in-kind space donations were rated most effective, whereas obtaining new/increased private or corporate funds and administrative claiming (i.e., use of available child welfare and Medicaid funds to cover administrative costs) were identified as the least effective.

Table 8. Strategies Used for Sustainability by Communities during Their Final Year of Funding

	General Strategies	Financing Strategies
Most Effective Strategies	• Cultivating strong interagency relationships • Establishing a strong family organization • Involving partners	• Fundraising • Using in-kind space donation • Obtaining new/increased local funds
Least Effective Strategies	• Making policy/regulatory changes that support the system of care approach • Mobilizing resources • Using evaluation/accountability results	• Obtaining new/increased private or corporate funds • Administrative claiming, (i.e., using available child welfare and Medicaid funds to cover administrative costs) • Obtaining new/increased foundation funds

Communities reported a wide range of goals related to ensuring sustainability during the final year of funding. Maintaining a designated agency/office as the focal point for the management of the system of care was cited as one of the goals most successfully achieved during the final year. Other goals attained included achieving general acceptance of the system of care philosophy among service providers and minimizing the need for children and youth and their families to leave their home communities for services. Communities reported being least successful in ensuring that services in the service array have sufficient capacity, and using evaluation data to inform policy and program decisions.

Summary of System Change and Sustainability

System Change

- Communities received higher ratings for having achieved adherence to the system of care principles in the service delivery domain than in the infrastructure domain. Among the system of care principles being assessed, the principle of family-driven care received the highest ratings in the infrastructure domain, and the principle of community-based care received the highest ratings in the service delivery domain.
- Almost all communities had established interagency governance structures and were in the process of implementing plans to begin interagency child and family teams.
- Not all communities had fully implemented their program evaluation, which resulted in lower ratings overall across the infrastructure domain.
- Most communities used an internal care review process that did not involve other agencies, youth, or families, which resulted in lower ratings overall across the service delivery domain.

Sustainability

- Communities used a variety of strategies to ensure sustainability.
- Cultivating strong interagency relationships was ranked as the most effective general sustainability strategy, while fundraising was found to be the most effective financing strategy.

Caregiver and Youth Assessment of System of Care Services

Measuring the satisfaction of caregivers responds to the authorizing legislation's mandate to have caregivers assess the effectiveness of systems of care. Caregivers and youth from communities initially funded in 2005–2006 responded to questions about their service experience and satisfaction with services. Overall satisfaction with services was high among caregivers and youth after 6 months of services.. Table 9 shows that 80 percent of caregivers and 78 percent of youth reported overall satisfaction with services. Caregivers were most satisfied with the cultural sensitivity of providers and access to services, and least satisfied with their child's functioning at school and at home, and service and treatment outcomes at 6 months. Like caregivers, most youth were satisfied with the cultural sensitivity of providers; however, they were least satisfied with their participation in their own treatment or services. The majority of caregivers (91 percent) reported that they would probably or definitely recommend their system of care to others.

Table 9. Satisfaction with Services 6 Months after Intake into Services

Areas of Satisfaction	Percent Satisfied	
	Caregivers (*n* = 1,534)	Youth (*n* = 1,362)
Cultural sensitivity	97%	93%
Access to services	90%	83%
Participation in services	87%	66%
Social connectedness to others	86%	91%
Outcomes of services and treatments	62%	76%
Functioning at home and school	61%	78%
Overall satisfaction	80%	78%

In addition, caregivers were asked a series of questions about whether several aspects of the treatment or services being provided to their child had been explained to them by providers, including (1) details about the treatment, (2) expected improvements resulting from the treatment, (3) the provider's experience using the treatment with similar children and youth, and (4) the research evidence supporting the effectiveness of the treatment.

Caregivers' satisfaction with services was related to whether they were informed about the services being provided to their children and the evidence supporting those services. Caregivers who received information about these aspects of their child's treatment were more satisfied with both the quality of services and the outcomes of the services than caregivers who did not receive the same information (see Table 10).

Table 10. Mean Caregiver Satisfaction 6, 12, and 18 Months after Intake Related to Whether Information about Services Was Received

Information Provided	Satisfaction with Service Quality[a]		Satisfaction with Service Outcomes[a]	
	Received Information	Did Not Receive Information[b]	Received Information	Did Not Receive Information[b]
6 Months after Intake				
Details about treatment	4.08	3.19	3.60	2.88
Expected improvements	4.15	3.39	3.66	3.03
Research evidence	4.23	3.64	3.75	3.21
Provider's experience	4.21	3.52	3.71	3.15
12 Months after Intake				
Details about treatment	4.14	3.11	3.68	3.03
Expected improvements	4.21	3.33	3.73	3.11
Research evidence	4.27	3.66	3.80	3.29
Provider's experience	4.24	3.58	3.77	3.23
18 Months after Intake				
Details about treatment	4.10	3.29	3.70	3.21
Expected improvements	4.17	3.41	3.76	3.19
Research evidence	4.22	3.71	3.81	3.38
Provider's experience	4.21	3.64	3.79	3.34

[a] On a scale of 1 to 5, where 1 = *strongly disagree* and 5 = *strongly agree*.
[b] Difference is significant at $p < .001$ level.

Caregivers from communities initially funded in 2005–2006 responded to questions about the importance of service providers' sensitivity to the unique culture of their families' life. More than half of caregivers (53 percent) reported that it was very important or extremely important for their providers to understand their child's culture. However, less than half of caregivers reported that it was very or extremely important for their child's culture to be integrated into service provision (46 percent) and for their provider be the same culture as their child (20 percent). While most caregivers (66 percent) did not find it important to have a provider with the same culture as their child, the majority reported that their provider was the same racial/ethnic group as their child.

Summary

- Caregivers and youth were satisfied overall with services 6 months after intake into systems of care. Both caregivers and youth were most satisfied with the cultural sensitivity of providers.
- Caregivers' satisfaction with services was related to whether they were informed about the services being provided to their children and the evidence supporting those services.
- Caregivers who received information about particular aspects of their child's treatment were more satisfied with the services and the outcomes of services than caregivers who did not receive the same information.
- More than half of caregivers reported that it was very important or extremely important for their providers to understand their child's culture, but did not find it important to have a provider with the same cultural background as their child.

CMHI Alignment with SAMHSA Strategic Initiatives

The CMHI has supported the development of the system of care philosophy in 173 communities across the nation's public health system. The system of care approach is a coherent framework for providing coordinated home- and community-based care. Through grant funding and cooperative agreements, the CMHI has helped to develop a successful and effective mechanism to coordinate service delivery for children and youth with serious mental health conditions and their families, resulting in the positive outcomes described in this report. The communities have served as "learning labs" where, over the past 18 years of funding, various approaches have been tested and evaluated in a wide range of geographic locations and with diverse service populations.

This collective learning provides a solid foundation upon which future mental health prevention, promotion, and treatment programs can be fashioned and implemented according to SAMHSA's Strategic Initiatives and brought to scale across states, and the Nation as a whole. Examples of the correspondence between the efforts of CMHI-funded communities and selected SAMHSA Initiatives that can inform the future direction for the children's mental health agenda include the following.

- **SAMHSA's Prevention of Substance Abuse and Mental Illness Strategic Initiative**—Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, suicide, and substance abuse including tobacco.

While the CMHI is not designed to be a primary prevention intervention, local implementation of system of care services often carries elements of secondary prevention, such as screening for and early detection of additional health challenges for which children and youth might be at risk. For example, the Positive Behavior and Intervention Supports (PBIS; Eber, Sugai, Smith, & Scott, 2002) model used in many school-based mental health programs can have a preventive effect. The model includes a universal services level that intends to create a mentally healthy environment in the school building to promote the wellbeing of all students, and social marketing campaigns to raise community awareness of mental health issues and reduce stigma.

- **SAMHSA's Trauma and Justice Strategic Initiative**—Reducing the pervasive, harmful, and costly impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

The national evaluation demonstrates that local CMHI-funded programs serve children and youth who likely have been exposed to potentially traumatic events. Specific evidence-based, trauma-informed interventions are used in many CMHI-funded communities, including Trauma-Focused Cognitive Behavioral Therapy and Trauma-Focused Foster Care. Some communities have co-located mental health staff with juvenile justice staff to screen all children and youth referred to juvenile justice systems for mental health concerns in an effort to divert them from the corrections system. Successful diversion is a measure of success for the Trauma and Justice Initiative, and the data in this report demonstrate the successful reduction of involvement with the justice system within the CMHI.

- **SAMHSA's Recovery Support Strategic Initiative**—Partnering with people in recovery from mental and substance-related disorders and family members to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

The system of care model implemented by the CMHI is predicated upon this very definition of recovery support for children and youth with serious mental health conditions and their families. The model suggests that formal service systems and providers and informal nontraditional and natural support systems come together to support or wrap around the child, youth, and family to promote recovery and resilience and then support them for continued wellness and healthy living. For almost two decades, the CMHI has led the mental health and substance abuse prevention and treatment fields in children's mental health.

- **SAMHSA's Health Reform Strategic Initiative**—Increasing access to appropriate high quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance-related disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions such as HIV/AIDS.

CMHI-funded communities are charged with developing interagency structures and working collaboratively at both the infrastructure and service delivery levels to provide an integrated set of services described in this Initiative. As this report shows, system of care communities have developed creative mechanisms to foster interagency collaboration that includes funding strategies as well as cross-agency service plan development and implementation.

- **SAMHSA's Data, Outcomes, and Quality Strategic Initiative**—Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

CMHI-funded communities engage in program evaluation activities at both the national and local levels. The information they gather at both the infrastructure and service delivery/treatment levels is used to direct their clinical work as well as their system-change efforts to improve the quality of behavioral health care. Again, the learned experience of these communities provides great insight and leadership in the successful implementation of this Initiative.

Report Summary

This 2011 *Annual Report to Congress* on the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, also known as the Children's Mental Health Initiative (CMHI), provides critical information about the characteristics of children, youth, and families served in CMHI-funded systems of care; the outcomes attained for children and youth and their families, as well as their service use and service experience; how well communities have implemented system of care principles; and the sustainability of systems of care. Overall, short- and long-term outcomes for children and youth served in systems of care and their caregivers demonstrate initial improvement after intake into services, and continued improvement over time. Data from the national evaluation of systems of care demonstrate that the system of care communities

- **Reach many children and youth typically underserved by the mental health system**—A majority of children, youth, and families served were persons of color, were largely impacted by poverty, and were dealing with complex issues.
- **Improve outcomes for children and youth**—Among the improved outcomes for children and youth were
  - increased emotional stability,
  - lower levels of depression and anxiety,
  - a decline in suicide attempts,
  - improved school performance,
  - more stable living situations.
- **Enhance family outcomes**—Caregivers' levels of strain associated with caring for their children decreased and caregivers were able to work more days in their employment situations.
- **Expand the availability of effective supports and services**—Children, youth, and families had access to a broad array of services, including assessment and evaluation, a variety of therapies, care management services, and community support services.
- **Reduce exposure to potentially traumatic events**—The percentage of children and youth who were exposed to any potentially traumatic events decreased over time. The greatest reduction in exposure to potentially traumatic events occurred within the first 6 months in system of care services, with smaller changes reported at 18 and 30 months after intake.
- **Save money by reducing the amount spent on inpatient treatment and juvenile justice services**—Within the six communities that provided data, an average estimated reduction of $406 per child or youth served (whose caregivers provided information during their intake and 12-month interviews related to their children's inpatient service use) was achieved for inpatient hospital care during the first 12 months in services. In addition, an estimated reduction of $818 per youth aged 11 and older (who provided information during their intake and 12-month interviews related to their arrest histories), on average, was achieved in relation to arrests during their first 12 months in services.
- **Implement and maintain fidelity to the principles of accessible, community-based services**—The system of care assessment demonstrated that communities are providing accessible and community-based services to support the individualization of service plans.

- **Develop and use successful sustainability strategies**—Communities reported that cultivating strong interagency relationships, establishing a strong family organization, and involving partners in system of care activities were among the most effective general sustainability strategies they had used once CMHI funding was drawing to a close. They also reported that fundraising, using in-kind space donations, and obtaining new or increased local funds were the most effective financing strategies they had used.
- **Promote satisfaction through the use of evidence-based treatments**—Overall, 80 percent of caregivers and 78 percent of youth reported that they were satisfied with the services they received. Caregivers were more likely to report being satisfied if they were told about the evidence that supported the treatments that were being used in services.

References

Abidin, R. (1990). *The Parental Stress Index: Short Form*. Charlottesville, VA: Pediatric Psychology Press.

Achenbach, T., & Rescorla, L. (2000). *Manual for ASEBA Preschool Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Achenbach, T., & Rescorla, L. (2001). *Manual for ASEBA School-Age Forms & Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families.

Agency for Healthcare Research and Quality. (2008). *Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2008.* Rockville, MD: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271–285. doi:10.1037 /0003-066X.61.4.271

Bird, H. R., Shaffer, D., Fisher, P., Gould, M. S., Staghezza, B., Chen, J. Y., & Hoven, C. (1993). The Columbia Impairment Scale (CIS): Pilot findings on a measure of global impairment for children and adolescents. *International Journal of Methods in Psychiatric Research, 3*, 167–176.

Brannan, A., Heflinger, C., & Bickman, L. (1998). The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5*, 212–222. doi: 10.1177/ 106342669700500404

Brunk, M., Koch, J. R., & McCall, B. (2000). *Report on parent satisfaction with services at community services boards*. Richmond, VA: Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services.

Clark, H. B., Deschenes, N., Sieler, D., Green, M. E., White, G., & Sondheimer, D. L. (2008). Services for youth in transition to adulthood in systems of care. In B. A. Stroul & G. M. Blau (Eds.), *The System of Care Handbook* (pp. 25-69). Baltimore, MD: Paul H. Brookes Publishing Co.

Cocozza, J. J., Skowyra, K. R., Burrell, J. L., Dollard, T. P., & Scales, J. P. (2008). Services for youth in the juvenile justice system in systems of care. In B. A. Stroul & G. M. Blau (Eds.), *The System of Care Handbook* (pp. 25-69). Baltimore, MD: Paul H. Brookes Publishing Co.

Eber, L., Sugai, G., Smith, C. R., & Scott, T. M. (2002). Wraparound and positive behavioral interventions and supports in schools. *Journal of Emotional and Behavioral Disorders, 10*(3), 171–180. doi:10.1177 /10634266020100030501

Epstein, M. (2004). *Behavioral and Emotional Rating Scale: A strength-based approach to assessment. Examiner's manual* (2nd ed.). Austin, TX: Pro-Ed.

Epstein, M. H., Nelson, J. R., Trout, A. L., & Mooney, P. (2005). Achievement and emotional disturbance: Academic status and intervention research. In M. H. Epstein, K. Kutash, & A. J. Duchnowski (Eds.), *Outcomes for Children and Youth with Emotional and Behavioral Disorders and their Families: Programs and Evaluation Best Practices* (2nd ed.) (pp. 451–477). Austin, TX: Pro-Ed.

Epstein, M. H., Synhorst, L. L., Cress, C. J., & Allen, E. . (2009). Development and standardization of a test to measure the emotional and behavioral strengths of preschool children. *Journal of Emotional and Behavioral Disorders, 17*(1), 29–37. doi: 10.1177/1063426608317710

Greene, W. H. (1997). *Econometric analysis* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Hawkins, E. H. (2009). A tale of two systems: Co-occurring mental health and substance abuse disorders treatment for adolescents. *Annual Review of Psychology, 60,* 197-227. doi: 10.1146/ annurev.psych.60.110707.163456

Isaacs, M. R., Huang, L. N., Hernandez, M., and Echo-Hawk, H. (2005). *The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health.* Washington, DC: The National Alliance of Multi-Ethnic Behavioral Health Associations.

Kessler, R. C., Berglund, P., Demier, O, Jin, R., Merikangas, K. R., & Walters E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(7), 768. doi: 10.1001/archpsyc.62.7.768

LeBuffe, P. A., & Naglieri, J. A. (1999). *The Devereux Early Childhood Assessment.* Lewisville, NC: Kaplan Press Publishing.

Liang, K.-Y., & Zeger, S. L. (1986). Longitudinal data analysis using generalized lineral models. *Biometrika, 73*(1), 13–22. doi:10.1093/biomet/ 73.1.13

Manteuffel, B., Stephens, R. L., Brashears, F., Krivelyova, A., & Fisher, S. K. (2008). Evaluation results and systems of care: A review. In B. A. Stroul & G. M. Blau (Eds.), *The System of Care Handbook* (pp. 25-69). Baltimore, MD: Paul H. Brookes Publishing Co.

Mullahey, J. (1986). Specification and testing of some modified count data models. *Journal of Econometrics, 33,* 341–365.

National Center on Addiction and Substance Abuse (CASA) at Columbia University. (2004). *Criminal neglect: Substance abuse, juvenile justice and the children left behind*. New York: Author.

Pullmann, M. D., Kerbs, J., Koroloff, N., Veach-White, E., Gaylor, R., & Sieler, D. (2006). Juvenile offenders with mental health needs: Reducing recidivism using wraparound. *Crime and Delinquency, 52*(3), 375-397. doi:10.1177/0011128705278632

Reynolds, C., & Richmond, B. (1978). What I think and feel: A revised measure of children's manifest anxiety. *Journal of Abnormal Psychology, 6*(2), 271–280.

Reynolds, C. R., & Richmond, B. O. (2008). *Revised Children's Manifest Anxiety Scale: Second Edition (RCMAS–2) manual*. Los Angeles, CA: Western Psychological Services.

Reynolds, W. (1986). *Reynolds Adolescent Depression Scale, Second Edition (RADS2)*. Lutz, FL: Psychological Assessment Resources.

Sparrow, S., Carter, A., & Cicchetti, D. (1993) *Vineland Screener: Overview, reliability, validity, administration and scoring*. New Haven, CT: Yale University Child Study Center.

Stroul, B. A. & Friedman, R. M. (1994). A system of care for children and youth with severe emotional disturbances. (Revised edition). Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Titus, J. C., & Dennis, M. L. (2003). *Global Appraisal of Individual Needs–Quick: Administration and Scoring Manual for* *the GAIN-Q (version 2).* Chestnut Health Systems, Lighthouse Institute: Bloomington, IL. Retrieved February 26, 2010, from http://www.chestnut.org/LI/gain/GAIN_Q/GAIN-Q_v2_Instructions_09-07-2005.pdf

U.S. Department of Health and Human Services. (2010, August 3). The HHS poverty guidelines for the remainder of 2010 [Electronic version]. *Federal Register, 75*(148), 45628–45629.

U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. (2012). *National healthcare quality report, 2011* (AHRQ Publication No. 12-0005). Retrieved from http://www.ahrq.gov/qual/nhqr11/nhqr11.pdf

Wagner, M., & Cameto, R. (2004). The characteristics, experiences, and outcomes of youth with emotional disturbances. *National Longitudinal Transition Study 2 (NLTS2) Data Brief, 3*(2). Retrieved from http://www.ncset.org/publications/nlts2/NCSETNLTS2Brief_3.2.pdf

Wagner, M., Kutash, K., Duchnowski, A. J., Epstein, M. H., & Sumi, W. C. (2005). The children and youth we serve: A national picture of the characteristics of students with emotional disturbances receiving special education. *Journal of Emotional and Behavioral Disorders, 13*(2), 79–96. doi: 10.1177/10634266050130020201

Walker, J. S. & Bruns, E. J. (2006). Building on practice-based evidence: Using expert perspectives to define the wraparound process. *Psychiatric Services, 57,* 1579–1585. doi:10.1176/appi.ps.57.11.1579

Wu, P., Hoven, C. W., Liu, X., Fuller, C. J., Fan, B., Musa, G., . . . Cook, J. A. (2008). The relationship between depressive symptom levels and subsequent increases in substance use among youth with severe emotional disturbance. *Journal of Studies on Alcohol and Drugs, 69*(4), 520–527.

ZERO TO THREE. (2005). *Diagnostic classification of mental health and developmental disorders of infancy and early childhood, Revised (DC:0–3R).* Washington, DC: ZERO TO THREE Press.

---

[1] Hereafter, this report uses the term *serious mental health conditions.*

[2] $p < .001$

[3] $p < .001$

[4] $p < .001$

[5] $p < .001$

[6] $p < .001$

[7] $p < .001$

[8] $p < .001$

[9] $p < .01$

[10] $p < .05$

[11] $p < .001$

[12] The cost estimate is provided by the Healthcare Cost and Utilization Project's 2008 Nationwide Inpatient Sample (NIS) of the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2008), and adjusted to 2010 dollars using the September 2010 Bureau of Labor Statistics Consumer Price Index Calculator (http://www.bls.gov/data/inflation_calculator.htm, retrieved September 19, 2011).

[13] The estimated cost comes from 2000 data from the Bureau of Justice Statistics (National Center on Addiction and Substance Abuse, 2004), and adjusted to 2010 dollars using the September 2010 Bureau of Labor statistics Consumer Price Index Calculator (http://www.bls.gov/data/inflation_calculator.htm, retrieved September 19, 2011).

[14] $p < .001$

[15] This report uses the term *serious mental health conditions.*

[16] Throughout this report, the term *child* refers to someone younger than 11 years old, whereas the term *youth* refers to someone 11–21 years old.

[17] No sites were funded in FY 2007.

[18] Interviews for the national evaluation are conducted even if the child or youth has left services.

[19] Being interviewed for the national evaluation is not equivalent to receiving system of care services.

[20] Gender and age data are taken from United States Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Bridged-Race Population Estimates, United States July 1st resident population, compiled from 2000–2009 (Vintage 2009) bridged-race postcensal population estimates, on CDC WONDER On-line Database for the year 2007. Accessed July 13, 2011 at http://wonder.cdc.gov/bridged-race-v2009.html. Race/Ethnicity data taken from U.S. Census Bureau: U.S. population estimates, by age, sex, race and Hispanic origin: Monthly postcensal resident populations, from July 1, 2000 to July 1, 2006 by age, sex, race, and Hispanic origin. Available from http://www.census.gov/popest/ national/asrh/2009-nat-res.html [data for April 1, 2000 and July 1, 2006]. Published in *National Center for Health Statistics Health, United States, 2007 With Chartbook on Trends in the Health of Americans.* Hyattsville, MD: 2007.

[21] Legal custody comparison data is derived from the U.S. Census Bureau: Housing, Household, and Economic Statistics Division. Fertility & Family Statistics Branch. Available from http://www. census.gov/population/www/ socdemo/hh-fam/cps 2010.html. Accessed July 14, 2011.

[22] Poverty categories are based on the U.S. Department of Health and Human Services (HHS) poverty guidelines. The categories take into account calendar year, state, family income, and household size. For example, according to these guidelines, in 2010 a family of four residing in the 48 contiguous states was living in poverty if its income was below $22,050 (HHS, 2010).

[23] Other adults in the household may have been employed.

[24] Based on the DC:0–3R, Axis I.

[25] Based on the *DSM–IV–TR*, Axes I and II.

[26] For several measures, the proportion of children and youth showing statistically significant improvement from intake to individual follow-up periods was determined by using reliable change indicators. To determine whether proportions of children and youth showing each outcome remained stable over time or statistically increased or decreased, generalized estimating equations (GEE) were used. For each of these GEE analyses, the level of statistical significance from these GEE analyses is given in a footnote. Additional information about the data analysis techniques used in this report is in Appendix F.

[27] $p < .001$

[28] $p < .001$

[29] $p < .001$

[30] $p < .001$

[31] $p < .001$

[32] $p < .001$

[33] $p < .001$

[34] $p < .001$

[35] $p < .001$

[36] $p < .001$

[37] $p < .001$

---

[38] $p < .001$
[39] $p < .001$
[40] $p < .001$
[41] $p < .001$
[42] $p < .001$
[43] $p < .001$
[44] $p < .001$
[45] $p < .001$
[46] $p < .001$
[47] $p < .001$
[48] $p < .001$
[49] $p < .001$
[50] $p < .05$
[51] $p < .001$
[52] $p < .01$
[53] $p < .001$
[54] $p < .001$
[55] $p < .001$
[56] $p < .001$
[57] $p < .001$
[58] $p < .001$
[59] $p < .001$ for both questioning and arrest.
[60] $p < .01$ for both questioning and arrest.
[61] $p < .001$
[62] $p < .01$
[63] $p < .05$
[64] $p < .001$
[65] $p < .05$
[66] $p < .001$
[67] $p < .001$
[68] $p < .001$
[69] $p < .001$
[70] $p < .001$
[71] $p < .001$
[72] $p < .05$
[73] $p < .001$
[74] $p < .001$
[75] $p < .001$
[76] $p < .001$
[77] $p < .001$ for both measures.
[78] $p < .001$
[79] $p < .05$
[80] $p < .001$
[81] $p < .001$
[82] $p < .05$
[83] $p < .05$

[84] Follow-up data were not available for children and youth receiving services in communities funded in 2009. Because the first year of funding is a planning year, these communities did not begin providing services and collecting national evaluation data until late 2010 and thus follow-up data were not yet available at the time this report was prepared.

[85] While all 29 communities participated in the national evaluation, not all communities have the services and cost data required to conduct these analyses. Hence, the analysis only included grantees with sufficient data.

[86] Community-based support services include caregiver support/family support, respite care, advocacy, legal service, recreational activity/ recreational therapy, afterschool program or childcare, training/tutoring/education/mentoring, social work service, vocational/life skills training/ independent living skills/youth transition, transportation, child protective service, case evaluation and monitoring, family preservation, adoption service, self-help group/peer counseling/ support group, counseling from clergy, informal transportation.

[87] Community-based mental health services include intake/screening/diagnosis/assessment, evaluation, consultation/meeting, case management/clinical coordination, service planning, crisis intervention/ crisis stabilization/crisis hotline, emergency room psychiatric service, early intervention/prevention, behavioral/therapeutic aide service, medication treatment/administration/monitoring, medical care, physical health care/laboratory related to mental health, day treatment/partial-day treatment, individual therapy/counseling/psycho-social therapy/play therapy, group therapy/group counseling, family therapy/family counseling, psycho-social rehabilitation/cognitive rehabilitation, tribal healing service, diversion/prevention service, court services, parole/aftercare service, probation/ monitoring, Early Head Start program, early intervention (Part C), Head Start program, preschool special education program (Part B), other early care and education programs, special education class, special education resource service, special education inclusion, physical/occupational/speech/hearing/ language service, teacher aide service/other paraprofessional service.

[88] $p < .05$

[89] The cost estimate is provided by the Healthcare Cost and Utilization Project’s 2008 Nationwide Inpatient Sample (NIS) of the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2008), and adjusted to 2010 dollars using the September 2010 Bureau of Labor Statistics Consumer Price Index Calculator

---

(http://www.bls.gov/data/inflation_calculator.htm, retrieved September 19, 2011).

[90] The estimated cost comes from 2000 data from the Bureau of Justice Statistics (National Center on Addiction and Substance Abuse, 2004), and adjusted to 2010 dollars using the September 2010 Bureau of Labor Statistics Consumer Price Index Calculator (http://www.bls.gov/data/inflation_calculator.htm, retrieved September 19, 2011).

Appendices

Appendix A
SAMHSA Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness

Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

2. Trauma and Justice

Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.

3. Military Families

Supporting America 's service men and women—Active Duty, National Guard, Reserve, and Veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.

4. Recovery Support

Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program-, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers.

5. Health Reform

Increasing access to appropriate high-quality prevention, treatment, and recovery services; reducing disparities that currently exist between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and supporting integrated, coordinated care, especially for people with behavioral health and co-occurring health conditions, such as HIV/AIDS.

6. Health Information Technology

Ensuring the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).

7. Data, Outcomes, and Quality

Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.

8. Public Awareness and Support

Increasing the understanding of mental and substance use disorders and the many pathways to recovery to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.

Appendix B
System of Care Communities of the Comprehensive Community Mental Health Services for Children and Their Families Program, 1993-2010

Grants Awarded in 1993 and 1994

Arizona, New Mexico, and Utah: *K'é Project;* Navajo Nation

California: *Children's Systems of Care/California 5;* Riverside, San Mateo, Santa Cruz, Solano, and Ventura Counties

California: *Multiagency Integrated System of Care (MISC);* Santa Barbara County

California: *Sonoma-Napa Comprehensive System of Care;* Sonoma and Napa Counties

Hawaii: *Hawaii 'Ohana Project;* Wai'anae Coast and Leeward Oahu

Illinois: *Community Wraparound Initiative;* Lyons, Riverside, and Proviso Townships

Kansas: *COMCARE;* Sedgwick County

Kansas: *KanFocus;* 13 southeastern counties

Maine: *Wings for Children and Families;* Piscataquis, Hancock, Penobscot, and Washington Counties

Maryland: *East Baltimore Mental Health Partnership;* East Baltimore, Maryland

New Mexico: *Olympia (formerly Doña Ana County Child and Adolescent Collaborative);* Doña Ana County

New York: *Families Reaching in Ever New Directions (FRIENDS);* Mott Haven

North Carolina: *Pitt-Edgecombe-Nash Public-Academic Liaison Project (PEN-PAL);* Pitt, Edgecombe, and Nash Counties

North Dakota: *Partnerships Project;* Minot, Bismarck, and Fargo regions

Ohio: *Stark County Family Council and Southern Consortium;* Stark County and 10 southeastern counties

Oregon: *New Opportunities;* Lane County

Pennsylvania: *South Philadelphia Family Partnership Project;* South Philadelphia

Rhode Island: *Project REACH Rhode Island;* Statewide

South Carolina: *The Village Project;* Charleston and Dorchester Counties

Virginia: *City of Alexandria System of Care;* City of Alexandria

Vermont: *ACCESS;* Statewide

Wisconsin: *Wraparound Milwaukee;* Milwaukee County

Grants Awarded in 1997 and 1998

Alabama: *The Jefferson County Community Partnership;* Jefferson County

California: *Children's Mental Health Services Initiative;* San Diego County

Florida: *Tampa-Hillsborough Integrated Network for Kids (THINK) System;* Hillsborough County

Kentucky: *Kentucky Bridges Project;* 3 Appalachian regions

Maine: *Kmihqitahasultipon ("We Remember") Project;* Passamaquoddy Tribe Indian Township

Michigan: *Mno Bmaadzid Endaad ("Be in good health at his house");* Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Ojibwa Indian Community; Chippewa, Mackinac, and Schoolcraft Counties

Michigan: *Southwest Community Partnership;* Detroit

Missouri: *Partnership With Families;* St. Charles County

Nebraska: *Families First and Foremost;* Lancaster County

Nebraska: *Nebraska Family Central;* 22 central counties

Nevada: *Neighborhood Care Centers;* Clark County

North Carolina: *North Carolina Families and Communities Equal Success (FACES);* Blue Ridge, Cleveland, Guilford, and Sandhills

North Dakota: *Sacred Child Project;* Fort Berthold, Standing Rock, Spirit Lake, and Turtle Mountain Indian reservations

Oregon: *Clackamas Partnership;* Clackamas County

Pennsylvania: *Community Connections for Families;* Allegheny County

Rhode Island: *Project Hope;* Statewide

Texas: *The Children's Partnership;* Travis County

Utah: *Utah Frontiers Project;* Beaver, Carbon, Emery, Garfield, Grand, and Kane Counties

Vermont: *Children's UPstream Services;* Statewide

Washington: *Children and Families in Common;* King County

Washington: *Clark County Children's Mental Health Initiative;* Clark County

Wisconsin: *Northwoods Alliance for Children and Families;* Forest, Langlade, Lincoln, Marathon, Oneida, and Vilas Counties

Wyoming: *With Eagle's Wings;* Wind River Indian Reservation

Grants and Cooperative Agreements Awarded in 1999 and 2000

Alaska: *Yuut Calilriit Ikaiyuquulluteng ("People Working Together") Project;* Delta region of southwest Alaska

Arizona: *Project MATCH (Multi-Agency Team for CHildren);* Pima County

California: *AK-O-NES;* Humboldt and Del Norte Counties

California: *Spirit of Caring Project;* Contra Costa County

Colorado: *Colorado Cornerstone System of Care Initiative;* Denver, Jefferson, Clear Creek, and Gilpin Counties

Delaware: *Families and Communities Together (FACT) Project;* Statewide

Florida: *Family HOPE (Helping Organize Partnerships for Empowerment);* West Palm Beach

Georgia: *KidsNet;* Rockdale and Gwinnett Counties

Indiana: *Circle Around Families;* East Chicago, Gary, and Hammond

Indiana: *Dawn Project;* Marion County

Maryland: *Community Kids;* Montgomery County

Massachusetts: *Worcester Communities of Care;* Worcester

Minnesota: *PACT (Putting All Communities Together) 4 Families Collaborative;* Kandiyohi, Meeker, Renville, and Yellow Medicine Counties

Mississippi: *COMPASS (Children of Mississippi and Their Parents Accessing Strength-Based Services);* Hinds County

New Hampshire: *CARE NH: Community Alliance Reform Effort;* Manchester, Littleton, and Berlin

New Jersey: *Burlington Partnership;* Burlington County

New York: *Westchester Community Network;* Westchester County

North Carolina: *North Carolina System of Care Network;* 11 counties

South Carolina: *Gateways to Success;* Greenwood County

South Dakota: *Nagi Kicopi–Calling the Spirit Back Project;* Oglala Sioux Tribe, Pine Ridge Indian Reservation, Pine Ridge

Tennessee: *Nashville Connection;* Nashville

West Virginia: *Mountain State Family Alliance;* 12 counties

Cooperative Agreements Awarded in 2002, 2003, and 2004

Alaska: *Ch'eghutsen' A System of Care;* Fairbanks Native Association

California: *Glenn County Children's System of Care;* Glenn County

California: *La Familia Sana;* Monterey County

California: *OASIS (Obtaining and Sustaining Independent Success);* Sacramento County

California: *San Francisco Children's System of Care;* San Francisco

California: *Urban Trails;* Oakland

Colorado: *Project BLOOM;* El Paso, Fremont, and Mesa Counties, and the City of Aurora

Connecticut: *Partnership for Kids (PARK) Project;* Statewide

Florida: *One Community Partnership;* Broward County

Guam: *I'Famagu'onta (Our Children);* Territorywide

Idaho: *Building on Each Other's Strengths;* Statewide

Illinois: *System of Care Chicago;* Chicago

Kentucky: *Kentuckians Encouraging Youth to Succeed (KEYS);* Boone, Campbell, Carroll, Gallatin Grant, Kenton, Owen, and Pendleton Counties

Louisiana: *Louisiana Youth Enhanced Services for Children's Mental Health (LA–YES);* Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany Parishes

Missouri: *Show Me Kids;* Barry, Christian, Green, Lawrence, Stone, and Taney Counties

Missouri: *Transitions;* St. Louis County and City

Montana: *Kids Integrated Delivery System for Montana (KIDS fm);* Statewide and Crow Indian Nation

New York: *Families Together in Albany County;* Albany County

New York: *Family Voices Network;* Erie County

New York: *Coordinated Children's Services Initiative (CCSI)/The Family Network;* New York City

Ohio: *Tapestry*, Cuyahoga County

Oklahoma: *Choctaw Nation CARES;* Choctaw Nation of Oklahoma

Oklahoma: *Great Plains Systems of Care;* Beckham, Canadian, Kay, Oklahoma, and Tulsa Counties

Oregon: *Columbia River Wraparound;* Gilliam, Hood River, Sherman, and Wasco Counties

Puerto Rico: *Puerto Rico Mental Health Initiative for Children;* Llorens Torres Housing Project in San Juan and Municipality of Gurabo

South Carolina: *YouthNet;* Chester, Lancaster, and York Counties and Catawba Indian Nation

Texas: *Border Children's Mental Health Collaborative;* El Paso County

Texas: *Community Solutions;* Fort Worth

Washington, District of Columbia: *D.C. Children Inspired Now Gain Strength (D.C. CINGS);* Districtwide

Cooperative Agreements Awarded in 2005 and 2006

Arizona: *Sewa Uusim/Flower Children, Our Hope, Our Light, Our Future;* Pascua Yaqui Tribe of Arizona

Arkansas: *ACTION for Kids (Arkansas Collaborating to Improve Our Network);* Craighead, Lee, Mississippi, and Phillips Counties

California: *Connecting Circles of Care;* Butte County

California: *Seven Generations;* Los Angeles County

California: *About Building Connections for Young Children and Families (Project ABC);* Los Angeles County

California: *Transforming Children's Mental Health Through Community and Parent Partnerships;* Placer County

Connecticut: *Building Blocks for Bright Beginnings;* New London County

Florida: *Sarasota Partnership for Children's Mental Health;* Sarasota County

Hawaii: *Project Ho'omohala (Transition to Adulthood);* Honolulu

Illinois: *McHenry County Family CARE (Child/Adolescent Recovery Experience);* McHenry County

Iowa: *Community Circle of Care;* 10 northeastern counties

Maine: *Thrive: A Trauma-Informed System of Care for Children with Serious Emotional Disturbance in Maine;* Androscoggin, Franklin, and Oxford Counties

Massachusetts: *Central Massachusetts Communities of Care;* Worcester County (excluding the City of Worcester)

Michigan: *Impact;* Ingham County

Michigan: *Kalamazoo Wraps;* Kalamazoo County

Minnesota: *Our Children Succeed Initiative;* Kittson, Mahnomen, Marshall, Norman, Polk, and Red Lake Counties

Minnesota: *System Transformation of Area Resources and Services (STARS);* Benton, Sherburne, Stearns, and Wright Counties

Mississippi: *CommUNITY Cares;* Forrest, Lamar, and Marion Counties

Mississippi: *Circle of H.O.P.E. (Home, Opportunities, Parents and Professionals, Empowerment);* Andrew and Buchanan Counties

Montana: *Blackfeet Po'Ka System of Care;* Blackfeet Reservation

New York: *Monroe County Achieving Culturally Competent and Effective Services and Supports (ACCESS);* Monroe County

North Carolina: *MeckCARES;* Mecklenburg County

Oregon: *Wraparound Oregon: Early Childhood;* Multnomah County

Pennsylvania: *Starting Early Together (SET);* Allegheny County

Pennsylvania: *Beaver County System of Care: Optimizing Resources, Education, and Supports (BC–SCORES);* Beaver County

Rhode Island: *Rhode Island Positive Educational Partnership (PEP);* Statewide

South Dakota: *Tiwahe Wakan (Families as Sacred);* Yankton Sioux Reservation

Tennessee: *Mule Town Family Network;* Maury County

Texas: *Systems of Hope;* Harris County

Wyoming: *Wyoming Support, Access, Growth, and Empowerment (SAGE) Initiative;* Statewide

Cooperative Agreements Awarded in 2008

Delaware: *Delaware's B.E.S.T. (Bringing Evidence-based System-of-Care & Treatment) for Young Children and Their Families;* Statewide

Georgia: *WIN-GA (Wraparound Initiative of Northwest Georgia);* Bartow, Dade, Floyd, Haralson, Paulding, Polk, and Walker Counties

Indiana: *One Community, One Family;* Dearborn, Decatur, Franklin, Jennings, Ohio, Ripley, Rush, and Switzerland Counties

Kentucky: *Kentucky SEED (System to Enhance Early Development);* Statewide

Maryland: *MD CARES (Maryland Crisis and At Risk for Escalation Diversion Services);* Baltimore City

New York: *Tapestry of Chautauqua Initiative;* Chautauqua County

New York: *Nassau County Family Support System of Care;* Nassau County

New York: *Orange County System of Care;* Orange County

North Carolina: *Alamance Alliance for Children and Families;* Alamance County

Oklahoma: *Protecting the Future;* Muscogee (Creek) Nation

Oklahoma: *Oklahoma Systems of Care Statewide Initiative (OSOCSI);* Statewide

Oregon and Washington: *Nak-Nu-Wit;* Clackamas, Multnomah, and Washington Counties, Oregon, and Clark County, Washington

Tennessee: *JustCare Family Network;* Shelby County

Texas: *Hand in Hand: Planting Seeds for Healthy Families;* Hood, Johnson, Palo Pinto, Parker, and Tarrant Counties

Texas*: Rural Children's Initiative;* 11 Panhandle counties

Vermont: *Youth in Transition Project;* Statewide

Washington: *Lummi System of Care;* Lummi Nation

Washington: *Yakima Valley Youth and Family Coalition;* Yakima County

Cooperative Agreements Awarded in 2009 and 2010

Alabama: *East Central Children's Health Collaborative (ECCHCO);* Bulloch, Macon, and Pike Counties

California: *Early Connections;* Alameda County

California: *Project ABC (About Building Connections) Family Network;* Los Angeles County

California: *Urban Trails San Francisco;* San Francisco City and County

Florida: *Families and Communities Empowered for Success (FACES);* Miami-Date County

Florida: *Families and Communities Together in Seminole (FACTS);* Seminole County

Florida: *Jacksonville System of Care Initiative;* Jacksonville

Florida: *Wraparound Orange System of Care;* Orange County

Guam: *Project Kariñu;* Territorywide

Hawaii: *Project Kealahou;* Honolulu County

Idaho: *Madison CARES;* Madison County

Illinois: *ACCESS Initiative;* Champaign County

Illinois: *Project Connect;* Gallatin, Saline, and White Counties

Maryland: *RURAL Crisis and At Risk for Escalation Diversion Services (CARES);* Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties

Massachusetts: *Massachusetts Young Children's Health Interventions for Learning and Development (MYCHILD);* Boston

Michigan: *Community Family Partnership (CFP);* Kent County

Michigan: *Saginaw System of Care;* Saginaw County

Mississippi: *Mississippi Transitional Outreach Program;* Statewide

New Mexico: *Families and Organizations Collaborating for a United System (FOCUS);* Highland Cluster School District in Albuquerque; Grant, Hidalgo, and Luna Counties, and Santa Clara Pueblo

New Mexico: *Mescalero System of Care;* Mescalero Apache Tribe

New York: *ON CARE;* Onondaga County

North Carolina: *Building Every Chance Of Making It Now and Grown-up (BECOMING);* Durham County

Ohio: *FAST TRAC;* Clermont County

Ohio: *Journey to Successful Living (Journey);* Hamilton County

Pennsylvania: *Pennsylvania System of Care Partnership;* 15 counties

Puerto Rico: *Puerto Rico Mental Health Initiative for Children/2 (PR-MHIC/2);* Culebra, Fajardo, and Vieques

South Dakota: *Tiwahe Glu Kini Pi: Bringing the Family Back Together System of Care;* Rosebud Sioux Reservation

Tennessee: *Early Connections Network: Fulfilling the Promise;* Cheatham, Dickson, Montgomery, Robertson, and Sumner Counties

Tennessee: *K-Town Youth Empowerment Network (K-Town);* Knox County

Appendix C
Glossary of Terms

Accessible services: services that are affordable, located nearby, and open during evenings and weekends. Staff are sensitive to and incorporate individual and cultural values. Staff also are sensitive to barriers that may keep a person from getting help. An accessible service can handle consumer demand without placing people on a long waiting list.

Collaborative: draws on the resources of a community, or works in coordination with other programs to provide a range of services, in-house or through interagency agreements.

Community based: the provision of services within close geographical proximity to the targeted community.

Cultural competence: requires systems and organizations to

- have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve;
- incorporate the above in all aspects of policy making, administration, practice, and service delivery;
- involve systematically consumers, key constituencies, and communities.

Evidence-based practice: defined by the American Psychological Association as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006).

Evidence-based practices: *interventions* that have been proven effective through rigorous research methodologies.

Evidence-based treatments: *treatments* that have been proven effective through rigorous research methodologies.

Family-driven care: families have a primary decision-making role in the care of their own children, as well as the policies and procedures governing care for all children in their community, State, tribe, territory, and nation.

Fidelity: the quality or state of adherence. For example, the System of Care Assessment measures the extent to which communities adhere to the system of care model or are faithful in implementation in accordance with the model.

Fiscal year (FY): a term that is used to differentiate a budget year from the calendar year. The Federal fiscal year runs from October 1 of one year through September 30 of the following year. For example, FY 2011 runs from October 1, 2010, through September 30, 2011.

Flexible funds: represent a pool of discretionary funds that all system of care communities are provided to spend specifically on children, youth, and families by purchasing items or services that are not covered by other funds. Flexible funds may be supplied by multiple sources, including CMHI system of care grants.

Individualized services: services designed to meet the unique needs of each child and family.

Interagency: the involvement and partnership of core agencies in multiple child-serving sectors, including child welfare, health, juvenile justice, education, substance abuse, and mental health.

Intersex: Individuals with medically defined biological attributes that are not exclusively male or female; frequently "assigned" a gender at birth, which may differ from their gender identity later in life.

Least restrictive: the priority that services should be delivered in settings that maximize freedom of choice.

Linguistic competence: the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Poverty threshold: based on U.S. Department of Health and Human Services poverty guidelines, which are available for the 50 States.

Practice-based evidence: evidence that is derived from community consensus to support the effectiveness of treatments that are unique to a culture and supportive of cultural traditions (Isaacs, Huang, Hernandez, & Echo-Hawk, 2005).

Serious emotional disturbance: defined in the authorizing legislation, Public Law 102-321, Section 290ff-4 (d)(4) as "a serious emotional disorder, a serious behavioral disorder, or a serious mental disorder."

Serious mental health condition: defined by the CMHI program as

- an emotional, socio-emotional, behavioral, or mental disorder diagnosable under the *DSM–IV–TR* or its *ICD–9–CM* equivalents, or *the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood–Revised* (DC:0–3R);
- a disability in functioning at home, school, or community, or in a combination of these settings; or a level of functioning such that intervention is required that involves two or more community agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;
- the identified disability present for at least 1 year or, on the basis of diagnosis, severity, or multiagency intervention, expected to last longer than 1 year.

Strengths based: the priority that services should attend to the needs and strengths of the child and individual family members.

Sustainability: the ability of a community to maintain the services and infrastructure when CMHI funding ends.

System of care: an organizational philosophy and framework that involves collaboration across agencies, families, and youth for the purpose of improving access and expanding the array of coordinated, community-based, culturally and linguistically competent services and supports for children and youth who are diagnosed with serious mental health conditions and their families.

Transition age: youth transitioning from adolescence to adulthood, defined as young adults aged 16 to 25, and 16 to 21 by CMHI, which includes children and youth from birth to 21 years.

Two-Spirit: a term created in 1990 in Winnipeg during the third annual inter-tribal Native American/First Nations gay and lesbian conference, to describe Native Americans who fulfill one of many mixed gender roles found traditionally among many Native Americans and Canadian First Nations indigenous groups.

Wraparound: “a team-based, collaborative process for developing and implementing individualized care plans for children with severe disorders and their families. . . . The values associated with wraparound specified that care was to be strengths based, culturally competent, and organized around family members’ own perceptions of their needs and goals” (Walker & Bruns, 2006).

Youth-guided care: youth are engaged as equal partners in creating systems change in policies and procedures at the individual, community, State, and national levels, and in making decisions about their own care.

Appendix D
Description of Study Components

Core Components of the National Evaluation

Cross-Sectional 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 CMHI-funded 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.

Longitudinal Child and Family Outcome Study

The primary purpose of the Outcome Study is to assess changes over time among children, youth, 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 unlawful 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 E 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 Outcome Study:

- Enter the CMHI-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 (care 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).
- 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.

Service Experience Study

This study, conducted among the sample of children participating in the Longitudinal Outcome Study, examines whether clients experience services according to system of care principles. To determine whether efforts to develop a system infrastructure that supports service delivery and embodies system of care principles result in changes in how services are provided directly to children, youth, and families, the study assesses intervention fidelity, satisfaction with services, cultural competence of service providers, accessibility and coordination of services, and perceived helpfulness of services. Data are collected from caregivers and youth at all follow-up data collection points if the child and family have received services in the previous 6 months. See Appendix E for detailed descriptions of the instruments used in this study component.

Services and Costs Study

The primary purpose of the Services and Costs Study is to describe the types of services used by children, youth, and families; their patterns of service use; and the costs associated with these services. Additionally, the study explores the relationship among service use, costs, and outcomes. Data on services and costs provide opportunities to demonstrate at the local and national levels how system of care services affect both service outcomes and behavioral and emotional outcomes among those served. This information can be used in the aggregate to track changes in systems of care over time. Such changes include shifts in expenditures and service use patterns (e.g., reductions in use of residential services, increase in family support service use). When services and costs data are available from multiple partner agencies within a system of care community, aggregate data can be used to identify cost-shifting across service sectors (e.g., from juvenile justice to mental health).

Data are submitted by communities via an online tool, where communities can either enter data directly into the system or upload data files that are structured according to the dictionary developed for the national evaluation.

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, youth, 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 E for a detailed description of this assessment tool. Site visits were conducted in communities funded in 2005–2006 every 18 to 24 months, and communities funded in 2008 will receive a maximum of two assessments. Information was collected through a combination of document reviews, review of randomly selected case records, semistructured interviews, observations made onsite, and follow-up telephone interviews to clarify information.

Separate semistructured interview guides were used to collect data from key constituencies at each system of care community, including the project director, representatives from core agencies, family organization representatives, direct service providers, youth coordinators, youth who are being served, 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 care managers and not of the project director. 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 constituent informants were rated separately.

Sustainability Study

The Sustainability Study explores the extent to which systems of care are maintained after funding from the CMHI funding 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 CMHI support. The intent of the study is to learn from the experience of earlier funding recipients in order to assist current and future recipients to maximize the likelihood that their systems of care will be maintained over time.

The study method is primarily built around a Web-based survey completed by key constituencies in graduated sites and those nearing graduation. Hard copies of the survey in English and Spanish are available upon request. Four constituents in each community complete the Web-based survey: the 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 community.

Special Studies of the National Evaluation Active in FY 2011

Evidence-Based Practices Study

The purpose of the Evidence-Based Practice (EBP) Study is to examine the effects of various factors on the implementation of EBP in system of care sites initially funded in 2005 and 2006. The EBP Study includes a multi-level, mixed-method approach to the collection of information from multiple respondent groups within and across communities.

Family and Youth Experiences Substudy (FYES)

For this substudy of the EBP Study, data are collected from participants in the Longitudinal Child and Family Outcome Study at all communities initially funded in 2005 and 2006 regarding their participation in and experience with EBPs. This is accomplished through the Evidence-Based Practices Experience Measure (EBPEM), an addendum to the Multi-Sector Service Contacts–Revised (MSSC–R), which assesses families' perceptions of services provided and their effectiveness in combination with other community-specific measures such as the System of Care Assessment. The instrument is administered every 6 months at Longitudinal Outcome Study follow-up data collection points.

Alumni Networking Study

The Alumni Networking and Collaboration Survey was designed to measure the extent and nature of collaboration among system of care communities by examining how collaboration via the Alumni Network Web site is used as a conduit for sharing and transferring knowledge, resources, and technology to achieve system of care goals. The core research question addressed by the Alumni Networking and Collaboration Survey is *"To what extent and degree do currently and formerly funded system of care communities collaborate?* For this study, *collaboration* was defined as communicating or interacting with each other for the purpose of sharing information or resources, learning from each other, working together in partnership, and similar activities.

The aim of the study was to

- assess the nature and extent of collaboration among currently and formerly funded system of care communities;
- determine the effectiveness of the Alumni Network Web site as a venue for sharing and transferring knowledge, resources, and technology across system of care communities;
- learn how the Alumni Network Web site's activities and features can be improved to facilitate collaboration;
- examine the level of collaboration between system of care communities and program partners as it pertains to technical assistance.

The Alumni Networking and Collaboration Survey was conducted as a Web-based survey and administered to a total of 442 respondents from January through March 2011. The survey was administered to up to three representatives from currently funded sites (e.g., project director/principal investigator, evaluator, lead family representative, youth coordinator) and to the project director or the principal investigator for each previously funded community). For this study, social network analysis (SNA) was applied to assess the extent of community collaboration across previous and currently funded communities.

Appendix E
Measures

Descriptive, Outcome, and Service Experience Study Measures

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 Longitudinal Child and Family Outcome Study, caregivers reported on children's strengths, behavioral and emotional problems, cultural competence of services, caregiver strain, social functioning, educational history, family functioning, stability of the child's living situation, service utilization, and child development. Youth aged 11 or older reported on their behavioral and emotional problems, unlawful behaviors, anxiety, depression, and history of substance use. Both caregivers and youth reported on the child's demographic information, medications, and chronic illnesses, and their satisfaction with services.

Table E-1 provides a summary of the instruments used in each of these studies by domain, and the communities included in this report that are using each measure. Many of these measures also were used to evaluate communities during earlier phases of program funding. See previous *Reports to Congress* for report of findings on earlier cohorts.

Table E-1. National Evaluation Instruments

Domain	Instrument	Initial Funding Date of Communities Using Measure
Cross-Sectional Descriptive Study		
Descriptive characteristics	Enrollment and Demographic Information Form (EDIF)	2005–2006 2008–2009
	Child Information Update Form (CIUF)	2005–2006 2008–2009
Longitudinal Child and Family Outcome Study		
Additional descriptive information: Demographics, medications, chronic illnesses	Caregiver Information Questionnaire (CIQ)	2005–2006
	Caregiver Information Questionnaire, Revised (CIQ–R)	2008–2009
	Youth Information Questionnaire (YIQ)	2005–2006
	Youth Information Questionnaire, Revised (YIQ–R)	2008–2009
Caregiver strain	Caregiver Strain Questionnaire (CGSQ; Brannan et al., 1998)	2005–2006 2008–2009
	Parenting Stress Index (PSI; Abidin, 1990)	2008–2009
Child and youth behavior	Child Behavior Checklist 1½–5 (CBCL 1½–5; Achenbach & Rescorla, 2000)	2005–2006 2008–2009
	Child Behavior Checklist 6–18 (CBCL 6–18; Achenbach & Rescorla, 2001)	2005–2006 2008–2009

Table E-1. Measures (continued)

Domain	Instrument	Initial Funding Date of Communities Using Measure
Child development	Vineland Screener (VS; Sparrow, Carter, & Cicchetti, 1993)	2005–2006
	Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999)	2008–2009
Child and youth social functioning	Columbia Impairment Scale (CIS; Bird et al., 1993)	2005–2006 2008–2009
Child and youth strengths	Behavioral and Emotional Rating Scale—Second Edition, Parent Rating Scale (BERS–2C; Epstein, 2004)	2005–2006 2008–2009
	Behavioral and Emotional Rating Scale—Second Edition, Youth Rating Scale (BERS–2Y; Epstein, 2004)	2005–2006 2008–2009
	Preschool Behavioral and Emotional Rating Scale (PreBERS; Epstein, Synhorst, Cress, & Allen, 2009)	2008–2009
Unlawful behaviors	Delinquency Survey, Revised (DS–R)	2005–2006 2008–2009
Education	Education Questionnaire, Revised (EQ–R)	2005–2006
	Education Questionnaire, Revision 2 (EQ–R2)	2008–2009
Family functioning	Family Life Questionnaire (FLQ)	2005–2006
Stability of living situation	Living Situations Questionnaire (LSQ)	2005–2006 2008–2009
Substance use and dependency	GAIN Quick–R: Substance Problem Scale (GAIN; Titus & Dennis, 2005)	2005–2006 2008–2009
	Substance Use Survey, Revised (SUS–R)	2005–2006 2008–2009
Youth anxiety	Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978)	2005–2006
	Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS–2; Reynolds & Richmond, 2008)	2008–2009
Youth depression	Reynolds Adolescent Depression Scale, Second Edition (RADS–2; Reynolds, 1986)	2005–2006 2008–2009
Service Experience Study		
Cultural competence of services	Cultural Competence and Service Provision Questionnaire (CCSP)	2005–2006
	Cultural Competence and Service Provision Questionnaire, Revised (CCSP–R)	2008–2009
Satisfaction with services	Youth Services Survey (YSS; Brunk, Koch, & McCall., 2000)	2005–2006 2008–2009
	Youth Services Survey for Families (YSS–F, Brunk et al., 2000)	2005–2006 2008–2009
Service use	Multi-Sector Service Contacts, Revised (MSSC–R)	2005–2006 2008–2009

Sustainability Survey

The Sustainability Survey was developed to collect data from graduated sites (post-funding) and sites nearing graduation (including the period when funding is diminished). To reduce response burden and to facilitate data collection, the survey is Web based, and after pilot testing and revision, was first launched in 2003.

The survey is comprised of six sections, including questions about the demographics of the respondent's agency/organization and his or her role and length of involvement with the system of care community, and a budget worksheet that only project directors complete. Most question are in two parts, assessing whether the idea or element was present during different timeframes and to what degree it was effective, using either a 4- (from 1 to 4, where 4 is the highest) or 5-point scale (where 5 is the highest.) The survey items are designed to compare the status of system of care elements—services, principles, goals, maintenance factors, general strategies, and financing strategies—during the CMHI-funded period (described as any time during the funding period prior to the previous 12 months) and during the current period (defined as the previous 12 months). Ratings allow for an assessment of positive or negative changes in status that occurred for each element or section, particularly with the end of the Federal funding period.

The survey is available in English and Spanish. Respondents are provided with instruction and technical assistance and can complete the survey in multiple sittings over the moderate amount of time provided during the data collection period.

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 contain 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 program evaluation. The service delivery domain is comprised of four components that address intake into services, service planning, service provision, and care review. Definitions of the components are provided in Table E–2.

Table E-2. Definition of Service System Components

Infrastructure	
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.

Table E-2. Definition of Service System Components (continued)

Infrastructure (continued)	
Program Evaluation	Program evaluation conducted through the integration of process assessment and outcome measurement, and the use of continuous feedback loops to improve service delivery.
Service Delivery	
Entry into Service System (i.e., Intake)	The processes and activities associated with children, youth, and families' initial contact with the service system, including eligibility determination.
Service Planning	The identification of services for children, youth, 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.
Care Review	Processes and activities related to the formal review of care of individual children and youth to address complex issues and challenging problems, to prevent the use of more restrictive services or settings.

The rows of the framework table are comprised of nine system of care principles: family driven, youth guided, individualized, culturally and linguistically competent, interagency, collaborative and coordinated, accessible, community based, and least restrictive. Definitions of the system of care principles are provided in Table E–3.

Table E-3. Definitions of System of Care Principles

Principle	Definition
Family Driven	The recognition that (1) the ecological context of the family is central to the care of all children; (2) families are primary decision makers and equal partners in all efforts to serve children; and (3) all system and service processes should be planned to maximize family involvement and decision making.
Youth Guided	The recognition that young people have a right to be empowered, educated, and given the opportunity to make decisions about their own care; and about the policies and procedures governing the care of all youth.
Individualized	The provision of care that is expressly child- and youth-centered, that addresses the child or youth's specific needs and that recognizes and incorporates the child or youth's strengths.
Culturally and Linguistically 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, mental health, and substance abuse.
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.

Table E-3. Definitions of System of Care Principles (continued)

Principle	Definition
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?”

Inter-rater 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.

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.

Services and Costs Study

The national evaluation provides a common data structure in which communities can format their electronic data and flexible funds data.

A Services and Costs Data Dictionary outlines a common data file structure and identifies variable names, descriptions, format, length, and category specifications for submitting data on services provided to children and youth, and the costs of those services.

A Flexible Funds Data Dictionary outlines a common data file structure and identifies variable names, descriptions, and category specifications for submitting data on flexible funds used to provide services to children, youth, and families.

Appendix F
Data Analysis Techniques Used in This Report

General Linear Model Repeated Measures Analysis of Variance

The General Linear Model (GLM) Repeated Measures procedure is a type of Analysis of Variance (ANOVA) when the same measurement is made several times on each subject or case. Between-subjects factors can be used to test differences in changes over time by the factors. GLM methods are used with continuous data. Using this GLM procedure, null hypotheses about the effects of both the between-subjects factors and the within-subjects factors can be tested. Interactions between factors as well as the effects of individual factors can also be investigated. In addition, the effects of constant covariates and covariate interactions with the between-subjects factors can be included. For example, a GLM Repeated Measures can be conducted to examine whether changes in the CBCL scores from intake to 6 months to 12 months are significant. Furthermore, one can include an individual-level characteristic like referral source or history of a particular risk factor as a between-subjects factor to analyze the effect of this factor on changes over time.

Generalized Estimating Equations (GEE)

The Generalized Estimating Equations (GEE) technique is a method of parameter estimation for correlated data. GEE methods are used with categorical data. When data are collected on the same units across successive points in time, these repeated observations are correlated over time. If this correlation is not taken into account, the standard errors of the parameter estimates will not be valid and hypothesis testing results will be non-replicable. Liang and Zeger (1986) proposed the GEE approach, which is an extension of generalized linear models (GLM), to estimate the population averaged estimates of categorical variables while accounting for the dependency between the repeated measurements. Specifically, the dependency or correlation between repeated measures is taken into account by robust estimation of the variances of the regression coefficients. In fact, the GEE approach treats the time dependency as a nuisance parameter, and a "working correlation" matrix for the vector of repeated observations from each subject is specified to account for the dependency among the repeated observations. The working correlation is assumed to be the same for all subjects, reflecting average dependence among the repeated observations over subjects. Several working correlation structures can be specified, including independent, exchangeable, autoregressive, and unstructured.

Zero-Inflated Poisson

Zero-inflated Poisson (ZIP) models are used to analyze count data where a large number of outcomes have a value of zero. The zero produced by the data generating process is assumed to be qualitatively different form the positive values. ZIP models allow for "excess zeros" under the assumption that the population is characterized by two regimens, one where members always have zero counts, and one where members have zero or positive counts. The likelihood of being in either regimen is estimated using a binary probability specification, while the counts in the second regimen are estimated using a Poisson specification (Greene, 1997; Mullahey, 1986).

Appendix G
Descriptive, Outcomes, and Service Experience Data Tables

The tables included in this appendix provide an overview of descriptive, outcome, and service experience data for communities funded in 2005–2006 and in 2008–2009.

Data Sources and Sample

The Longitudinal Child and Family Outcome Study of communities initially funded in 2005–2006 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. Children and youth receiving services in communities funded in 2008–2009 will be assessed for up to 24 months. These assessments allow 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. The number of children enrolled in the evaluation is impacted by variation in level and focus of funding as communities may be 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 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 only 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 communities.

Tables G-1 and G-2 present study enrollment and data completion rates through June 11, 2011, for each community initially funded in 2005–2006 and in 2008–2009. In these tables, the Descriptive Sample was based on the number of cases with at least one piece of descriptive information, and the Outcome Sample was based on the number of cases with data from at least one of the required outcome instruments at baseline.

Organization of Data Tables

Table G-3 presents detailed information on the baseline child, youth, and family demographics and enrollment information of children, youth, and families enrolled in communities initially funded in 2005–2006. Table G-4 presents this information for communities initially funded in 2008–2009.

Baseline child and youth history and family characteristics are shown in Table G-5 for children, youth, and families enrolled in communities initially funded in 2005–2006, and in Table G-6 for children, youth, and families receiving services in communities funded in 2008–2009.

Information on child, youth, and family clinical and functional outcome indicators at intake, 6 months, 12 months, 18 months, and 24 months, and service experience (at follow-up only), are presented for children, youth, and families enrolled in communities initially funded in 2005–2006 in Table G-7. Table G-8 presents this information for communities initially funded in 2008–2009. These data tables provide *descriptive* information on each clinical and functional outcome measure at each data collection point and do not represent analysis of change over time. Some children, youth, and families may not have data collected across all data collection points.

Table G-1. Study Enrollment and Program Interview Completion for Communities Initially Funded in 2005-2006

Community	Descriptive Sample[a]	Outcome Sample[b]	Eligible for Interview at Each Assessment Point[c]						Completed Interview at Each Assessment Point[d]						Interview Completion Rate at Each Assessment Point[e]					
			6-Month	12-Month	18-Month	24-Month	30-Month	36 Month	6-Month	12-Month	18-Month	24-Month	30-Month	36-Month	6-Month	12-Month	18-Month	24-Month	30-Month	36-Month
100	297	145	137	109	91	81	62	47	80	50	48	39	24	26	58.4%	45.9%	52.7%	48.1%	38.7%	55.3%
101	206	101	101	97	86	66	46	41	77	64	55	27	23	22	76.2%	66.0%	64.0%	40.9%	50.0%	53.7%
102	421	90	88	79	74	68	60	49	56	42	43	41	39	30	63.6%	53.2%	58.1%	60.3%	65.0%	61.2%
103	443	290	290	266	226	197	168	131	145	96	63	37	32	20	50.0%	36.1%	27.9%	18.8%	19.0%	15.3%
104	452	132	131	120	104	84	53	19	85	52	31	17	5	1	64.9%	43.3%	29.8%	20.2%	9.4%	5.3%
105	246	184	174	158	123	99	81	66	158	123	90	66	58	42	90.8%	77.8%	73.2%	66.7%	71.6%	63.6%
106	529	259	256	223	201	166	115	93	184	144	106	75	48	39	71.9%	64.6%	52.7%	45.2%	41.7%	41.9%
107	161	72	71	65	56	43	31	24	45	34	23	13	9	4	63.4%	52.3%	41.1%	30.2%	29.0%	16.7%
108	1,009	210	200	169	141	114	88	86	77	39	33	28	12	21	38.5%	23.1%	23.4%	24.6%	13.6%	24.4%
109	193	125	121	116	93	76	64	50	73	58	40	25	24	11	60.3%	50.0%	43.0%	32.9%	37.5%	22.0%
110	470	241	240	231	216	194	166	130	196	165	139	121	97	64	81.7%	71.4%	64.4%	62.4%	58.4%	49.2%
111	665	279	268	243	185	157	122	98	180	136	87	61	54	39	67.2%	56.0%	47.0%	38.9%	44.3%	39.8%
112	323	244	243	226	206	176	144	118	167	134	92	65	47	44	68.7%	59.3%	44.7%	36.9%	32.6%	37.3%
113	540	334	324	299	257	217	152	111	254	205	151	132	88	63	78.4%	68.6%	58.8%	60.8%	57.9%	56.8%
114	84	51	51	48	48	44	39	28	42	40	39	29	21	15	82.4%	83.3%	81.3%	65.9%	53.8%	53.6%
115	1,270	259	253	233	203	160	101	74	166	115	98	63	34	19	65.6%	49.4%	48.3%	39.4%	33.7%	25.7%
116	625	331	327	306	281	234	188	143	232	192	174	132	96	70	70.9%	62.7%	61.9%	56.4%	51.1%	49.0%
117	101	71	71	67	63	56	52	42	56	53	45	33	29	23	78.9%	79.1%	71.4%	58.9%	55.8%	54.8%
118	136	98	98	97	85	71	58	34	86	74	58	47	33	14	87.8%	76.3%	68.2%	66.2%	56.9%	41.2%
119	253	101	101	89	65	54	36	23	70	53	40	19	7	1	69.3%	59.6%	61.5%	35.2%	19.4%	4.3%
120	387	142	142	138	123	114	103	78	89	67	53	50	40	25	62.7%	48.6%	43.1%	43.9%	38.8%	32.1%
121	91	34	34	34	30	30	23	14	21	12	8	5	1	1	61.8%	35.3%	26.7%	16.7%	4.3%	7.1%
122	307	227	219	193	171	141	112	87	169	122	107	85	63	46	77.2%	63.2%	62.6%	60.3%	56.3%	52.9%
123	201	95	95	84	78	72	61	54	56	36	32	23	18	14	58.9%	42.9%	41.0%	31.9%	29.5%	25.9%

Table G-1. Study Enrollment and Program Interview Completion for Communities Initially Funded in 2005-2006 (continued)

Community	Descriptive Sample[a]	Outcome Sample[b]	Eligible for Interview at Each Assessment Point[c]						Completed Interview at Each Assessment Point[d]						Interview Completion Rate at Each Assessment Point[e]					
			6-Month	12-Month	18-Month	24-Month	30-Month	36 Month	6-Month	12-Month	18-Month	24-Month	30-Month	36-Month	6-Month	12-Month	18-Month	24-Month	30-Month	36-Month
124	60	39	39	39	39	39	35	23	27	18	11	5	1	0	69.2%	46.2%	28.2%	12.8%	2.9%	0.0%
125	144	14	1	0	0	0	0	0	0	0	0	0	0	0						
126	764	227	184	146	113	85	34	0	96	48	31	19	4	0	52.2%	32.9%	27.4%	22.4%	11.8%	
127	293	113	106	95	75	61	38	24	76	66	52	37	17	10	71.7%	69.5%	60.7%	44.7%	41.7%	60.7%
128	310	195	181	155	125	84	55	38	115	112	80	53	30	20	63.5%	72.3%	63.1%	54.5%	52.6%	63.1%
129	455	269	255	236	156	47	27	16	140	41	25	13	2	0	93.3%	85.6%	83.0%	85.2%	81.3%	83.0%
Aggregated Number[f]	11,436	4,972	4,801	4,361	3,714	3,030	2,314	1,741	3,316	2,552	1,954	1,386	977	697	69.1%	58.5%	52.6%	45.7%	42.2%	40.0%

[a] Descriptive Sample was based on number of cases with at least one piece of descriptive information.

[b] Outcome Sample was based on number of cases with at least one of the required outcome instruments at baseline.

[c] 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 follow-up), 12 months or longer (for 12-month follow-up), 18 months or longer (for 18-month follow-up), 24 months or longer (for 24-month follow-up), 30 months or longer (for 30-month follow-up), or 36 months or longer (for 36-month follow-up); and (b) the child had at least one of the required outcome instruments administered at intake.

[d] 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; (e) 30-month outcome sample: cases with 30-month data on at least one of the required outcome instruments; and (f) 36-month outcome sample: cases with 36-month data on at least one of the required outcome instruments.

[e] 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%

[f] The baseline descriptive and outcome sample numbers reflect the enrollment and data collection efforts of all sites since the beginning of the grant program.

Table G-2. Study Enrollment and Program Interview Completion for Communities Initially Funded in 2008-2009

Community	Descriptive Sample[a]	Outcome Sample[b]	Eligible for Interview at Each Assessment Point[c]				Completed Interview at Each Assessment Point[d]				Interview Completion Rate at Each Assessment Point[e]			
			6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month
130	37	36	22	7			16	4			72.7%	57.1%		
131	153	82	63	20			24	4			38.1%	20.0%		
132	130	33	24	16			7	0			29.2%			
133	279	33	26	8			8	3			30.8%	37.5%		
134	64	11	6	4			3	0			50.0%			
135	22	11	7	5			3	1			42.9%	20.0%		
136	90	45	34	14			21	1			61.8%	7.1%		
137	366	93	69	37			51	24			73.9%	64.9%		
138	192	88	58	22			32	8			55.2%	36.4%		
139	150	24	11	0			1	0			9.1%			
140	188	87	51	29			32	10			62.7%	34.5%		
141	51	24	13	3			9	1			69.2%	33.3%		
142	161	44	33	15			12	3			36.4%	20.0%		
143	53	8	1	0			0	0						
144	63	58	40	27			34	17			85.0%	63.0%		
145	207	72	51	19			33	5			64.7%	26.3%		
146	7	0	0	0			0	0						
147	74	30	24	9			15	0			62.5%			
148	206	0	0	0										
149	9	7	0	0										
150	24	16	2	0										
151	4	3	0	0										
152	41	8	0	0										
155	5	4	0	0										
157	100	60	0	0										
158	33	0	0	0										
159	48	5	0	0										
161	26	0	0	0										
163	20	0	0	0										
164	76	29	0	0										
165	74	4	0	0										
167	42	36	0	0										
Aggregated Number[f]	2,995	951	535	235			301	81			56.5%	34.5%		

---

[a] Descriptive Sample was based on number of cases with at least one piece of descriptive information.

[b] Outcome Sample was based on number of cases with at least one of the required outcome instruments at baseline.

[c] 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 follow-up), 12 months or longer (for 12-month follow-up).

[d] 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;

[e] 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.

[f] The baseline descriptive and outcome sample numbers reflect the enrollment and data collection efforts of all sites since the beginning of the grant program.

Table G-3. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2005-2006

Communities Initially Funded in 2005–2006			
	Overall Sample (*n* = 11,436)	**Descriptive Sample (*n* = 6,455)**	**Outcome Sample (*n* = 4,981)**
Gender	(*n* = 11,341)	(*n* = 6,426)	(*n* = 4,915)
Male	61.7%	60.3%	63.5%
Female	38.3%	39.7%	36.5%
Age in Years	(*n* = 11,285)	(*n* = 6,378)	(*n* = 4,907)
Mean (*SD*)	11.0 (4.7)	11.3 (4.6)	10.6 (4.8)
0–5 Years	17.0%	14.1%	20.7%
6–11 Years	30.0%	31.0%	28.8%
12–15 Years	34.7%	35.2%	34.2%
16 Years or Older	18.2%	19.7%	16.3%
Race and Ethnicity	(*n* = 11,265)	(*n* = 6,380)	(*n* = 4,885)
American Indian or Alaska Native Alone	4.6%	5.4%	3.5%
Asian Alone	1.2%	1.3%	1.0%
Black or African American Alone	20.1%	18.9%	21.7%
Native Hawaiian or Other Pacific Islander Alone	0.5%	0.5%	0.6%
White Alone	49.3%	50.4%	48.0%
Of Hispanic Origin	17.6%	17.3%	17.9%
Multiracial	6.5%	6.0%	7.2%
Other, Single Race	0.2%	0.2%	0.1%
Participating in Service Plan Development[a]	(*n* = 8,739)	(*n* = 4,271)	(*n* = 4,468)
Caregiver	96.5%	96.0%	97.0%
Child	75.9%	81.1%	71.0%
Other Family Member	25.7%	23.2%	28.2%
Care Manager	66.6%	66.1%	67.0%
Therapist	42.8%	41.4%	44.2%
Other Mental Health Staff	19.5%	17.5%	21.5%
Education Staff	15.6%	13.8%	17.3%
Child Welfare Staff	8.7%	8.5%	8.9%
Juvenile Justice	7.2%	7.2%	7.3%
Health Staff	6.3%	7.8%	4.9%
Family Advocate	20.2%	16.8%	23.5%
Other Participant	18.8%	15.0%	22.5%

Table G-3. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006			
	Overall Sample (*n* = 11,436)	**Descriptive Sample (*n* = 6,455)**	**Outcome Sample (*n* = 4,981)**
Referral Sources	(*n* = 11,157)	(*n* = 6,325)	(*n* = 4,832)
Corrections	0.3%	0.4%	0.1%
Juvenile Court	7.1%	6.5%	7.9%
Probation	3.2%	3.5%	3.0%
School	13.7%	13.7%	13.8%
Mental Health Agency, Clinic, Provider	33.8%	34.5%	32.8%
Physical Health Care Agency, Clinic, Provider	3.2%	3.4%	2.9%
Child Welfare	11.6%	11.7%	11.4%
Substance Abuse Agency, Clinic, Provider	0.5%	0.6%	0.4%
Family Court	1.0%	1.2%	0.6%
Caregiver	14.1%	13.2%	15.2%
Self (youth referred himself or herself)	1.8%	1.7%	1.8%
Other	8.8%	9.1%	8.4%
Early Care: Early Head Start Program	0.2%	0.0%	0.3%
Early Care: Head Start Program	0.3%	0.2%	0.4%
Early Care: Early Intervention (Part C)	0.3%	0.1%	0.5%
Early Care: Preschool Special Education Program (Part B)	0.1%	0.0%	0.2%
Other Early Care and Education Programs/Providers	0.1%	0.1%	0.2%
Early Care: Other	0.1%	0.1%	0.1%
Agency Involvement[a]	(*n* = 11,348)	(*n* = 6,431)	(*n* = 4,917)
Corrections	1.3%	1.4%	1.3%
Juvenile Court	13.1%	11.7%	14.9%
Probation	10.8%	10.6%	11.2%
School	66.9%	68.4%	64.9%
Mental Health	69.3%	66.5%	72.9%
Physical Health	27.0%	27.9%	25.7%
Child Welfare	18.1%	17.5%	18.8%
Substance Abuse Clinic	2.9%	3.2%	2.6%
Family Court	5.4%	6.1%	4.5%
Other	12.7%	12.5%	12.9%
Early Care: Early Head Start Program	1.0%	0.6%	1.4%
Early Care: Head Start Program	1.9%	1.5%	2.5%
Early Intervention	0.9%	0.6%	1.3%
Preschool Special Education Program (Part B)	1.1%	0.7%	1.6%
Other Early Care and Education Programs/Providers	2.5%	2.4%	2.6%
Early Care: Other	1.2%	1.1%	1.4%

Table G-3. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006	Overall Sample (*n* = 11,436)	Descriptive Sample (*n* = 6,455)	Outcome Sample (*n* = 4,981)
***DSM–IV–TR* Axis I and II Diagnosis at Intake**[a]	(*n* = 9,378)	(*n* = 5,097)	(*n* = 4,281)
Substance Use Disorders	7.6%	8.2%	6.9%
Schizophrenia and Other Psychotic Disorders	1.8%	2.0%	1.4%
Mood Disorders	36.9%	38.5%	35.1%
Autism and Other Pervasive Developmental Disorders	4.7%	3.9%	5.7%
Anxiety Disorder	11.4%	12.1%	10.6%
Adjustment Disorders	14.1%	15.1%	12.9%
Posttraumatic Stress Disorder and Acute Stress Disorder	8.0%	8.0%	8.1%
Impulse Control Disorders	2.2%	2.1%	2.3%
Oppositional Defiant Disorder	24.4%	24.1%	24.8%
Attention-Deficit/Hyperactivity Disorder (ADHD)	37.6%	37.2%	38.2%
Personality Disorders	1.1%	1.2%	1.0%
Mental Retardation	1.7%	2.0%	1.3%
Learning, Motor Skills, and Communication Disorders	4.2%	4.4%	3.9%
Conduct Disorder	4.2%	4.7%	3.7%
Disruptive Behavior Disorder	7.9%	6.7%	9.4%
Other	8.7%	8.0%	9.6%
V Code	6.6%	6.9%	6.2%
Substance-Induced Disorders	0.5%	0.6%	0.3%
DC:0–3R Axis I Diagnosis at Intake[a]	(*n* = 423)	(*n* = 66)	(*n* = 357)
Posttraumatic Stress Disorder	8.3%	7.6%	8.4%
Deprivation/Maltreatment Disorder	4.3%	7.6%	3.6%
Disorders of Affect	4.7%	6.1%	4.5%
Prolonged Bereavement/Grief Reaction	1.2%	3.0%	0.8%
Anxiety Disorders	10.6%	10.6%	10.6%
Depression	1.4%	1.5%	1.4%
Mixed Disorders of Emotional Expressiveness	3.3%	0.0%	3.9%
Adjustment Disorder	22.5%	15.2%	23.8%
Regulation Disorders of Sensory Processing	8.3%	15.2%	7.0%
Hypersensitive	9.9%	6.1%	10.6%
Hyposensitive/Underresponsive	1.4%	4.5%	0.8%
Sensory Stimulation-Seeking/Impulsive	13.7%	13.6%	13.7%
Sleep Disorders	5.0%	3.0%	5.3%
Feeding Disorders	0.9%	0.0%	1.1%
Disorders of Relating and Communicating	2.8%	3.0%	2.8%
Multi-System Developmental Disorder (MSDD)	3.5%	6.1%	3.1%
Other Disorders	13.7%	12.1%	14.0%

Table G-3. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006			
	Overall Sample (*n* = 11,436)	**Descriptive Sample (*n* = 6,455)**	**Outcome Sample (*n* = 4,981)**
Presenting Problems[a]	(*n* = 10,632)	(*n* = 5,969)	(*n* = 4,663)
Suicide Ideation/Self-Injury	14.5%	15.5%	13.2%
Depression	32.0%	32.8%	31.1%
Anxiety	30.9%	31.5%	30.2%
Hyperactivity/Attention	41.2%	39.6%	43.2%
Conduct/Delinquency	55.1%	54.5%	56.0%
Substance Use	13.9%	13.6%	14.3%
Adjustment	29.4%	29.7%	29.0%
Psychotic Behaviors	4.8%	5.0%	4.5%
Pervasive Development Disability	6.2%	5.1%	7.5%
Specific Development Disability	6.2%	5.2%	7.5%
Learning Disability	13.7%	13.3%	14.2%
School Performance	34.5%	33.1%	36.3%
Eating Disorder	1.9%	1.8%	1.9%
Other	11.8%	11.7%	12.0%
Presenting Problems Relevant for Early Childhood[a b]	(*n* = 2,263)	(*n* = 1,090)	(*n* = 1,173)
Feeding Problems in Young Children	4.9%	3.7%	6.0%
Disruptive Behaviors in Young Children	66.0%	59.7%	71.8%
Persistent Noncompliance	30.7%	29.8%	31.5%
Excessive Crying/Tantrums	31.8%	27.2%	36.0%
Separation Problems	15.4%	15.3%	15.5%
Non-Engagement with People	9.5%	9.2%	9.7%
Sleeping Problems	17.4%	15.3%	19.4%
Excluded from Preschool or Childcare Program	7.9%	7.8%	7.9%
At Risk for or Has Failed Family Home Placement	10.4%	9.4%	11.3%
Maltreatment (child abuse and neglect)	10.8%	11.9%	9.8%
Other Problems That Are Related to Child's Health	4.0%	3.2%	4.8%
Maternal Depression	14.2%	13.1%	15.3%
Maternal Mental Health (other than depression)	12.5%	13.3%	11.7%
Paternal Mental Health	6.5%	6.0%	7.0%
Other Caregiver Mental Health	1.4%	1.5%	1.4%
Maternal Substance Abuse/Use	12.4%	15.2%	9.8%
Paternal Substance Abuse/Use	9.7%	11.1%	8.4%
Other Caregiver Substance Abuse/Use	1.2%	1.7%	0.8%
Family Health Problems	6.3%	6.0%	6.6%
Other Parent/Caregiver/Family Problems	17.5%	18.5%	16.5%
Housing Problems	9.5%	11.1%	7.9%
Other	11.9%	9.9%	13.8%
Financial Resources for Services[a]	(*n* = 10,552)	(*n* = 5,921)	(*n* = 4,631)
Medicaid	71.3%	69.2%	74.0%
Child Health Insurance Program (CHIP)	2.5%	2.7%	2.2%
Supplemental Security Income (SSI)	6.5%	5.1%	8.4%
Temporary Assistance for Needy Families (TANF)	5.8%	4.3%	7.7%
Private Insurance	20.6%	21.3%	19.6%
Other Assistance	11.8%	11.6%	12.2%

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.
[b] Presenting Problems of Early Childhood presents additional presenting problems that are asked only for children younger than 9.

Table G-4. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2008-2009

Communities Initially Funded in 2008–2009			
	Overall Sample (*n* = 2,995)	**Descriptive Sample (*n* = 2,040)**	**Outcome Sample (*n* = 955)**
Gender	(*n* = 2,942)	(*n* = 2,040)	(*n* = 903)
Male	60.5%	58.7%	64.5%
Female	38.2%	39.5%	35.4%
Transgender (male to female)	0.0%	0.0%	0.0%
Transgender (female to male)	0.1%	0.0%	0.1%
Don't Know/Not Sure	1.1%	1.6%	0.0%
Other	0.1%	0.1%	0.0%
Age in Years	(*n* = 2,868)	(*n* = 1,969)	(*n* = 899)
Mean (*SD*)	11.5 (5.4)	11.6 (5.4)	11.1 (5.4)
0–5 Years	23.8%	22.9%	25.8%
6–11 Years	20.1%	19.4%	21.6%
12–15 Years	27.2%	27.1%	27.5%
16–21 Years	28.9%	30.6%	25.1%
Race and Ethnicity	(*n* = 2,826)	(*n* = 1,938)	(*n* = 888)
American Indian or Alaska Native Alone	8.2%	9.0%	6.3%
Asian Alone	0.5%	0.5%	0.3%
Black or African American Alone	22.6%	24.8%	17.7%
Native Hawaiian or Other Pacific Islander Alone	0.0%	0.1%	0.0%
White Alone	50.2%	48.6%	53.7%
Of Hispanic Origin	12.7%	11.6%	15.2%
Multiracial	5.9%	5.5%	6.8%
Participating in Service Plan Development[a]	(*n* = 1,092)	(*n* = 521)	(*n* = 1,613)
Caregiver	79.9%	79.3%	81.2%
Child	76.9%	76.6%	77.7%
Other Family Member	20.8%	17.7%	27.3%
Care Manager	66.2%	65.3%	67.9%
Therapist	48.7%	55.2%	35.1%
Other Mental Health Staff	13.5%	11.4%	17.9%
Education Staff	16.7%	15.4%	19.4%
Child Welfare Staff	11.3%	11.9%	10.0%
Juvenile Justice	4.8%	4.4%	5.8%
Health Staff	0.6%	0.5%	0.6%
Family Advocate	32.5%	24.8%	48.6%
Other Participant	14.9%	12.1%	20.9%

Table G-4. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009			
	Overall Sample (*n* = 2,995)	**Descriptive Sample (*n* = 2,040)**	**Outcome Sample (*n* = 955)**
Referral Sources	(*n* = 2,943)	(*n* = 2,040)	(*n* = 903)
Corrections	0.7%	0.7%	0.8%
Juvenile Court	4.2%	4.0%	4.8%
Probation	2.7%	2.5%	3.0%
School	14.3%	13.7%	15.6%
Mental Health Agency, Clinic, Provider	32.7%	32.3%	33.7%
Physical Health Care Agency, Clinic, Provider	2.8%	3.1%	2.2%
Public Child Welfare	13.7%	14.6%	11.6%
Substance Abuse Agency, Clinic, Provider	0.6%	0.3 %	1.2%
Family Court	0.1%	0.1%	0.1%
Caregiver	8.5%	8.0%	9.6%
Self (youth referred himself or herself)	2.3%	2.1%	2.8%
Other	9.0%	8.8%	9.5%
Early Care: Early Head Start Program	0.2%	0.2%	0.2%
Early Care: Head Start Program	0.5%	0.3%	0.8%
Early Care: Early Intervention (Part C)	0.9%	0.6%	1.7%
Early Care: Preschool Special Education Program (Part B)	0.2%	0.2%	0.1%
Other Early Care and Education Programs, Providers	0.4%	0.4%	0.4%
Other	9.4%	9.5%	9.4%
Not Applicable	0.8%	0.8%	0.1%
Unknown	0.2%	0.1%	0.2%
Missing	4.7%	6.5%	0.8%
Agency Involvement[a]	(*n* = 2,943)	(*n* = 2,040)	(*n* = 903)
Corrections	2.2%	2.4%	2.0%
Juvenile Court	10.3%	10.0%	10.9%
Probation	8.4%	8.2%	8.7%
School	56.3%	56.4%	55.9%
Mental Health agency, clinic, provider	66.1%	66.0%	66.3%
Physical Health Care agency, clinic, provider	19.9%	18.1%	24.1%
Public Child Welfare	25.2%	25.1%	25.5%
Substance Abuse agency, clinic, provider	3.3%	3.3%	3.3%
Family Court	4.1%	4.1%	4.1%
Early Care: Early Head Start Program	1.6%	1.3%	2.2%
Early Care: Head Start Program	2.3%	2.2%	2.7%
Early Care: Early Intervention	1.0%	0.6%	1.9%
Early Care: Preschool Special Education Program (Part B)	1.1%	1.1%	1.1%
Other Early Care and Education Programs/Providers	3.8%	3.6%	4.2%
Other	10.6%	10.7%	10.2%

Table G-4. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009	Overall Sample (*n* = 2,995)	Descriptive Sample (*n* = 2,040)	Outcome Sample (*n* = 955)
***DSM–IV–TR* Axis I and II Diagnosis at Intake[a]**	(*n* = 2,210)	(*n* = 1,500)	(*n* = 710)
Substance Use Disorders	5.6%	5.5%	5.8%
Schizophrenia and Other Psychotic Disorders	2.4%	2.6%	2.1%
Mood Disorders	38.5%	38.9%	37.6%
Pervasive Developmental Disorders	3.8%	3.6%	4.1%
Anxiety Disorders NOT including PTSD or Acute Stress Disorder	7.3%	6.6%	8.7%
Adjustment Disorders	14.1%	14.3%	13.7%
Posttraumatic Stress Disorder and Acute Stress Disorder	10.5%	10.7%	10.0%
Impulse Control Disorders	2.4%	2.5%	2.3%
Oppositional Defiant Disorder	19.0%	18.9%	19.0%
Attention-Deficit/Hyperactivity Disorder (ADHD)	34.6%	33.3%	37.3%
Personality Disorders	2.2%	2.1%	2.4%
Mental Retardation	2.0%	1.9%	2.3%
Learning, Motor Skills, and Communication Disorders	2.4%	2.2%	3.0%
Conduct Disorder	4.7%	5.1%	3.8%
Disruptive Behavior Disorder	9.9%	8.4%	13.0%
Other	9.9%	9.9%	9.9%
V Code (does not include V71.09)	6.0%	6.7%	4.5%
Substance-Induced Disorders	0.2%	0.3%	0.0%
DC:0–3R Axis I Diagnosis at Intake[a]	(*n* = 22)	(*n* = 18)	(*n* = 4)
Posttraumatic Stress Disorder	4.5%	0.0%	25.0%
Disorders of Affect	13.6%	5.6%	50.0%
Anxiety Disorders	4.5%	5.6%	0.0%
Adjustment Disorder	18.2%	22.2%	0.0%
Sensory Stimulation-Seeking/Impulsive	4.5%	5.6%	0.0%
Multi-System Developmental Disorder (MSDD)	4.5%	5.6%	0.0%
Other Disorders	72.7%	77.8%	50.0%
Presenting Problems[a]	(*n* = 2,620)	(*n* = 1,790)	(*n* = 830)
Suicide-Related Problems	18.1%	17.1%	20.2%
Depression-Related Problems	37.1%	36.4%	38.8%
Anxiety-Related Problems	36.9%	35.5%	40.0%
Hyperactivity and Attention-Related Problems	47.4%	46.9%	48.4%
Conduct/Delinquency-Related Problems	53.2%	52.8%	53.9%
Substance Use, Abuse, and Dependence-Related Problems	14.4%	14.7%	13.6%
Adjustment-Related Problems	33.7%	33.2%	34.9%
Psychotic Behaviors	6.9%	7.2%	6.3%
Pervasive Development Disabilities	8.3%	7.5%	9.9%
Specific Development Disabilities	8.9%	7.8%	11.3%
Learning Disabilities	17.1%	16.6%	18.0%
School Performance	36.2%	34.7%	39.4%
Eating Disorders	3.4%	2.8%	4.7%
Gender Identity	0.8%	0.8%	0.8%

Table G-4. Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009			
	Overall Sample (*n* = 2,995)	**Descriptive Sample (*n* = 2,040)**	**Outcome Sample (*n* = 955)**
Presenting Problems Relevant for Early Childhood[a b]	(*n* = 1,958)	(*n* = 1,335)	(*n* = 623)
Feeding Problems in Young Children	0.8%	0.4%	1.6%
Disruptive Behaviors in Young Children	36.9%	33.3%	44.5%
Persistent Noncompliance	31.6%	28.3%	38.7%
Excessive Crying/Tantrums	20.0%	17.8%	24.6%
Separation Problems	13.2%	12.3%	15.2%
Non-Engagement with People	9.9%	10.0%	9.6%
Sleeping Problems	20.4%	18.8%	23.9%
Excluded from Preschool or Childcare Program	2.1%	1.3%	3.7%
At Risk for or Has Failed Family Home Placement	11.0%	11.0%	11.1%
Maltreatment (child abuse and neglect)	16.1%	16.3%	15.7%
Other Problems That Are Related To Child's Health	5.7%	5.2%	6.7%
Maternal Depression	14.7%	14.6%	14.8%
Maternal Mental Health (other than depression)	15.5%	17.2%	11.7%
Paternal Mental Health	9.2%	9.1%	9.3%
Caregiver Mental Health (other than maternal or paternal)	2.9%	2.9%	2.9%
Maternal Substance Abuse/Use	10.6%	10.9%	10.0%
Paternal Substance Abuse/Use	9.4%	9.4%	9.5%
Caregiver Substance Abuse/Use	2.5%	2.8%	1.9%
Family Health Problems	6.8%	6.8%	6.7%
Other Parent/Caregiver/Family Problems	18.7%	17.8%	20.7%
Problems Related to Housing (including homelessness)	9.5%	10.2%	8.0%
Other	20.2%	18.7%	23.4%
Financial Resources for Services[a]	(*n* = 2,388)	(*n* = 1,588)	(*n* = 800)
Medicaid	79.3%	79.4%	79.1%
Child Health Insurance Program (CHIP)	5.1%	4.3%	6.6%
Supplemental Security Income (SSI)	11.1%	10.4%	12.5%
Temporary Assistance for Needy Families (TANF)	5.0%	4.6%	5.8%
Private Insurance	13.3%	12.7%	14.6%
Other Funding	8.8%	8.9%	8.8%

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.
[b] Presenting Problems of Early Childhood presents additional presenting problems that are asked only for children younger than 9.

Table G-5. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2005-2006

Communities Initially Funded in 2005–2006	
	Outcome Sample (*n* = 4,981)
Custody Status	(*n* = 4,733)
Two Parents	30.7%
Biological Mother Only	46.9%
Biological Father Only	4.1%
Adoptive Parents	4.8%
Sibling(s)	0.1%
Aunt and/or Uncle	1.5%
Grandparent(s)	5.5%
Adult Friend	0.1%
Ward of the State	4.3%
Other	2.0%
Living Situation[a]	(*n* = 4,775)
Biological Parent(s)	70.6%
Adoptive Family	4.5%
Relative(s)	15.9%
Non-Family or Foster Care	7.9%
Independent	1.1%
Primary Caregiver Relationship to Child	(*n* = 4,672)
Biological Parent	81.0%
Adoptive Parent	5.9%
Foster Parent	3.5%
Live-In Partner of Parent	0.1%
Sibling	0.3%
Aunt or Uncle	1.6%
Grandparent	6.3%
Cousin	0.1%
Other Relative	0.2%
Adult Friend	0.3%
Other	0.7%
Primary Caregiver Gender	(*n* = 4,745)
Male	8.1%
Female	91.9%
Primary Caregiver Age in Years	(*n* = 4,684)
Mean (*SD*)	38.7 (10.2)
16–25 Years	6.4%
26–30 Years	15.5%
31–35 Years	20.4%
36–40 Years	20.4%
41–45 Years	14.5%
46–50 Years	9.5%
51 Years or Older	13.3%

Table G-5. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006	
	Outcome Sample (*n* = 4,981)
Primary Caregiver Race and Ethnicity	(*n* = 4,727)
American Indian or Alaska Native Alone	4.0%
Asian Alone	0.7%
Black or African American Alone	21.2%
Native Hawaiian or Other Pacific Islander Alone	0.3%
White Alone	56.7%
Of Hispanic Origin	14.8%
Multiracial	2.4%
Other, Single Race	4.0%
Whether Primary Caregiver Employed[b]	(*n* = 4,662)
Yes	44.4%
No	55.6%
Whether Primary Caregiver Paid for Child's Services[b]	(*n* = 4,686)
Yes	18.0%
No	82.0%
Family Income	(*n* = 4,564)
Less Than $5,000	13.5%
$5,000–$9,9999	13.6%
$10,000–$14,000	14.4%
$15,000–$19,999	10.8%
$20,000–$24,999	10.1%
$25,000–$34,999	12.4%
$35,000–$49,999	10.7%
$50,000–$74,999	8.9%
$75,000–$99,999	3.3%
$100,000 and Over	2.3%
Family Poverty Level Status	(*n* = 4,501)
Below Poverty	55.8%
At Poverty	15.8%
Above Poverty	28.4%
Whether Child Uses Medication	(*n* = 4,736)
Yes	53.0%
No	47.0%

Table G-5. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006	
	Outcome Sample (*n* = 4,981)
Current Medications	(*n* = 2,182)
Abilify	14.2%
Adderall	16.6%
Benzodiazepine	0.4%
Carbamazepine	0.5%
Catapres	10.5%
Celexa	5.1%
Klonopin	2.2%
Concerta	16.5%
Depakote	7.6%
Desyrel	3.6%
Dexedrine	0.8%
Effexor	0.6%
Haldol	0.3%
Lexapro	2.6%
Lamictal	4.4%
Lithium	3.1%
Neurontin	0.6%
Orap	0.1%
Paxil	0.8%
Prozac	10.5%
Risperdal	17.5%
Ritalin	6.6%
Seroquel	9.6%
Stratera	6.6%
Symbiax	5.7%
Tenex	3.8%
Trileptal	4.5%
Wellbutrin	0.3%
Xanax	6.3%
Zoloft	1.3%
Zyprexa	26.3%
Other	14.2%
Child Risk Factors	(*n* = 4,477)
None	48.6%
One or More	51.4%
Physical Abuse	21.1% (*n* = 4,497)
Sexual Abuse	14.3% (*n* = 4,375)
Running Away	25.5% (*n* = 4,721)
Attempted Suicide	9.3% (*n* = 4,697)
Substance Abuse	15.9% (*n* = 4,643)

Table G-5. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006	
	Outcome Sample (*n* = 4,981)
Family History of Illness	(*n* = 4,652)
Yes	85.9%
No	14.1%
Depression	71.2% (*n* = 4,552)
Other Mental Illness	49.7% (*n* = 4,524)
Alcohol or Substance Abuse	59.8% (*n* = 4,629)
Recent Caregiver History of Illness[c]	(*n* = 4,616)
Yes	48.6%
No	51.4%
Depression	42.9% (*n* = 4,650)
Other Mental Illness	17.2% (*n* = 4,659)
Alcohol or Substance Abuse	8.3% (*n* = 4,670)
Household Risk Factors	
Domestic Violence	44.6% (*n* = 4,630)
Household Member with Criminal History	34.2% (*n* = 4,639)
Household Member Depression	66.4% (*n* = 4,590)
Household Member Mental Illness	37.0% (*n* = 4,589)
Household Member Substance Abuse	44.5% (*n* = 4,627)
Child Substance Use History[d]	
Number of Substances	(*n* = 2,387)
None	35.8%
One	13.4%
Two	13.2%
Three	16.8%
Four or More	20.8%
Substances Used[e]	
Alcohol	77.2% (*n* = 1,532)
Cigarettes	76.3% (*n* = 1,532)
Chewing Tobacco or Snuff	15.4% (*n* = 1,529)
Marijuana	70.2% (*n* = 1,530)
Cocaine	10.8% (*n* = 1,531)
Hallucinogens	9.2% (*n* = 1,530)
PCP	1.4% (*n* = 1,529)
Ketamine	0.5% (*n* = 1,530)
MDMA (Ecstasy)	9.7% (*n* = 1,531)
GHB	0.2% (*n* = 1,530)
Inhalants	7.8% (*n* = 1,531)
Heroin	1.8% (*n* = 1,531)
Amphetamines/Stimulants	4.6% (*n* = 1,531)
Painkillers	18.3% (*n* = 1,530)
Ritalin, Adderall, Desoxyn	12.6% (*n* = 1,529)
Tranquilizers	6.3% (*n* = 1,529)
Barbiturates/Sedatives	2.0% (*n* = 1,531)
Over-the-Counter/Nonprescription Drugs	10.0% (*n* = 1,531)
Other	4.5% (*n* = 1,533)

Table G-5. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2005-2006 (continued)

Communities Initially Funded in 2005–2006	Outcome Sample (*n* = 4,981)
Child Juvenile Justice Contacts[d]	
Lifetime Contacts	(*n* = 2,400)
None	40.3%
One or More	59.7%
Recent Contacts[b]	
Questioned by Police	24.2% (*n* = 2,391)
Arrested	21.0% (*n* = 2,389)
Told to Appear in Court	23.1% (*n* = 2,386)
Convicted of a Crime	14.0% (*n* = 2,392)
On Probation	30.1% (*n* = 2,396)
Sentenced to Secure Facility	11.5% (*n* = 2,391)

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.
[b] Information pertains to the 6 months prior to intake.
[c] Caregiver with a history of illness who provided care or supervision in the 6 months prior to intake.
[d] Drug use history and juvenile justice contacts obtained only for children 11 years and older.
[e] Percentages for each substance are based on the number of adolescents who reported any substance use history. Youth may report using more than one substance; therefore, percentages may sum to more than 100%.

Table G-6. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2008-2009

Communities Initially Funded in 2008–2009	
	Outcome Sample (*n* = 955)
Custody Status	(*n* = 818)
Two Parents or One Biological Parent and One Step or Adoptive Parent	30.1%
Biological Mother Only	41.1%
Biological Father Only	5.1%
Adoptive Parent(s)	6.2%
Sibling(s)	0.2%
Aunt and/or Uncle	1.8%
Grandparent(s)	7.2%
Adult Friend	0.4%
Ward of the State	4.9%
Other	2.9%
Living Situation[a]	(*n* = 911)
Biological Family	62.7%
Adoptive Family	5.8%
Non- Parent Relative(s)	19.3%
Non-Relative	7.7%
Independent	4.5%
Primary Caregiver Relationship to Child	(*n* = 813)
Biological Parent	76.1%
Adoptive/Step-Parent	8.1%
Foster Parent	2.6%
Sibling	0.1%
Aunt or Uncle	1.8%
Grandparent	9.1%
Cousin	0.5%
Other Family Relative	0.6%
Adult Friend	0.4%
Other	0.6%
Primary Caregiver Gender	(*n* = 821)
Male	8.9%
Female	91.1%
Primary Caregiver Age in Years	(*n* = 817)
Mean (*SD*)	39.5 (10.3)
16–25 Years	7.6%
26–30 Years	13.6%
31–35 Years	19.1%
36–40 Years	18.8%
41–45 Years	13.2%
46–50 Years	11.6%
51 Years or Older	16.1%

Table G-6. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009	
	Outcome Sample (*n* = 955)
Primary Caregiver Race and Ethnicity	(*n* = 818)
American Indian or Alaska Native Only	5.6%
Asian Only	0.1%
Black or African American Only	16.7%
Native Hawaiian or Other Pacific Islander Only	0.4%
White Only	59.5%
Of Hispanic Origin	12.6%
Multiracial	5.0%
Whether Primary Caregiver Employed[b]	(*n* = 822)
Yes	50.9%
No	48.1%
Whether Primary Caregiver Paid for Child's Services[b]	(*n* = 821)
Yes	46.0%
No	54.0%
Family Income	(*n* = 790)
Less Than $5,000	16.7%
$5,000–$9,9999	11.6%
$10,000–$14,000	15.2%
$15,000–$19,999	9.5%
$20,000–$24,999	11.6%
$25,000–$34,999	11.1%
$35,000–$49,999	9.5%
$50,000–$74,999	7.8%
$75,000–$99,999	3.5%
$100,000 and Over	3.3%
Family Poverty Level Status	(*n* = 446)
Below Poverty	58.1%
At/Near Poverty	15.5%
Above Poverty	26.5%
Whether Child Uses Medication	(*n* = 822)
Yes	54.7%
No	45.3%

Table G-6. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009	
	Outcome Sample (*n* = 955)
Current Medications	(*n* = 432)
Abilify	19.4%
Adderall	15.0%
Catapres	10.2%
Celexa	8.1%
Concerta	16.0%
Daytrana	1.2%
Depakote	9.0%
Desyrel	5.8%
Dexedrine	1.9%
Effexor	1.2 %
Eskalith	0.9%
Focalin	5.8%
Geodon	5.8%
Haldol	0.9%
Klonopin	1.4%
Lamictal	7.9%
Lexapro	4.2 %
Lithobid	1.6%
Lithonate	2.3%
Metadate	1.6%
Neurontin	0.5%
Paxil	1.6%
Prozac	7.6%
Remeron	0.9%
Risperdal	25.0%
Ritalin	4.4%
Seroquel	10.4%
Strattera	7.6%
Symbyax	0.5%
Tegretol	0.9%
Tenex	8.1%
Topamax	3.7%
Trileptal	3.0%
Vyvanse	10.6%
Wellbutrin	5.3%
Xanax	0.2%
Zoloft	7.4%
Zyprexa	3.7%
Other	15.5%

Table G-6. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009	
	Outcome Sample (*n* = 955)
Child Risk Factors	(*n* = 809)
None	40.9%
One or More	59.1%
Physical Abuse	29.3% (*n* = 803)
Sexual Abuse	16.2% (*n* = 803)
Running Away	28.0% (*n* = 822)
Attempted Suicide	14.1% (*n* = 818)
Substance Abuse	15.6% (*n* = 815)
Family History of Illness	(*n* = 798)
Yes	88.0%
No	12.0%
Depression	72.1% (*n* = 789)
Other Mental Illness	55.2% (*n* = 776)
Alcohol or Substance Abuse	61.9% (*n* = 793)
Recent Caregiver History of Illness[c]	(*n* = 810)
Yes	51.6%
No	48.4%
Depression	44.8% (*n* = 817)
Other Mental Illness	18.8% (*n* = 810)
Alcohol or Substance Abuse	8.0% (*n* = 814)
Household Risk Factors	
Domestic Violence	44.4% (*n* = 807)
Household Member with Criminal History	36.4% (*n* = 806)
Household Member Depression	68.5% (*n* = 810)
Household Member Mental Illness	41.9% (*n* = 801)
Household Member Substance Abuse	47.8% (*n* = 809)

Table G-6. Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Initially Funded in 2008-2009 (continued)

Communities Initially Funded in 2008–2009	
	Outcome Sample (*n* = 955)
Child Substance Use History[d]	
Number of Substances	(*n* = 450)
None	31.8%
One	14.9%
Two	9.8%
Three	9.8%
Four or More	33.8%
Substances Used[e]	
Alcohol	78.0% (*n* = 304)
Cigarettes	77.2% (*n* = 302)
Chewing Tobacco or Snuff	30.5% (*n* = 302)
Marijuana or Hashish	69.6% (*n* = 303)
Cocaine	16.2% (*n* = 302)
Hallucinogens	18.9% (*n* = 302)
PCP	5.0% (*n* = 303)
Ketamine	0.7% (*n* = 303)
MDMA (Ecstasy)	17.5% (*n* = 303)
GHB	0.3% (*n* = 301)
Inhalants	13.9% (*n* = 303)
Heroin	4.0% (*n* = 303)
Methamphetamine, crystal, ice, glass, or other form of methedrine	6.9% (*n* = 303)
Painkillers	31.0% (*n* = 303)
Ritalin, Adderall, Desoxyn	18.8% (*n* = 303)
Tranquilizers or anti-anxiety drugs	14.2% (*n* = 303)
Barbiturates/Sedatives	6.6% (*n* = 303)
Over-the-Counter/Nonprescription Drugs	13.5% (*n* = 303)
Other	5.3% (*n* = 304)
Child Juvenile Justice Contacts[d]	
Lifetime Contacts	(*n* = 449)
None	45.2%
One or More	54.8%
Recent Contacts[b]	
Questioned by Police	19.9% (*n* = 328)
Arrested	21.5% (*n* = 448)
Appeared in Court	21.5% (*n* = 448)
Convicted of a Crime	12.6% (*n* = 446)
On Probation	19.7% (*n* = 447)

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.
[b] Information pertains to the 6 months prior to intake.
[c] Caregiver with a history of illness who provided care or supervision in the 6 months prior to intake.
[d] Drug use history and juvenile justice contacts obtained only for children 11 years and older.
[e] Percentages for each substance are based on the number of adolescents who reported any substance use history. Youth may report using more than one substance; therefore, percentages may sum to more than 100%.

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006

Communities Funded in 2005–2006							
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)	30 Months Mean (*SD*)	36 Months Mean (*SD*)
Child Behavior Checklist 1½–5 (CBCL 1½–5)							
Emotionally Reactive	64.9 (11.1) (*n* = 909)	62.7 (11.0) (*n* = 561)	61.9 (10.7) (*n* = 352)	61.6 (10.8) (*n* = 198)	61.2 (10.4) (*n* = 109)	58.3 (9.8) (*n* = 66)	61.7 (13.0) (*n* = 33)
Sleep Problems	61.1 (11.8) (*n* = 909)	59.2 (10.8) (*n* = 561)	58.9 (11.1) (*n* = 352)	58.8 (10.5) (*n* = 198)	58.8 (11.1) (*n* = 109)	56.0 (8.9) (*n* = 66)	59.0 (10.5) (*n* = 33)
Withdrawn	63.5 (10.3) (*n* = 909)	61.3 (9.7) (*n* = 561)	60.7 (9.8) (*n* = 352)	60.3 (9.8) (*n* = 198)	59.1 (9.7) (*n* = 109)	57.2 (7.8) (*n* = 66)	57.3 (10.4) (*n* = 33)
Somatic Complaints	58.5 (8.4) (*n* = 909)	56.9 (7.9) (*n* = 561)	56.6 (8.1) (*n* = 352)	56.7 (7.7) (*n* = 198)	56.9 (7.9) (*n* = 109)	54.0 (6.4) (*n* = 66)	56.5 (7.6) (*n* = 33)
Anxious/Depressed	62.0 (10.4) (*n* = 909)	59.9 (10.1) (*n* = 561)	59.1 (9.2) (*n* = 352)	59.6 (9.4) (*n* = 198)	58.1 (8.1) (*n* = 109)	57.0 (8.8) (*n* = 66)	58.8 (10.0) (*n* = 33)
Attention Problems	63.3 (9.2) (*n* = 909)	61.6 (9.1) (*n* = 561)	60.5 (8.8) (*n* = 352)	60.6 (9.1) (*n* = 198)	60.8 (9.4) (*n* = 109)	56.7 (7.9) (*n* = 66)	59.6 (10.2) (*n* = 33)
Aggressive Problems	69.6 (13.3) (*n* = 909)	65.6 (12.8) (*n* = 557)	64.1 (12.8) (*n* = 350)	63.5 (12.8) (*n* = 197)	63.8 (12.8) (*n* = 108)	59.6 (13.0) (*n* = 65)	61.6 (13.0) (*n* = 31)
Internalizing Problems	63.4 (10.2) (*n* = 909)	60.2 (11.5) (*n* = 561)	59.1 (11.8) (*n* = 352)	58.9 (12.3) (*n* = 198)	58.1 (11.7) (*n* = 109)	54.4 (11.2) (*n* = 66)	55.9 (14.8) (*n* = 33)
Externalizing Problems	67.7 (12.6) (*n* = 909)	63.8 (13.0) (*n* = 561)	61.9 (13.1) (*n* = 352)	61.1 (14) (*n* = 198)	61.1 (14.5) (*n* = 109)	55.8 (14.4) (*n* = 66)	57.5 (16.4) (*n* = 33)
Total Problems	**66.6 (11.2)** **(*n* = 909)**	**62.8 (12.2)** **(*n* = 561)**	**61.5 (12.5)** **(*n* = 352)**	**60.7 (13.4)** **(*n* = 198)**	**59.9 (13.3)** **(*n* = 109)**	**55.1 (12.8)** **(*n* = 66)**	**57.3 (16.1)** **(*n* = 33)**
At/Above Clinical Level (Total Problems)	**61.4%** **(*n* = 909)**	**49.6%** **(*n* = 561)**	**44.0%** **(*n* = 352)**	**44.4%** **(*n* = 198)**	**45.9%** **(*n* = 109)**	**24.2%** **(*n* = 66)**	**36.4%** **(*n* = 33)**

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)	30 Months Mean (*SD*)	36 Months Mean (*SD*)
Child Behavior Checklist 6–18 (CBCL 6–18)							
Activities Competence	36.1 (9.5) (*n* = 3,664)	35.7 (9.4) (*n* = 2,525)	35.6 (9.7) (*n* = 2,033)	35.8 (10.0) (*n* = 1,572)	35.6 (9.8) (*n* = 1,158)	35.8 (9.6) (*n* = 804)	35.8 (9.6) (*n* = 590)
Social Competence	37.7 (9.0) (*n* = 3,595)	38.5 (9.1) (*n* = 2,480)	38.4 (9.0) (*n* = 1,989)	38.9 (8.7) (*n* = 1,540)	38.9 (8.6) (*n* = 1,141)	39.1 (8.5) (*n* = 792)	38.7 (8.6) (*n* = 579)
School Competence	37.7 (8.9) (*n* = 3,340)	38.8 (8.9) (*n* = 2,286)	39.2 (9.0) (*n* = 1,818)	39.0 (9.2) (*n* = 1,414)	39.1 (8.8) (*n* = 992)	39.3 (8.9) (*n* = 694)	39.1 (8.9) (*n* = 481)
Total Competence	32.0 (8.6) (*n* = 3,234)	32.6 (8.9) (*n* = 2,218)	32.7 (9.1) (*n* = 1,772)	32.9 (9.3) (*n* = 1,373)	32.9 (8.9) (*n* = 978)	33.4 (8.9) (*n* = 676)	33.5 (9.6) (*n* = 472)
Anxious/Depressed	64.6 (10.8) (*n* = 3,713)	62.1 (10.3) (*n* = 2,562)	61.6 (10.1) (*n* = 2,050)	60.7 (10.0) (*n* = 1,601)	60.4 (9.9) (*n* = 1,171)	59.7 (9.4) (*n* = 821)	59.7 (9.5) (*n* = 599)
Withdrawn	65.2 (10.1) (*n* = 3,713)	63.3 (9.9) (*n* = 2,562)	62.4 (9.7) (*n* = 2,050)	61.7 (9.6) (*n* = 1,601)	61.5 (9.6) (*n* = 1,171)	60.7 (9.0) (*n* = 821)	60.6 (9.2) (*n* = 599)
Somatic Complaints	61.0 (9.3) (*n* = 3,713)	59.5 (8.9) (*n* = 2,562)	59.0 (8.9) (*n* = 2,050)	58.6 (8.8) (*n* = 1,601)	58.5 (8.8) (*n* = 1,171)	58.2 (8.7) (*n* = 821)	58.2 (8.4) (*n* = 599)
Social Problems	65.5 (9.8) (*n* = 3,713)	63.9 (9.8) (*n* = 2,562)	63.4 (9.9) (*n* = 2,050)	62.8 (9.9) (*n* = 1,601)	62.6 (9.6) (*n* = 1,171)	61.9 (9.4) (*n* = 821)	61.6 (9.3) (*n* = 599)
Thought Problems	66.8 (10.2) (*n* = 3,713)	64.7 (10.1) (*n* = 2,562)	63.8 (10.2) (*n* = 2,050)	63.0 (10.3) (*n* = 1,601)	63.0 (10.3) (*n* = 1,171)	62.1 (10.0) (*n* = 821)	61.6 (10.0) (*n* = 599)
Attention Problems	67.5 (10.8) (*n* = 3,713)	65.2 (10.3) (*n* = 2,562)	64.8 (10.6) (*n* = 2,050)	63.7 (10.1) (*n* = 1,601)	63.7 (10.3) (*n* = 1,171)	63.4 (10.2) (*n* = 821)	62.9 (9.6) (*n* = 599)
Rule-Breaking Behavior	67.0 (9.0) (*n* = 3,713)	65.2 (9.2) (*n* = 2,562)	64.4 (9.0) (*n* = 2,050)	63.4 (8.8) (*n* = 1,601)	63.2 (8.8) (*n* = 1,171)	62.9 (9.0) (*n* = 821)	62.9 (8.9) (*n* = 599)
Aggressive Behavior	71.1 (12.3) (*n* = 3,713)	68.4 (12.0) (*n* = 2,562)	67.4 (12.0) (*n* = 2,050)	66.3 (12.0) (*n* = 1,601)	65.9 (11.6) (*n* = 1,171)	65.6 (11.9) (*n* = 821)	64.9 (11.5) (*n* = 599)
Internalizing	64.5 (10.6) (*n* = 3,713)	61.9 (11.1) (*n* = 2,562)	60.7 (11.9) (*n* = 2,050)	59.7 (11.9) (*n* = 1,601)	59.4 (12.0) (*n* = 1,171)	58.6 (11.8) (*n* = 821)	58.6 (11.7) (*n* = 599)
Externalizing	68.9 (10.1) (*n* = 3,713)	66.6 (10.5) (*n* = 2,562)	65.5 (11.1) (*n* = 2,050)	64.1 (11.5) (*n* = 1,601)	63.9 (11.2) (*n* = 1,171)	63.6 (11.6) (*n* = 821)	63.2 (11.2) (*n* = 599)
Total Problems	**68.6 (9.8) (*n* = 3,713)**	**66.1 (10.6) (*n* = 2,562)**	**64.8 (11.6) (*n* = 2,050)**	**63.6 (12.0) (*n* = 1,601)**	**63.4 (12.1) (*n* = 1,171)**	**62.7 (12.1) (*n* = 821)**	**62.3 (12.0) (*n* = 599)**
At/Above Clinical Level (Total Problems)	**75.4% (*n* = 3,713)**	**66.1% (*n* = 2,562)**	**63.1% (*n* = 2,050)**	**58.0% (*n* = 1,601)**	**58.5% (*n* = 1,171)**	**55.1% (*n* = 821)**	**52.1% (*n* = 599)**

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

Communities Funded in 2005–2006							
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)	30 Months Mean (*SD*)	36 Months Mean (*SD*)
Behavioral and Emotional Rating Scale–2, Caregiver (BERS–2C)							
Intrapersonal Strengths	7.7 (3.3) (*n* = 3,961)	8.1 (3.4) (*n* = 2,759)	8.3 (3.3) (*n* = 2,183)	8.4 (3.4) (*n* = 1,676)	8.5 (3.3) (*n* = 1,213)	8.7 (3.4) (*n* = 855)	9.0 (3.4) (*n* = 623)
Interpersonal Strengths	6.6 (3.0) (*n* = 3,978)	7.2 (3.1) (*n* = 2,767)	7.3 (3.0) (*n* = 2,186)	7.5 (3.1) (*n* = 1,682)	7.6 (3.1) (*n* = 1,215)	7.7 (3.1) (*n* = 856)	8.0 (3.1) (*n* = 623)
School Functioning	6.6 (3.0) (*n* = 3,737)	7.1 (3.0) (*n* = 2,582)	7.3 (3.0) (*n* = 2,067)	7.5 (3.1) (*n* = 1,579)	7.6 (3.1) (*n* = 1,129)	7.7 (3.2) (*n* = 784)	7.8 (3.3) (*n* = 554)
Family Involvement	7.1 (2.8) (*n* = 3,980)	7.4 (2.8) (*n* = 2,767)	7.5 (2.8) (*n* = 2,183)	7.7 (2.9) (*n* = 1,682)	7.8 (3.0) (*n* = 1,216)	7.8 (2.9) (*n* = 856)	7.8 (3.0) (*n* = 623)
Affective Strengths	8.1 (3.1) (*n* = 3,987)	8.4 (3.1) (*n* = 2,769)	8.4 (3.0) (*n* = 2,191)	8.5 (3.0) (*n* = 1,683)	8.6 (3.1) (*n* = 1,217)	8.8 (3.1) (*n* = 856)	8.8 (3.1) (*n* = 623)
Career Strengths	8.8 (3.6) (*n* = 3,309)	9.0 (3.6) (*n* = 2,365)	9.1 (3.6) (*n* = 1,856)	9.2 (3.5) (*n* = 1,433)	9.3 (3.6) (*n* = 1,024)	9.5 (3.6) (*n* = 702)	9.3 (3.6) (*n* = 522)
Strengths Quotient	**80.8 (16.9) (*n* = 3,717)**	**83.9 (17.7) (*n* = 2,573)**	**84.7 (17.4) (*n* = 2,053)**	**86.0 (17.8) (*n* = 1,574)**	**86.7 (18.2) (*n* = 1,124)**	**87.3 (18.3) (*n* = 782)**	**88.5 (18.2) (*n* = 554)**
Behavioral and Emotional Rating Scale–2, Youth (BERS–2Y)							
Intrapersonal Strengths	9.3 (3.0) (*n* = 2,456)	9.5 (3.0) (*n* = 1,661)	9.6 (3.1) (*n* = 1,321)	9.8 (2.9) (*n* = 1,076)	10.0 (3.0) (*n* = 765)	10.1 (3.0) (*n* = 569)	10.2 (3.0) (*n* = 423)
Interpersonal Strengths	8.5 (3.3) (*n* = 2,454)	9.0 (3.4) (*n* = 1,658)	9.1 (3.3) (*n* = 1,320)	9.4 (3.4) (*n* = 1,076)	9.6 (3.5) (*n* = 765)	9.8 (3.5) (*n* = 569)	9.7 (3.4) (*n* = 423)
School Functioning	8.3 (3.0) (*n* = 2,405)	8.7 (3.0) (*n* = 1,602)	8.8 (3.1) (*n* = 1,260)	9.1 (3.1) (*n* = 1,011)	9.1 (3.2) (*n* = 710)	9.3 (3.1) (*n* = 503)	9.3 (3.2) (*n* = 370)
Family Involvement	8.7 (2.9) (*n* = 2,456)	9.1 (3.0) (*n* = 1,659)	9.1 (2.9) (*n* = 1,322)	9.4 (2.9) (*n* = 1,075)	9.5 (2.9) (*n* = 765)	9.5 (2.9) (*n* = 568)	9.7 (3.0) (*n* = 423)
Affective Strengths	9.7 (3.0) (*n* = 2,461)	10.0 (3.1) (*n* = 1,660)	10.1 (3.0) (*n* = 1,321)	10.3 (2.9) (*n* = 1,077)	10.5 (2.9) (*n* = 765)	10.7 (2.9) (*n* = 569)	10.7 (2.9) (*n* = 423)
Career Strengths	9.5 (2.9) (*n* = 2,348)	9.7 (2.9) (*n* = 1,613)	9.8 (2.8) (*n* = 1,283)	9.8 (2.8) (*n* = 1,046)	9.9 (2.8) (*n* = 746)	9.9 (2.8) (*n* = 550)	9.7 (2.9) (*n* = 411)
Strengths Quotient	**92.3 (16.7) (*n* = 2,399)**	**94.9 (17.4) (*n* = 1,598)**	**95.4 (17.4) (*n* = 1,257)**	**97.3 (17.1) (*n* = 1,010)**	**98.2 (17.4) (*n* = 710)**	**99.2 (17.5) (*n* = 503)**	**99.5 (17.6) (*n* = 369)**

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)	30 Months Mean (*SD*)	36 Months Mean (*SD*)
Columbia Impairment Scale (CIS)							
Overall Level of Impairment	**21.8 (10.4) (*n* = 4,485)**	**19.2 (10.3) (*n* = 3,037)**	**18.5 (10.8) (*n* = 2,372)**	**17.4 (10.6) (*n* = 1,795)**	**17.3 (10.6) (*n* = 1,279)**	**16.9 (10.5) (*n* = 896)**	**16.5 (10.3) (*n* = 639)**
At/Above Clinical Level	**73.0%**	**63.6%**	**60.2%**	**57.9%**	**57.9%**	**55.4%**	**54.6%**
Revised Children's Manifest Anxiety Scale (RCMAS)							
Worry/Oversensitivity	10.1 (3.5) (*n* = 2,435)	9.7 (3.5) (*n* = 1,641)	9.4 (3.6) (*n* = 1,313)	9.2 (3.5) (*n* = 1,067)	9.1 (3.6) (*n* = 759)	9.0 (3.4) (*n* = 569)	9.1 (3.6) (*n* = 420)
Social Concerns/Concentration	11.0 (3.3) (*n* = 2,319)	10.4 (3.3) (*n* = 1,543)	10.2 (3.3) (*n* = 1,239)	9.9 (3.4) (*n* = 983)	9.7 (3.4) (*n* = 697)	9.7 (3.4) (*n* = 505)	9.5 (3.4) (*n* = 374)
Physiological Anxiety	11.3 (3.4) (*n* = 2,440)	10.8 (3.4) (*n* = 1,646)	10.6 (3.5) (*n* = 1,315)	10.4 (3.6) (*n* = 1,068)	10.2 (3.6) (*n* = 759)	10.1 (3.4) (*n* = 569)	10.2 (3.6) (*n* = 422)
Total Anxiety	**54.5 (12.0) (*n* = 2,426)**	**52.4 (12.3) (*n* = 1,629)**	**51.5 (13.1) (*n* = 1,307)**	**50.5 (13.1) (*n* = 1,065)**	**49.9 (13.2) (*n* = 757)**	**49.2 (12.8) (*n* = 566)**	**49.7 (13.4) (*n* = 419)**
At/Above Clinical Level (Total Anxiety)	**31.2% (*n* = 2,426)**	**25.3% (*n* = 1,629)**	**24.1% (*n* = 1,307)**	**21.7% (*n* = 1,065)**	**20.9% (*n* = 757)**	**21.6% (*n* = 566)**	**23.6% (*n* = 419)**
Reynolds Adolescent Depression Scale–2 (RADS–2)							
Dysphoric Mood	50.3 (10.8) (*n* = 2,470)	48.9 (10.8) (*n* = 1,666)	48.6 (10.4) (*n* = 1,319)	47.9 (10.6) (*n* = 1,075)	47.5 (10.8) (*n* = 761)	46.9 (10.6) (*n* = 561)	46.8 (11.0) (*n* = 424)
Anhedonia/Negative Affect	50.4 (7.7) (*n* = 2,465)	49.7 (7.7) (*n* = 1,658)	49.2 (7.4) (*n* = 1,308)	48.9 (7.1) (*n* = 1,067)	49.2 (7.6) (*n* = 750)	48.9 (7.2) (*n* = 547)	49.1 (7.6) (*n* = 418)
Negative Self-Evaluation	52.9 (10.7) (*n* = 2,466)	50.7 (10.4) (*n* = 1,662)	49.9 (10.0) (*n* = 1,319)	49.3 (9.7) (*n* = 1,076)	48.4 (9.5) (*n* = 761)	48.4 (9.7) (*n* = 560)	47.9 (9.7) (*n* = 424)
Somatic Complaints	52.1 (10.5) (*n* = 2,473)	50.5 (10.8) (*n* = 1,668)	50.2 (10.8) (*n* = 1,320)	49.2 (10.5) (*n* = 1,077)	48.8 (10.8) (*n* = 760)	48.1 (11.0) (*n* = 561)	48.1 (11.3) (*n* = 424)
Total Depression	**51.9 (10.3) (*n* = 2,471)**	**49.9 (10.4) (*n* = 1,668)**	**49.3 (10.2) (*n* = 1,319)**	**48.5 (10.0) (*n* = 1,077)**	**48 (10.0) (*n* = 761)**	**47.5 (10.3) (*n* = 561)**	**47.4 (10.5) (*n* = 424)**
At/Above Clinical Level (Total Depression)	**21.0% (*n* = 2,471)**	**16.5% (*n* = 1,668)**	**14.5% (*n* = 1,319)**	**12.6% (*n* = 1,077)**	**10.5% (*n* = 761)**	**11.1% (*n* = 561)**	**12.7% (*n* = 424)**

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)	30 Months Mean (*SD*)	36 Months Mean (*SD*)
Vineland Screener (VS)							
Communication	93.5 (20.9) (*n* = 868)	93.6 (20.5) (*n* = 671)	94.1 (21.0) (*n* = 475)	95.3 (21.4) (*n* = 336)	96.5 (23.6) (*n* = 228)	97.8 (21.6) (*n* = 152)	95.5 (22.7) (*n* = 109)
Daily Living Skills	90.0 (23.4) (*n* = 866)	91.4 (22.7) (*n* = 661)	92.9 (23.5) (*n* = 474)	95.6 (26.1) (*n* = 333)	96.2 (25.2) (*n* = 224)	99.0 (24.6) (*n* = 154)	99.3 (25.3) (*n* = 107)
Socialization	101.5 (23.9) (*n* = 869)	101.2 (24.1) (*n* = 685)	101.1 (24.2) (*n* = 486)	98.4 (22.9) (*n* = 344)	97.9 (21.2) (*n* = 235)	101.3 (21.5) (*n* = 164)	98.7 (23.5) (*n* = 114)
Motor Skills	98.7 (22.2) (*n* = 845)	97.9 (22.6) (*n* = 510)	97.2 (22.2) (*n* = 308)	98.2 (21.8) (*n* = 168)	98.1 (21.1) (*n* = 96)	97.1 (21.6) (*n* = 59)	96.2 (22.1) (*n* = 31)
Caregiver Strain Questionnaire (CGSQ)							
Subjective Externalizing Strain	2.3 (1.0) (*n* = 4,700)	2.1 (0.9) (*n* = 3,123)	2.0 (0.9) (*n* = 2,389)	2.0 (0.9) (*n* = 1,796)	2.0 (0.8) (*n* = 1,275)	2.0 (0.9) (*n* = 885)	1.9 (0.9) (*n* = 630)
Subjective Internalizing Strain	3.4 (1.1) (*n* = 4,694)	3.1 (1.1) (*n* = 3,122)	2.9 (1.1) (*n* = 2,387)	2.8 (1.1) (*n* = 1,795)	2.8 (1.1) (*n* = 1,275)	2.7 (1.1) (*n* = 885)	2.6 (1.1) (*n* = 631)
Objective Strain	2.6 (1.1) (*n* = 4,702)	2.3 (1.0) (*n* = 3,118)	2.2 (1.0) (*n* = 2,390)	2.1 (1.0) (*n* = 1,794)	2 (1.0) (*n* = 1,274)	2.0 (0.9) (*n* = 887)	1.9 (0.9) (*n* = 634)
Global Strain	**8.2 (2.7)** **(*n* = 4,690)**	**7.4 (2.6)** **(*n* = 3,115)**	**7.1 (2.6)** **(*n* = 2,386)**	**6.9 (2.6)** **(*n* = 1,794)**	**6.8 (2.5)** **(*n* = 1,274)**	**6.7 (2.6)** **(*n* = 885)**	**6.5 (2.5)** **(*n* = 630)**
Family Life Questionnaire (FLQ)							
Family Functioning Scale	**3.4 (0.7)** **(*n* = 4,755)**	**3.4 (0.7)** **(*n* = 3,177)**	**3.5 (0.7)** **(*n* = 2,451)**	**3.5 (0.7)** **(*n* = 1,853)**	**3.5 (0.7)** **(*n* = 1,318)**	**3.5 (0.7)** **(*n* = 941)**	**3.5 (0.7)** **(*n* = 672)**

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**	**30 Months %**	**36 Months %**
Living Situations Questionnaire (LSQ)							
Type of Living Arrangement[a]	(*n* = 4,692)	(*n* = 3,110)	(*n* = 2.431)	(*n* = 1,830)	(*n* = 1,293)	(*n* = 922)	(*n* = 657)
Homeless	1.1%	0.6%	0.8%	0.8%	1.1%	0.9%	0.9%
Home	96.3%	95.4%	96.1%	95.8%	95.6%	96.4%	96.0%
School Dormitory	0.2%	0.2%	0.3%	0.7%	0.5%	0.3%	0.5%
Recreational Camp	0.1%	0.1%	0.3%	0.1%	0.2%	0.3%	0.5%
Emergency Shelter	1.2%	1.0%	0.5%	0.3%	0.2%	0.3%	0.5%
Foster Home	3.5%	2.9%	2.1%	2.6%	2.4%	1.6%	1.7%
Therapeutic/Specialized Foster Home	0.7%	0.7%	0.6%	0.5%	0.3%	0.2%	0.8%
Group Home	2.2%	1.8%	1.6%	1.6%	1.9%	1.4%	0.6%
Medical Hospital	0.4%	0.3%	0.4%	0.1%	0.5%	0.5%	0.3%
Residential Treatment Center	4.1%	4.4%	3.9%	3.6%	2.8%	3.1%	3.3%
Psychiatric Hospital	3.4%	2.4%	2.1%	1.7%	1.2%	1.0%	1.1%
Youth Justice Related	4.2%	3.7%	2.4%	1.7%	2.9%	2.4%	1.4%
Adult Justice Related	0.2%	0.3%	0.3%	0.3%	0.5%	0.4%	0.9%
Other	1.8%	1.2%	1.2%	1.0%	0.9%	0.9%	1.1%
Stability in Living Arrangements	(*n* = 4,692)	(*n* = 3,110)	(*n* = 2.431)	(*n* = 1,830)	(*n* = 1,293)	(*n* = 922)	(*n* = 657)
One Living Arrangement	73.6%	80.2%	80.8%	83.5%	81.7%	82.1%	83.6%
Multiple Living Arrangements	26.4%	19.8%	19.2%	16.5%	18.3%	17.9%	16.4%
Education Questionnaire–Revised (EQ–R)							
Attending School	(*n* = 4,801) 90.8%	(*n* = 3,220) 92.1%	(*n* = 2,485) 92.2%	(*n* = 1,879) 91.7%	(*n* = 1,326) 89.8%	(*n* = 947) 86.0%	(*n* = 678) 85.1%
Excused and Unexcused Absences	(*n* = 4,007)	(*n* = 2,766)	(*n* = 2,153)	(*n* = 1,605)	(*n* = 1,104)	(*n* = 770	(*n* = 530)
No Absences	16.8%	19.8%	24.3%	25.6%	28.3%	31.9%	29.6%
Less Than 1 Day Per Month	28.6%	31.5%	32.7%	33.0%	30.4%	26.8%	25.7%
About 1 Day a Month	18.9%	18.5%	17.7%	17.8%	16.6%	14.8%	19.4%
About 1 Day Every 2 Weeks	12.9%	12.4%	10.9%	10.3%	11.7%	11.8%	10.2%
About 1 Day a Week	7.8%	8.6%	5.6%	5.3%	5.4%	5.5%	7.2%
2 Days Per Week	6.3%	4.0%	4.4%	3.8%	3.4%	4.4%	3.8%
3 or More Days Per Week	8.7%	5.2%	4.5%	4.2%	4.2%	4.8%	4.2%

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Education Questionnaire–Revised (EQ–R)							
Educational Placement	(*n* = 4,044)	(*n* = 2,781)	(*n* = 2,160)	(*n* = 1,614)	(*n* = 1,106)	(*n* = 778)	(*n* = 531)
Public Day School	72.9%	72.6%	73.4%	74.2%	72.2%	70.6%	69.0%
Private Day/Boarding School	2.5%	2.8%	2.5%	1.4%	1.9%	1.3%	1.4%
Home School	1.6%	1.4%	1.8%	2.0%	2.4%	2.4%	2.6%
Alternative/Special Day School	15.8%	16.1%	15.4%	14.9%	15.9%	17.1%	17.9%
School in 24-Hour Restrictive Setting[c]	3.8%	3.7%	3.7%	3.1%	3.5%	3.7%	2.9%
Postsecondary School	0.1%	0.3%	0.7%	1.1%	1.2%	2.4%	1.7%
Other	3.4%	3.0%	2.5%	3.2%	2.8%	2.5%	4.5%
School Performance	(*n* = 3,885)	(*n* = 2,683)	(*n* = 2,099)	(*n* = 1,578)	(*n* = 1,085)	(*n* = 752)	(*n* = 513)
Grade Average A	17.2%	12.1%	11.1%	10.4%	8.8%	8.6%	7.6%
Grade Average B	8.4%	7.3%	6.2%	6.4%	6.5%	6.0%	7.6%
Grade Average C	21.4%	23.1%	23.4%	23.3%	23.7%	23.4%	25.3%
Grade Average D	19.4%	21.5%	22.3%	23.1%	23.9%	24.6%	21.1%
Failing All or Most Classes	7.0%	6.9%	9.2%	8.9%	10.3%	10.4%	11.3%
School Does Not Grade	23.4%	26.1%	24.9%	25.3%	24.6%	23.8%	24.0%
Other	3.2%	2.9%	2.9%	2.7%	2.3%	3.2%	3.1%
Individualized Education Plan (IEP)	(*n* = 3,995) 50.5%	(*n* = 2,755) 55.8%	(*n* = 2,132) 56.1%	(*n* = 1,588) 57.8%	(*n* = 1,093) 58.4%	(*n* = 754) 58.0%	(*n* = 519) 59.0%
Reasons for IEP[a]	(*n* = 2,009)	(*n* = 1,530)	(*n* = 1,187)	(*n* = 914)	(*n* = 618)	(*n* = 422)	(*n* = 296)
Behavior/Emotional Problems	71.8%	75.6%	72.4%	74.7%	78.0%	80.6%	76.0%
Learning Disability	50.6%	47.3%	47.4%	46.5%	48.1%	49.1%	50.7%
Physical Disability	4.2%	2.9%	3.4%	3.8%	2.8%	3.6%	3.0%
Developmental Disability or Mental Retardation	17.2%	15.4%	16.8%	16.2%	0.0%	0.0%	0.0%
Vision Impairment	3.7%	3.1%	3.0%	3.2%	4.2%	5.0%	5.1%
Speech Impairment	19.9%	17.6%	17.8%	16.6%	17.5%	16.8%	17.6%
Other	6.3%	5.4%	7.5%	6.8%	6.1%	6.9%	5.7%

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Education Questionnaire–Revised (EQ–R)							
Type of Special Education Placement[a]	(*n* = 1,656)	(*n* = 1,227)	(*n* = 960)	(*n* = 737)	(*n* = 524)	(*n* = 359)	(*n* = 260)
Special Class All or Most of the Day	43.8%	43.5%	45.2%	46.7%	44.8%	48.5%	50.4%
Special Class for a Portion of the Day	34.2%	34.1%	32.0%	32.3%	35.7%	33.7%	25.4%
Special Instruction As Part of a General Education Class	27.2%	27.3%	28.8%	29.0%	26.0%	26.2%	31.5%
Disciplinary Actions	(*n* = 3,938)	(*n* = 2,717)	(*n* = 2,116)	(*n* = 1,570)	(*n* = 1,079)	(*n* = 752)	(*n* = 509)
Suspended	33.4%	26.7%	23.9%	23.0%	22.6%	18.5%	20.6%
Expelled	1.2%	0.7%	0.3%	0.5%	0.4%	0.4%	0.4%
Suspended and Expelled	2.3%	1.4%	1.2%	0.8%	0.6%	0.5%	1.6%
None	63.1%	71.2%	74.6%	75.7%	76.4%	80.6%	77.4%
Delinquency Survey–Revised (DS–R)							
Juvenile Justice Contacts							
Questioned by Police	24.5% (*n* = 2,402)	18.6% (*n* = 1,568)	13.6% (*n* = 1,200)	14.8% (*n* = 945)	15.2% (*n* = 657)	15.7% (*n* = 466)	13.2% (*n* = 333)
Arrested	21.4% (*n* = 2,402)	14.2% (*n* = 1,568)	12.9% (*n* = 1,200)	10.5% (*n* = 945)	12.0% (*n* = 657)	12.7% (*n* = 466)	12.3% (*n* = 333)
Told to Appear in Court	23.6% (*n* = 2,402)	16.3% (*n* = 1,568)	14.4% (*n* = 1,200)	14.1% (*n* = 945)	14.2% (*n* = 657)	13.9% (*n* = 466)	15.0% (*n* = 333)
Convicted of a Crime	14.0% (*n* = 2,392)	8.9% (*n* = 1,565)	7.1% (*n* = 1,194)	7.1% (*n* = 941)	7.8% (*n* = 655)	6.3% (*n* = 464)	6.3% (*n* = 333)
On Probation	30.1% (*n* = 2,396)	25.1% (*n* = 1,559)	20.2% (*n* = 1,196)	15.4% (*n* = 939)	18.5% (*n* = 653)	15.0% (*n* = 466)	17.6% (*n* = 330)
Sentenced to Secure Facility	11.5% (*n* = 2,391)	8.1% (*n* = 1,560)	6.9% (*n* = 1,196)	5.1% (*n* = 937)	5.3% (*n* = 656)	5.0% (*n* = 464)	4.8% (*n* = 330)
Substance Problem Urgency (GAIN)							
Substance Use and Abuse Scale (SUS–9)	(*n* = 871)	(*n* = 313)	(*n* = 233)	(*n* = 160)	(*n* = 114)	(*n* = 90)	(*n* = 64)
Mean (*SD*)	3.1 (2.3)	3.2 (2.3)	2.7 (2.3)	2.5 (2.0)	2.6 (2.0)	2.5 (2.0)	2.5 (2.2)
Minimal/No Urgency	45.7%	44.7%	54.9%	55.0%	55.3%	55.6%	60.9%
Moderate Urgency	44.9%	45.7%	37.3%	40.0%	41.2%	41.1%	32.8%
High Urgency	9.4%	9.6%	7.7%	5.0%	3.5%	3.3%	6.3%

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Substance Problem Urgency (GAIN)							
Substance Dependence Scale (SUS–7)	(*n* = 869)	(*n* = 312)	(*n* = 232)	(*n* = 160)	(*n* = 113)	(*n* = 90)	(*n* = 64)
Mean (*SD*)	1.7 (1.9)	1.7 (1.8)	1.5 (1.9)	1.3 (1.7)	1.6 (1.7)	1.3 (1.5)	1.4 (1.9)
Minimal/No Urgency	59.1%	60.3%	64.2%	68.1%	58.4%	65.6%	70.3%
Moderate Urgency	34.5%	33.7%	30.2%	28.1%	36.3%	32.2%	25.0%
High Urgency	6.3%	6.1%	5.6%	3.8%	5.3%	2.2%	4.7%
Substance Problem Scale (SPS)	(*n* = 871)	(*n* = 313)	(*n* = 233)	(*n* = 160)	(*n* = 114)	(*n* = 90)	(*n* = 64)
Mean (*SD*)	4.8 (3.9)	4.9 (3.8)	4.2 (3.9)	3.8 (3.5)	4.2 (3.4)	3.9 (3.2)	3.8 (3.9)
Minimal/No Urgency	47.5%	46.6%	54.5%	55.6%	48.2%	51.1%	60.9%
Moderate Urgency	44.9%	45.7%	39.1%	40.0%	47.4%	46.7%	32.8%
High Urgency	7.6%	7.7%	6.4%	4.4%	4.4%	2.2%	6.3%
Multi-Sector Service Contacts–Revised (MSSC–R)[d]							
Number of Different Services Utilized	n/a	(*n* = 2,621)	(*n* = 1,572)	(*n* = 1,068)	(*n* = 669)	(*n* = 442)	(*n* = 303)
Mean (*SD*)		4.9 (2.7)	4.8 (2.9)	4.7 (3)	4.7 (2.9)	4.3 (2.6)	4.5 (2.7)
None		0.0%	1.1%	1.3%	1.0%	0.7%	0.7%
1–3		33.5%	36.1%	39.2%	36.5%	44.3%	40.3%
4–6		41.4%	39.6%	36.5%	40.7%	36.7%	37.0%
7–9		18.9%	16.5%	15.4%	15.7%	14.5%	17.2%
10 or more		6.2%	6.6%	7.6%	6.1%	3.8%	5.0%

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Type of Services Utilized: Traditional							
Individual Therapy	n/a	67.2% (*n* = 2,613)	65.9% (*n* = 1,567)	66.9% (*n* = 1,067)	67.4% (*n* = 666)	68.7% (*n* = 441)	68.4% (*n* = 301)
Care Management	n/a	63.3% (*n* = 2,600)	59.5% (*n* = 1,562)	56.4% (*n* = 1,061)	50.7% (*n* = 669)	48.3% (*n* = 441)	47.0% (*n* = 300)
Assessment or Evaluation	n/a	55.4% (*n* = 2,592)	46.5% (*n* = 1,556)	41.4% (*n* = 1,054)	42.1% (*n* = 667)	36.7% (*n* = 439)	41.7% (*n* = 302)
Medication Treatment/Monitoring	n/a	41.5% (*n* = 2,603)	48.6% (*n* = 1,565)	52.2% (*n* = 1,067)	56.2% (*n* = 667)	54.8% (*n* = 440)	57.8% (*n* = 301)
Family Therapy	n/a	28.6% (*n* = 2,603)	27.4% (*n* = 1,560)	25.1% (*n* = 1,060)	24.6% (*n* = 668)	21.0% (*n* = 442)	31.1% (*n* = 302)
Group Therapy	n/a	20.4% (*n* = 2,600)	19.2% (*n* = 1,559)	19.5% (*n* = 1,062)	20.8% (*n* = 664)	15.6% (*n* = 441)	18.6% (*n* = 301)
Crisis Stabilization	n/a	11.6% (*n* = 2,600)	8.9% (*n* = 1,564)	8.8% (*n* = 1,063)	9.1% (*n* = 668)	9.0% (*n* = 442)	9.9% (*n* = 303)

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

Communities Funded in 2005–2006							
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Multi-Sector Service Contacts–Revised (MSSC–R)[d]							
Type of Services Utilized: Innovative							
Recreational Activities	n/a	27.4% (*n* = 2,603)	28.8% (*n* = 1,563)	28.4% (*n* = 1,063)	29.5% (*n* = 667)	24.2% (*n* = 442)	23.5% (*n* = 302)
Family Support	n/a	25.5% (*n* = 2,601)	21.5% (*n* = 1,560)	19.8% (*n* = 1,064)	18.3% (*n* = 665)	13.1% (*n* = 442)	15.9% (*n* = 301)
Transportation	n/a	21.5% (*n* = 2,609)	20.8% (*n* = 1,561)	20.0% (*n* = 1,064)	18.4% (*n* = 669)	16.2% (*n* = 439)	15.0% (*n* = 301)
Flexible Funds	n/a	19.0% (*n* = 2,602)	16.1% (*n* = 1,561)	16.7% (*n* = 1,061)	12.1% (*n* = 667)	12.3% (*n* = 438)	10.6% (*n* = 301)
Behavioral/Therapeutic Aide	n/a	16.5% (*n* = 2,601)	14.3% (*n* = 1,560)	14.1% (*n* = 1,063)	17.3% (*n* = 665)	14.7% (*n* = 442)	11.9% (*n* = 302)
Family Preservation	n/a	7.2% (*n* = 2,592)	5.7% (*n* = 1,561)	5.8% (*n* = 1,064)	6.0% (*n* = 669)	5.9% (*n* = 442)	6.3% (*n* = 302)
Respite	n/a	9.4% (*n* = 2,606)	11.9% (*n* = 1,560)	12.9% (*n* = 1,063)	14.6% (*n* = 669)	11.4% (*n* = 439)	11.3% (*n* = 302)
Transition	n/a	1.9% (*n* = 2,595)	1.7% (*n* = 1,562)	1.5% (*n* = 1,063)	3.9% (*n* = 666)	1.1% (*n* = 440)	2.3% (*n* = 302)
Independent Living	n/a	1.4% (*n* = 2,596)	1.8% (*n* = 1,558)	1.7% (*n* = 1,063)	1.2% (*n* = 666)	1.1% (*n* = 440)	2.3% (*n* = 302)
Afterschool Programs	n/a	14.7% (*n* = 2,597)	14.9% (*n* = 1,557)	14.6% (*n* = 1,057)	12.8% (*n* = 666)	10.8% (*n* = 437)	12.0% (*n* = 300)
Vocational Training	n/a	1.9% (*n* = 2,593)	2.6% (*n* = 1,560)	2.4% (*n* = 1,061)	4.3% (*n* = 667)	2.5% (*n* = 440)	2.3% (*n* = 301)

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

Communities Funded in 2005–2006							
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**	**30 Months %**	**36 Months %**
Multi-Sector Service Contacts–Revised (MSSC–R)[d]							
Type of Services Utilized: Restrictive							
Day Treatment	n/a	5.5% (*n* = 2,602)	5.1% (*n* = 1,561)	5.9% (*n* = 1,066)	7.6% (*n* = 668)	6.1% (*n* = 442)	7.3% (*n* = 302)
Inpatient Hospitalization	n/a	5.9% (*n* = 2,606)	4.9% (*n* = 1,564)	4.7% (*n* = 1,060)	4.5% (*n* = 663)	3.7% (*n* = 438)	5.4% (*n* = 299)
Residential Treatment Center	n/a	5.4% (*n* = 2,604)	5.1% (*n* = 1,560)	5.0% (*n* = 1,058)	5.1% (*n* = 663)	5.5% (*n* = 437)	4.3% (*n* = 299)
Therapeutic Group Home	n/a	1.8% (*n* = 2,601)	1.7% (*n* = 1,560)	1.6% (*n* = 1,058)	2.1% (*n* = 663)	0.7% (*n* = 437)	1.7% (*n* = 301)
Therapeutic Foster Care	n/a	2.2% (*n* = 2,601)	2.1% (*n* = 1,559)	2.4% (*n* = 1,057)	2.6% (*n* = 663)	2.5% (*n* = 438)	4.3% (*n* = 300)
Residential Camp	n/a	1.7% (*n* = 2,606)	1.8% (*n* = 1,563)	1.1% (*n* = 1,066)	1.5% (*n* = 665)	1.4% (*n* = 439)	1.3% (*n* = 302)
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**	**30 Months Mean (*SD*)**	**36 Months Mean (*SD*)**
Youth Services Survey for Families (YSS–F)[d]							
Caregiver Perception of Services	n/a	4.0 (0.6) (*n* = 2,447)	4.1 (0.6) (*n* = 1,466)	4.1 (0.6) (*n* = 1,024)	4.1 (0.6) (*n* = 645)	4.1 (0.7) (*n* = 429)	4.1 (0.7) (*n* = 300)
Access to Services	n/a	4.3 (0.8) (*n* = 2,441)	4.3 (0.7) (*n* = 1,466)	4.2 (0.8) (*n* = 1,023)	4.3 (0.7) (*n* = 645)	4.3 (0.8) (*n* = 430)	4.2 (0.8) (*n* = 300)
Participation in Treatment	n/a	4.3 (0.7) (*n* = 2,446)	4.3 (0.7) (*n* = 1,466)	4.3 (0.7) (*n* = 1,024)	4.3 (0.7) (*n* = 642)	4.3 (0.8) (*n* = 430)	4.3 (0.7) (*n* = 300)
Cultural Sensitivity	n/a	4.5 (0.6) (*n* = 2,381)	4.5 (0.6) (*n* = 1,428)	4.4 (0.6) (*n* = 1,001)	4.4 (0.6) (*n* = 633)	4.4 (0.6) (*n* = 417)	4.5 (0.6) (*n* = 297)
Satisfaction With Services	n/a	4.0 (0.9) (*n* = 2,447)	4.1 (0.8) (*n* = 1,466)	4.1 (0.8) (*n* = 1,024)	4.0 (0.9) (*n* = 645)	4.1 (0.8) (*n* = 430)	4.1 (0.8) (*n* = 300)
Outcomes	n/a	3.6 (0.9) (*n* = 2,438)	3.6 (0.9) (*n* = 1,464)	3.7 (0.9) (*n* = 1,024)	3.7 (0.9) (*n* = 645)	3.8 (0.9) (*n* = 429)	3.8 (0.9) (*n* = 300)

Table G-7. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Initially Funded in 2005-2006 (continued)

	Communities Funded in 2005–2006						
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**	**30 Months Mean (*SD*)**	**36 Months Mean (*SD*)**
Youth Services Survey (YSS)[d]							
Youth Perception of Services	n/a	3.9 (0.7) (*n* = 1,226)	4.0 (0.6) (*n* = 753)	4.0 (0.6) (*n* = 574)	4.1 (0.6) (*n* = 376)	4.0 (0.7) (*n* = 251)	4.1 (0.6) (*n* = 173)
Access to Services	n/a	4.0 (0.9) (*n* = 1,221)	4.1 (0.8) (*n* = 752)	4.0 (0.9) (*n* = 573)	4.2 (0.8) (*n* = 378)	4.2 (0.8) (*n* = 250)	4.1 (0.9) (*n* = 173)
Participation in Treatment	n/a	3.7 (0.9) (*n* = 1,225)	3.8 (0.9) (*n* = 754)	3.8 (0.9) (*n* = 574)	3.9 (0.8) (*n* = 377)	3.9 (0.9) (*n* = 250)	3.9 (0.8) (*n* = 173)
Cultural Sensitivity	n/a	4.3 (0.7) (*n* = 1,205)	4.3 (0.6) (*n* = 741)	4.3 (0.7) (*n* = 569)	4.3 (0.6) (*n* = 370)	4.3 (0.7) (*n* = 246)	4.4 (0.7) (*n* = 172)
Satisfaction With Services	n/a	3.9 (0.8) (*n* = 1,228)	4.0 (0.8) (*n* = 754)	4.0 (0.8) (*n* = 575)	4.1 (0.7) (*n* = 378)	4.0 (0.8) (*n* = 252)	4.1 (0.7) (*n* = 173)
Outcomes	n/a	3.8 (0.8) (*n* = 1,225)	3.9 (0.7) (*n* = 753)	4.0 (0.7) (*n* = 574)	3.9 (0.7) (*n* = 376)	3.9 (0.8) (*n* = 250)	4.0 (0.7) (*n* = 173)
Cultural Competence and Service Provision (CCSP)[d]							
Importance of Provider's Understanding of Family's Culture	n/a	2.7 (1.2) (*n* = 2,507)	2.8 (1.1) (*n* = 1,748)	2.7 (1.1) (*n* = 1,306)	2.7 (1.1) (*n* = 923)	2.8 (1.2) (*n* = 666)	2.8 (1.2) (*n* = 493)
Frequency of Provider's Culturally Competent Practices	n/a	4.6 (0.6) (*n* = 2,206)	4.6 (0.6) (*n* = 1,323)	4.6 (0.5) (*n* = 933)	4.6 (0.6) (*n* = 571)	4.6 (0.6) (*n* = 390)	4.6 (0.5) (*n* = 268)
Overall	**n/a**	**4.6 (0.6) (*n* = 2,206)**	**4.6 (0.6) (*n* = 1,323)**	**4.6 (0.5) (*n* = 933)**	**4.6 (0.6) (*n* = 571)**	**4.6 (0.6) (*n* = 390)**	**4.6 (0.5) (*n* = 268)**

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.

[b] Information reported for the Vineland Screener for the Communication Domain, the Daily Living Skills Domain and the Socialization Domain combine information from the VS1 (0 to under 3), the VS2 (3 to 5) and the VS3 (6 to12). Information reported for the Vineland Screener for the Motor Skills Subscale combine information from the VS1 (0 to 3) and the VS2 (3 to 5). The VS3 does not contain questions assessing motor skills.

[c] Includes school in 24-hour hospital setting, 24-hour juvenile justice facility, and 24-hour residential treatment setting.

[d] Information collected only at follow-up assessments.

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009

Communities Funded in 2008–2009					
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Child Behavior Checklist 1½–5 (CBCL 1½–5)					
Emotionally Reactive	66.0 (10.3) (*n* = 233)	64.2 (10.4) (*n* = 82)	68.7 (12.1) (*n* = 23)		
Sleep Problems	63.8 (11.6) (*n* = 233)	61.8 (12.1) (*n* = 82)	66.7 (12.8) (*n* = 23)		
Withdrawn	64.2 (9.9) (*n* = 233)	60.6 (8.5) (*n* = 82)	61.1 (8.0) (*n* = 23)		
Somatic Complaints	56.9 (7.5) (*n* = 233)	58.4 (8.2) (*n* = 82)	58.2 (8.9) (*n* = 23)		
Anxious/Depressed	63.2 (10.5) (*n* = 233)	60.8 (8.7) (*n* = 82)	64.7 (9.3) (*n* = 23)		
Attention Problems	63.9 (8.8) (*n* = 233)	62.3 (9.1) (*n* = 82)	66.7 (7.6) (*n* = 23)		
Aggressive Problems	70.4 (13.0) (*n* = 233)	67.8 (13.4) (*n* = 82)	72.7 (13.3) (*n* = 23)		
Internalizing Problems	64.0 (9.9) (*n* = 233)	62.0 (10.1) (*n* = 82)	65.0 (10.5) (*n* = 23)		
Externalizing Problems	68.6 (12.0) (*n* = 233)	66.0 (12.7) (*n* = 82)	68.0 (12.9) (*n* = 23)		
Total Problems	**67.9 (10.4)** **(*n* = 233)**	**64.9 (11.2)** **(*n* = 82)**	**69.7 (11.6)** **(*n* = 23)**		
At/Above Clinical Level (Total Problems)	**69.5%** **(*n* = 162)**	**53.7%** **(*n* = 44)**	**78.3%** **(*n* = 18)**		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Child Behavior Checklist 6–18 (CBCL 6–18)					
Activities Competence	35.5 (9.1) (*n* = 541)	35.2 (9.4) (*n* = 178)	38.4 (9.2) (*n* = 43)		
Social Competence	36.0 (9.0) (*n* = 527)	35.8 (8.7) (*n* = 178)	39.0 (9.4) (*n* = 42)		
School Competence	36.5 (8.5) (*n* = 453)	38.8 (8.2) (*n* = 155)	39.3 (8.8) (*n* = 38)		
Total Competence	30.6 (8.7) (*n* = 432)	30.6 (8.4) (*n* = 151)	34.1 (8.0) (*n* = 35)		
Anxious/Depressed	65.9 (10.5) (*n* = 550)	63.0 (10.1) (*n* = 183)	63.3 (9.0) (*n* = 48)		
Withdrawn/Depressed	67.1 (10.6) (*n* = 550)	64.4 (10.4) (*n* = 183)	61.0 (9.5) (*n* = 48)		
Somatic Complaints	63.2 (10.1) (*n* = 550)	60.9 (9.2) (*n* = 183)	61.4 (8.6) (*n* = 48)		
Social Problems	67.6 (10.0) (*n* = 550)	66.1 (10.0) (*n* = 183)	64.0 (10.0) (*n* = 48)		
Thought Problems	68.5 (10.1) (*n* = 550)	66.8 (10.1) (*n* = 183)	65.8 (10.2) (*n* = 48)		
Attention Problems	69.1 (11.1) (*n* = 550)	67.1 (10.8) (*n* = 183)	65.0 (10.5) (*n = 48*)		
Rule-Breaking Behavior	68.2 (9.3) (*n* = 550)	66.6 (9.3) (*n* = 183)	63.8 (9.0) (*n* = 48)		
Aggressive Behavior	72.8 (12.5) (*n* = 550)	71.1 (13.0) (*n* = 183)	67.9 (11.5) (*n* = 48)		
Internalizing	66.8 (9.6) (*n* = 550)	63.8 (10.8) (*n* = 183)	62.7 (10.5) (*n* = 48)		
Externalizing	70.4 (9.5) (*n* = 550)	68.4 (11.0) (*n* = 183)	66.0 (9.8) (*n* = 48)		
Total Problems	**70.6 (8.6)** **(*n* = 550)**	**68.1 (10.3)** **(*n* = 183)**	**66.6 (9.6)** **(*n* = 48)**		
At/Above Clinical Level (Total Problems)	**81.5%** **(*n* = 448)**	**73.2%** **(*n* = 134)**	**62.5%** **(*n* = 30)**		
Behavioral and Emotional Rating Scale–2, Caregiver (BERS–2C)					
Intrapersonal Strengths	7.1 (3.2) (*n* = 613)	8.0 (3.3) (*n* = 220)	8.4 (3.7) (*n* = 59)		
Interpersonal Strengths	6.2 (2.9) (*n* = 620)	6.7 (3.1) (*n* = 220)	7.2 (3.1) (*n* = 59)		
School Functioning	6.1 (3.0) (*n* = 570)	6.5 (2.9) (*n* = 198)	7.0 (2.9) (*n* = 56)		
Family Involvement	6.7 (2.8) (*n* = 622)	7.1 (3.0) (*n* = 220)	8.0 (2.9) (*n* = 59)		
Affective Strengths	8.0 (3.2) (*n* = 622)	8.4 (3.0) (*n* = 220)	9.0 (3.1) (*n* = 59)		
Career Strengths	8.4 (3.5) (*n* = 502)	8.8 (3.6) (*n* = 180)	9.4 (3.6) (*n* = 41)		
Strengths Quotient	**78.1 (16.8)** **(*n* = 566)**	**81.0 (17.5)** **(*n* = 198)**	**85.7 (18.7)** **(*n* = 56)**		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Behavioral and Emotional Rating Scale–2, Youth (BERS–2Y)					
Intrapersonal Strengths	9.5 (3.0) (*n* = 458)	10.1 (2.9) (*n* = 157)	9.7 (3.5) (*n* = 36)		
Interpersonal Strengths	9.3 (3.5) (*n* = 458	9.7 (3.4) (*n* = 157)	9.6 (3.6) (*n* = 36)		
School Functioning	8.4 (3.2) (*n* = 423)	9.0 (3.1) (*n* = 130)	9.3 (3.4) (*n* = 33)		
Family Involvement	8.7 (3.0) (*n* = 456)	9.1 (2.9) (*n* = 157)	9.5 (3.3) (*n* = 36)		
Affective Strengths	10.0 (3.3) (*n* = 459)	10.8 (3.0) (*n* = 157)	10.4 (3.6) (*n* = 36)		
Career Strengths	9.7 (2.8) (*n* = 439)	9.9 (2.6) (*n* = 155)	9.6 (2.7) (*n* = 36)		
Strengths Quotient	**94.4 (17.5)** **(*n* = 419)**	**97.5 (17.2)** **(*n* = 130)**	**97.4 (20.4)** **(*n* = 33)**		
Columbia Impairment Scale (CIS)					
Overall Level of Impairment	**23.3 (10.5)** **(*n* = 804)**	**19.6 (11.3)** **(*n* = 277)**	**19.5 (9.1)** **(*n* = 69)**		
At/Above Clinical Level	**77.7%**	**63.5%**	**72.5%**		
Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2)					
Worry/Oversensitivity	51.5 (11.7) (*n* = 406)	49.1 (12.4) (*n* = 136)	49.3 (13.7) (*n* = 32)		
Social Concerns/Concentration	51.9 (11.5) (*n* = 382)	49.6 (11.9) (*n* = 126)	51.1 (13.6) (*n* = 28)		
Physiological Anxiety	51.8 (10.5) (*n* = 390)	49.4 (10.8) (*n* = 125)	50.4 (12.2) (*n* = 29)		
Total Anxiety	**52.0 (11.5)** **(*n* = 373)**	**49.0 (12.5)** **(*n* = 123)**	**49.4 (12.9)** **(*n* = 27)**		
At/Above Clinical Level (Total Anxiety)	**26.8%** **(*n* = 100)**	**18.7%** **(*n* = 123)**	**22.2%** **(*n* = 6)**		
Reynolds Adolescent Depression Scale, Second Edition (RADS–2)					
Dysphoric Mood	50.3 (11.4) (*n* = 480)	47.5 (11.5) (*n* = 160)	49.9 (12.7) (*n* = 36)		
Anhedonia/Negative Affect	51.2 (8.4) (*n* = 474)	49.8 (7.2) (*n* = 158)	51.0 (9.1) (*n* = 36)		
Negative Self-Evaluation	52.7 (11.2) (*n* = 477)	49.0 (9.5) (*n* = 160)	52.7 (11.9) (*n* = 36)		
Somatic Complaints	52.5 (10.7) (*n* = 480)	50.7 (10.8) (*n* = 160)	50.1 (9.8) (*n* = 36)		
Total Depression	**52.2 (10.8)** **(*n* = 479)**	**49.0 (9.9)** **(*n* = 160)**	**51.4 (11.9)** **(*n* = 36)**		
At/Above Clinical Level (Total Depression)	**22.5%** **(*n* = 108)**	**13.1%** **(*n* = 21)**	**22.2%** **(*n* = 8)**		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Caregiver Strain Questionnaire (CGSQ)					
Subjective Externalizing Strain	2.3 (0.9) (*n* = 821)	2.2 (1.0) (*n* = 276)	2.0 (0.8) (*n* = 68)		
Subjective Internalizing Strain	3.6 (1.0) (*n* = 818)	3.2 (1.1) (*n* = 276)	3.1 (1.0) (*n =68*)		
Objective Strain	2.7 (1.1) (*n* = 823)	2.4 (1.1) (*n* = 276)	2.2 (1.0) (*n* = 68)		
Global Strain	8.6 (2.6) (*n* = 818)	7.8 (2.8) (*n* = 276)	7.3 (2.5) (*n* = 68)		
Parenting Stress Index (PSI)					
Total Stress Scale	**105.4 (23.3) (*n* = 460)**	**102.5 (22.9) (*n* = 152)**	**98.7 (21.9) (*n* = 41)**		
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**
Living Situations Questionnaire (LSQ)					
Type of Living Arrangement[a]	(*n* = 917)	(*n* = 315)	(*n* = 75)		
Homeless	2.8%	1.0%	1.3%		
Home	96.1%	96.8%	96.0%		
School Dormitory	0.3%	0.6%	2.7%		
Recreational Camp	0.3%	0.6%	0.0%		
Emergency Shelter	1.4%	0.6%	0.0%		
Foster Home	2.5%	1.9%	0.0%		
Therapeutic/Specialized Foster Home	0.8%	1.3%	0.0%		
Group Home	1.6%	1.9%	1.3%		
Medical Hospital	0.4%	.3%	0.0%		
Residential Treatment Center	5.2%	2.9%	2.7%		
Psychiatric Hospital	8.0%	4.8%	9.3%		
Youth Justice Related	2.2%	1.9%	0.0%		
Adult Justice Related	0.3%	0.0%	0.0%		
Other	1.7%	1.3%	0.0%		
Stability in Living Arrangements	(*n* = 917)	(*n* = 315)	(*n* = 75)		
One Living Arrangement	65.0%	72.1%	77.3%		
Multiple Living Arrangements	35.0%	27.9%	22.7%		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Education Questionnaire, Revision 2 (EQ–R2)					
Attending School	(*n* = 901) 83.7%	(*n* = 308) 82.5%	(*n* = 76) 86.8%		
Excused and Unexcused Absences	(*n* = 718)	(*n* = 249)	(*n* = 63)		
No Absences	12.1%	16.5%	11.1%		
Less Than 1 Day Per Month	21.7%	29.7%	34.9%		
About 1 Day a Month	19.6%	18.9%	20.6%		
About 1 Day Every 2 Weeks	14.3%	10.0%	15.9%		
About 1 Day a Week	9.9%	7.2%	6.3%		
2 Days Per Week	8.6%	4.0%	1.6%		
3 or More Days Per Week	13.6%	13.7%	9.5%		
Educational Placement	(*n* = 679)	(*n* = 233)	(*n* = 61)		
Public Day School	77.9%	76.0%	78.7%		
Private Day/Boarding School	1.5%	.9%	1.6%		
Home School	4.3%	5.2%	3.3%		
Alternative/Special Day School	22.8%	22.7%	13.1%		
School in 24-Hour Restrictive Setting[b]	10.0%	3.9%	6.6%		
Postsecondary School	0.9%	2.1%	4.9%		
Other	4.7%	4.3%	4.9%		
School Performance	(*n* = 530)	(*n* = 177)	(*n* = 41)		
A's	6.4%	5.6%	9.8%		
A's and B's	21.5%	29.4%	19.5%		
B's	5.8%	6.8%	7.3%		
B's and C's	17.4%	21.5%	26.8%		
C's	8.5%	2.8%	4.9%		
C's and D's	14.0%	9.0%	9.8%		
D's	2.3%	1.7%	0.0%		
D's and F's	10.6%	11.3%	4.9%		
F's	6.2%	2.3%	4.9%		
School Does Not Give These Grades	4.0%	6.8%	7.3%		
Other	3.4%	2.8%	4.9%		
Individualized Education Plan (IEP)	(*n* = 715) 52.9%	(*n* = 247) 62.3%	(*n* = 61) 57.4%		
Reasons for IEP[a]	(*n* = 378)	(*n* = 153)	(*n* = 35)		
Behavior/Emotional Problems	73.5%	75.2%	68.6%		
Learning Disability	51.3%	53.6%	37.1%		
Physical Disability	3.2%	2.0%	5.7%		
Developmental Disability or Mental Retardation	15.1%	13.7%	17.1%		
Vision and/or Hearing Impairment	3.2%	2.0%	2.9%		
Speech Impairment	63.0%	62.7%	65.7%		
Other	6.3%	5.2%	5.7%		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Education Questionnaire, Revision 2 (EQ–R2)					
Type of Special Education Placement[a]	(*n* = 287)	(*n* = 122)	(*n* = 29)		
Special education class, all children receive special education for all or most of the day	50.2 %	54.9%	48.3%		
Special education class, all children leave general education for special education	22.6%	21.3%	27.6%		
Special education provided in general education class to some children	14.6%	15.6%	17.2%		
Special instruction provided on basis of need	12.5%	8.3%	6.9%		
Disciplinary Actions	(*n* = 686)	(*n* = *228*)	(*n* = 58)		
None	58.9%	73.2%	77.6%		
Suspended	31.8%	22.4%	20.7%		
Expelled	1.9%	1.3%	1.7%		
Suspended and Expelled	4.1%	.9%	0.0%		
Delinquency Survey, Revised (DS–R)					
Juvenile Justice Contacts					
Questioned by Police	26.8% (*n* = 448)	22.8% (*n* = 149)	31.3% (*n* = 32)		
Arrested	21.5% (*n* = 452)	10.7% (*n* = 150)	6.3% (*n* = 32)		
Appeared in Court	21.5% (*n* = 452)	15.3% (*n* = 150)	21.9% (*n* = 32)		
Convicted of a Crime	11.4% (*n* = 446)	5.3% (*n* = 150)	6.3% (*n* = 32)		
On Probation	25.7% (*n* = 447)	18.1% (*n* = 149)	15.6% (*n* = 32)		
Substance Problem Urgency (GAIN)					
Substance Use and Abuse Scale (SUS–9)	(*n* = 169)	(*n* = 40)	(*n* = 12)		
Mean (*SD*)	3.2 (2.5)	3.3 (2.1)	2.0 (2.0)		
Minimal/No Urgency	45.6%	42.5%	66.7%		
Moderate Urgency	42.0%	50.0%	33.3%		
High Urgency	12.4%	7.5%	0.0%		
Substance Dependence Scale (SUS–7)	(*n* = 168)	(*n* = 38)	(*n* = 12)		
Mean (*SD*)	2.1 (2.0)	2.0 (1.9)	0.8 (1.1)		
Minimal/No Urgency	47.0%	52.6%	75.0%		
Moderate Urgency	45.8%	42.1%	25.0%		
High Urgency	7.1%	5.3%	0.0%		
Substance Problem Scale (SPS)	(*n* = 169)	(*n* = 40)	(*n* = 12)		
Mean (*SD*)	5.3 (4.2)	5.2 (3.7)	2.8 (2.6)		
Minimal/No Urgency	43.2%	35.0%	58.3%		
Moderate Urgency	47.3%	57.5%	41.7%		
High Urgency	9.5%	7.5%	0.0%		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Multi-Sector Service Contacts, Revised (MSSC–R)					
Number of Different Services Utilized	(*n* = 805)	(*n* = 289)	(*n* = 65)		
Mean (*SD*)	5.2 (2.8)	5.4 (2.9)	5.5 (3.1)		
1–3	31.7%	28.7%	29.2%		
4–6	40.5%	40.5%	38.5%		
7–9	18.8%	20.4%	24.6%		
10 or more	9.1%	10.4%	7.7%		
Type of Services Utilized: Traditional					
Individual Therapy	66.3% (*n* = 812)	63.1% (*n* = 290)	74.2% (*n* = 66)		
Care Management	39.1% (*n* = 808)	49.3% (*n* = 288)	51.5% (*n* = 66)		
Assessment or Evaluation	74.6% (*n* = 808)	46.9% (*n* = 288)	44.6% (*n* = 65)		
Medication Treatment/Monitoring	38.5% (*n* = 812)	43.8% (*n* = 290)	39.4% (*n* = 66)		
Family Therapy	23.6% (*n* = 812)	23.9% (*n* = 289)	27.3% (*n* = 66)		
Group Therapy	23.5% (*n* = 813)	23.6% (*n* = 288)	30.3% (*n* = 66)		
Crisis Stabilization	15.3% (*n* = 812)	8.6% (*n* = 290)	3.0% (*n* = 66)		
Type of Services Utilized: Innovative					
Recreational Activities	11.7% (*n* = 813)	19.4% (*n* = 289)	28.8% (*n* = 66)		
Family Support	30.0% (*n* = 810)	39.8% (*n* = 289)	35.4% (*n* = 65)		
Transportation	17.0% (*n* = 812)	23.4% (*n* = 290)	22.7% (*n* = 66)		
Flexible Funds	8.4% (*n* = 812)	25.9% (*n* = 290)	30.3% (*n* = 66)		
Behavioral/Therapeutic Aide	11.5% (*n* = 811)	13.5% (*n* = 289)	13.6% (*n* = 66)		
Family Preservation	7.3% (*n* = 810)	7.6% (*n* = 289)	8.1% (*n* = 66)		
Respite	6.2% (*n* = 813)	12.1% (*n* = 290)	7.6% (*n* = 66)		
Vocational Training	5.4% (*n* = 812)	4.5% (*n* = 290)	4.5% (*n* = 66)		
Transition	8.7% (*n* = 812)	10.4% (*n* = 289)	3.0% (*n* = 66)		
Independent Living	3.4% (*n* = 813)	3.1% (*n* = 290)	1.5% (*n* = 66)		
Afterschool Programs	11.1% (*n* = 810)	11.1% (*n* = 289)	6.1% (*n* = 66)		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

Communities Funded in 2008–2009					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Multi-Sector Service Contacts, Revised (MSSC–R)					
Type of Services Utilized: Restrictive					
Day Treatment	6.2% (*n* = 812)	7.9% (*n* = 290)	4.5% (*n* = 66)		
Inpatient Hospitalization	16.7% (*n* = 813)	10.3% (*n* = 290)	12.1% (*n* = 66)		
Residential Treatment Center	9.7% (*n* = 811)	5.2% (*n* = 289)	4.5% (*n* = 66)		
Therapeutic Group Home	1.7% (*n* = 812)	2.1% (*n* = 290)	3.0% (*n* = 66)		
Therapeutic Foster Care	2.1% (*n* = 811)	3.4% (*n* = 290)	1.5% (*n* = 66)		
Residential Camp	0.9% (*n* = 812)	2.8% (*n* = 290)	1.5% (*n* = 66)		
Informal Support	37.2% (*n* = 810)	38.5% (*n* = 288)	39.4% (*n* = 66)		
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Youth Services Survey for Families (YSS–F)[c]					
Caregiver Perception of Services	n/a	3.4 (0.7) (*n* = 253)	3.4 (0.8) (*n* = 62)		
Access to Services	n/a	4.1 (0.9) (*n* = 253)	3.9 (1.0) (*n* = 62)		
Participation in Treatment	n/a	4.1 (0.8) (*n* = 253)	4.1 (0.9) (*n* = 62)		
Cultural Sensitivity	n/a	4.4 (0.7) (*n* = 248)	4.3 (0.7) (*n* = 62)		
Satisfaction With Services	n/a	3.9 (0.9) (*n* = 253)	3.9 (1.0) (*n* = 62)		
Outcomes	n/a	3.4 (0.9) (*n* = 253)	3.5 (1.0) (*n* = 62)		
Youth Services Survey (YSS)[c]					
Youth Perception of Services	n/a	3.5 (0.6) (*n* = 147)	3.4 (0.9) (*n* = 31)		
Access to Services	n/a	3.9 (0.8) (*n* = 148)	3.7 (1.1) (*n* = 31)		
Participation in Treatment	n/a	3.8 (0.9) (*n* = 148)	3.7 (1.0) (*n* = 31)		
Cultural Sensitivity	n/a	4.3 (0.6) (*n* = 146)	4.0 (0.8) (*n* = 30)		
Satisfaction With Services	n/a	4.0 (0.7) (*n* = 149)	3.8 (1.0) (*n* = 31)		
Outcomes	n/a	3.9 (0.7) (*n* = 149)	3.8 (0.9) (*n* = 31)		

Table G-8. Child, Youth, and Family Outcomes and Service Experience at Intake, 6 Months, and 12 Months for Communities Initially Funded in 2008-2009 (continued)

	Communities Funded in 2008–2009				
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Cultural Competence and Service Provision, Revised (CCSP–R)[c]					
Importance of Provider's Understanding of Family's Culture	n/a	2.7 (1.2) (*n* = 303)	2.7 (1.2) (*n* = 73)		
Frequency of Provider's Culturally Competent Practices	n/a	4.1 (0.5) (*n* = 271)	4.1 (0.5) (*n* = 62)		

[a] An individual may provide more than one response; therefore, percentages may sum to more than 100%.
[b] Includes school in 24-hour hospital setting, 24-hour juvenile justice facility, and 24-hour residential treatment setting.
[c] Information collected only at follow-up assessments.

Appendix H

Performance Measurement

CQI Progress Report: Aggregate for Communities Initially Funded in 2005-2006

Comprehensive Community Mental Health Services for Children and Their Families Program
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2005 and 2006, August 31, 2011

Date Services Started: Aug-06
Number Enrolled in the Descriptive Study: 12,543
Number Enrolled in the Outcome Study: 5,014

	Change from Previous Report[1]	Previous Cumulative Raw Score	Current Cumulative Raw Score	Performance Mark[2]	Current Period Raw Score	Benchmark[3]	How to Interpret Raw Score
System-Level Outcomes							
Service Accessibility							
1. Number of Children Served (with descriptive data)	Score Improved	10,129	12,189		2,087	n/a	Community defined
2. Linguistic Competency Rate	Score Improved	88.5%	89.1%		95.0%	94.7%	Closer to 100% better
3. Agency Involvement Rate–Service Provision	Score Worsened	77.5%	77.1%		74.5%	85.9%	Closer to 100% better
4. Caregiver Satisfaction Rate–Access to Services	No Change	4.25	4.25		4.30	4.38	Closer to 5 better
5. Timeliness of Services (average days)*	Score Improved	14.44	13.27		8.75	6.00	Lower # better
Service Quality							
6. Agency Involvement Rate–Treatment Planning	Score Worsened	33.2%	32.9%		30.5%	54.6%	Closer to 100% better
7. Informal Supports Rate	Score Worsened	40.8%	40.6%		39.7%	51.8%	Closer to 100% better
8. Caregiver Satisfaction Rate–Quality of Services	Score Improved	4.01	4.03		4.15	4.18	Closer to 5 better
9. Youth Satisfaction Rate–Quality of Services	Score Improved	3.91	3.92		3.98	4.02	Closer to 5 better
10. Caregiver Satisfaction Rate–Outcomes	Score Improved	3.54	3.56		3.71	3.77	Closer to 5 better
11. Youth Satisfaction Rate–Outcomes	Score Improved	3.84	3.86		3.96	3.97	Closer to 5 better
Service Appropriateness							
12. Individualized Education Plan (IEP) Development (% at 6 months)	Score Worsened	57.2%	56.5%		51.1%	67.2%	Community defined
13. Substance Use Treatment Rate	Score Improved	59.8%	62.0%		77.4%	73.1%	Closer to 100% better
Child and Family Outcomes							
Caregiver Report							
Child Level							
14a. School Enrollment Rate	Score Worsened	96.1%	95.9%		94.8%	99.8%	Closer to 100% better
14b. School Enrollment Rate (Preschool)	Score Worsened	97.6%	97.2%		94.7%	100.0%	Closer to 100% better
15a. School Attendance Rate (80% of the time)	Score Improved	81.9%	82.1%		83.1%	87.2%	Closer to 100% better
15b. Daycare or Afterschool Care Program Attendance Rate	Score Worsened	80.0%	79.5%		73.7%	81.4%	Closer to 100% better
16. School Performance Improvement Rate (intake to 6 months)	No Change	33.5%	33.5%		33.3%	39.1%	Closer to 100% better
17. Stability in Living Situation Rate (intake to 6 months)	Score Improved	79.7%	80.5%		85.7%	84.7%	Closer to 100% better
18. Inpatient Hospitalization Days per Child (intake to 6 months)*	Score Worsened	2.87	2.94		3.37	0.80	Lower # better
19. Suicide Attempt Reduction Rate–Caregiver Report**	Score Improved	-45.5%	-46.0%		-50.0%	-50.0%	More negative % better

CQI Progress Report—Aggregate for Communities Initially Funded in 2005–2006 (continued)

Comprehensive Community Mental Health Services for Children and Their Families Program
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2005 and 2006, August 31, 2011

Date Services Started: Aug-06
Number Enrolled in the Descriptive Study: 12,543
Number Enrolled in the Outcome Study: 5,014

	Change from Previous Report[1]	Previous Cumulative Raw Score	Current Cumulative Raw Score	Performance Mark[2]	Current Period Raw Score	Benchmark[3]	How to Interpret Raw Score
Child and Family Outcomes (continued)							
Caregiver Report (continued)							
Child Level (continued)							
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	Score Worsened	29.4%	25.7%		22.1%	33.6%	Closer to 100% better
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	Score Improved	34.0%	35.7%		47.1%	35.6%	Closer to 100% better
20c. Socialization or Communication Problem Improvement Rate (intake to 6 months)	No Change	22.0%	22.0%		22.0%	33.5%	Closer to 100% better
Family Level							
21. Average Reduction in Employment Days Lost (intake to 6 months)**	Score Worsened	-1.32	-1.18		-0.17	-2.92	More negative # better
22. Family Functioning Improvement Rate (intake to 6 months)	Score Worsened	2.9%	2.8%		1.8%	5.7%	Higher % better
23. Caregiver Strain Improvement Rate (intake to 6 months)	Score Improved	25.7%	26.5%		31.4%	32.1%	Closer to 100% better
Youth Report							
24. Youth No Arrest Rate (intake to 6 months)	Score Improved	5.8%	6.5%		11.4%	17.6%	Higher % better
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)**	Score Worsened	-33.8%	-32.2%		-20.0%	-50.0%	More negative % better
26. Anxiety Improvement Rate (intake to 6 months)	Score Worsened	17.9%	15.7%		11.8%	18.5%	Closer to 100% better
27. Depression Improvement Rate (intake to 6 months)	Score Improved	11.6%	12.5%		18.3%	14.3%	Closer to 100% better
Satisfaction with Services							
28. Caregiver Overall Satisfaction	Score Improved	4.03	4.05		4.13	4.16	Closer to 5 better
29. Youth Overall Satisfaction	Score Improved	3.93	3.94		4.01	4.00	Closer to 5 better
Family and Youth Involvement							
30. Caregiver Satisfaction Rate–Participation	Score Improved	4.24	4.25		4.34	4.30	Closer to 5 better
31. Youth Satisfaction Rate–Participation	Score Improved	3.67	3.69		3.80	3.73	Closer to 5 better
32. Caregiver and Other Family Involvement in Service Plan	Score Improved	96.7%	96.9%		97.7%	99.4%	Closer to 100% better
33. Youth Involvement in Service Plan	Score Improved	89.0%	89.2%		91.6%	94.8%	Closer to 100% better
Cultural and Linguistic Competency							
34. Caregiver Satisfaction Rate–Cultural Competency	Score Improved	4.44	4.45		4.51	4.56	Closer to 5 better
35. Youth Satisfaction Rate–Cultural Competency	No Change	4.25	4.25		4.28	4.37	Closer to 5 better

[1] The change from previous report is reported as Score Worsened, No Change, or Score Improved.
[2] Performance marks are not reported in the aggregate report.
[3] The benchmark represents the 75th percentile score across all Phase IV and Phase V communities as of April 11, 2009.
* For these indicators, smaller average days represent positive outcomes. The smaller the raw score the better the outcome.
** For these indicators, a negative raw score represents a positive outcome. The more negative the raw score the better the outcome.

CQI Progress Report—Aggregate for Communities Initially Funded in 2005–2006 (continued)

Number and Standard Deviation Table for CQI Progress Report Indicators

CQI Progress Report Indicator	Cumulative Number of Cases at National Level*	Number of Sites with Complete Data to Calculate Indicator	Cumulative National Standard Deviation	Number of Cases at National Level for Current Period*	Data Source
1. Number of children served (with descriptive data)	12,189	30	325.85	2,087	EDIF**
2. Linguistic Competency Rate	184	5	0.12	20	Caregiver
3. Agency Involvement Rate–Service Provision	2,986	29	0.17	384	Caregiver
4. Caregiver Satisfaction Rate–Access to Services	2,851	29	0.19	369	Caregiver
5. Timeliness of Services (average days)	10,292	30	13.31	1,977	EDIF**
6. Agency Involvement Rate–Treatment Planning	8,621	30	0.22	1,025	EDIF**
7. Informal Supports Rate	2,999	29	0.20	385	Caregiver
8. Caregiver Satisfaction Rate–Quality of Services	2,859	29	0.24	370	Caregiver
9. Youth Satisfaction Rate–Quality of Services	1,516	22	0.26	194	Youth
10. Caregiver Satisfaction Rate–Outcomes	2,848	29	0.27	370	Caregiver
11. Youth Satisfaction Rate–Outcomes	1,512	22	0.23	195	Youth
12. Increase in Individualized Education Plan (IEP) Development (intake to 6 months)	2,520	29	0.15	321	Caregiver
13. Substance Use Treatment Rate	274	10	0.17	31	Caregiver
14a. School Enrollment Rate	3,112	29	0.06	407	Caregiver
14b. School Enrollment Rate (Preschool)	290	9	0.02	38	Caregiver
15a. School Attendance Rate (80% of the time)	2,843	29	0.09	372	Caregiver
15b. Daycare or Afterschool Care Program Attendance Rate	517	20	0.12	38	Caregiver
16. School Performance Improvement Rate (intake to 6 months)	1,619	24	0.09	201	Caregiver
17. Stability in Living Situation Rate (intake to 6 months)	3,209	29	0.14	419	Caregiver
18. Inpatient Hospitalization Days per Child (intake to 6 months)	3,209	29	4.73	419	Caregiver
19. Suicide Attempt Reduction Rate–Caregiver Report	3,163	20	0.49	412	Caregiver
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	2,515	26	0.09	458	Caregiver
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	541	9	0.05	70	Caregiver
20c. Socialization or Communication Problem Improvement Rate (intake to 6 months)	575	8	0.07	77	Caregiver
21. Average Reduction in Employment Days Lost (intake to 6 months)	1,414	28	4.00	174	Caregiver
22. Family Functioning Improvement Rate (intake to 6 months)	3,199	29	0.03	422	Caregiver
23. Caregiver Strain Improvement Rate (intake to 6 months)	3,145	29	0.08	417	Caregiver
24. Youth No Arrest Rate (intake to 6 months)	1,585	23	0.10	210	Youth
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)	1,570	20	0.67	210	Youth
26. Anxiety Improvement Rate (intake to 6 months)	1,545	23	0.07	255	Youth
27. Depression Improvement Rate (intake to 6 months)	1,587	23	0.04	208	Youth
28. Caregiver Overall Satisfaction	2,859	29	0.26	370	Caregiver
29. Youth Overall Satisfaction	1,513	22	0.22	195	Youth
30. Caregiver Satisfaction Rate–Participation	2,857	29	0.17	369	Caregiver
31. Youth Satisfaction Rate–Participation	1,512	22	0.28	194	Youth
32. Caregiver and Other Family Involvement in Service Plan	9,859	30	0.12	1,959	EDIF**
33. Youth Involvement in Service Plan	5,347	25	0.19	605	EDIF**
34. Caregiver Satisfaction Rate–Cultural Competency	2,781	29	0.16	356	Caregiver
35. Youth Satisfaction Rate–Cultural Competency	1,489	22	0.16	194	Youth

* Numbers reported as “0” represent fewer than 10 cases.

** The sources of information used to complete the EDIF include caregiver, staff-as-caregiver, youth, and case record review.

CARING FOR EVERY CHILD'S MENTAL HEALTH

Systems of Care

PEP13-CMHI2011