Comprehensive Community Mental Health Services for Children and Their Families Program

Evaluation Findings: Annual Report to Congress

2010

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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The Comprehensive Community Mental Health Services for Children and Their Families Program

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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 Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services. The CMHI was authorized by legislation (Public Law 102-321) and provides funds to public entities to promote the coordination of the multiple and often fragmented systems that serve children and youth from birth to age 21 diagnosed with a serious emotional disturbance and their families.

CMHI funding is provided to develop and implement systems of care in States and territories, local communities, and American Indian and Alaska Native communities. Children and youth with serious emotional disturbance face challenges in many aspects of their daily lives. They are at greater risk for substance abuse 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 emotional disturbance have lower grade point averages, miss more days of school, are not promoted to the next grade more than students with other disabilities, and have higher dropout rates (Clark, Deschenes, Sieler, Green, White, & Sondheimer, 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research further supports assertions about poor long-term outcomes for these children and adolescents, indicating a significant correlation between childhood emotional disorders and problems in adulthood (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Services that exist to address these issues are often inconsistent because they are often provided by a variety of professionals who work in diverse, relatively independent, and loosely coordinated public and private facilities, agencies, and systems. Therefore, families are challenged with obtaining services, and children and youth are left at risk for difficulties in school and/or in the community (National Research Council and Institute of Medicine, 2009).

Childhood emotional and behavioral disorders are the most costly of all chronic illnesses in children and youth (Soni, 2009; Roemer, 2011). It is estimated that 20 percent of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, and this costs the public $247 billion annually (National Research Council and Institutes of Medicine, 2009). Of children and youth in need of mental health services, 75–80 percent of these youth do not receive services (Kataoka, Zhang, & Wells, 2002). The Children's Mental Health Initiative has addressed these issues by providing quality, cost effective services that have been demonstrated to improve the lives of children and youth with serious mental health conditions and their families.

The system of care philosophy revolves around the following eight principles that state 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.

Accordingly, services should be both comprehensive and coordinated among public and private providers, consumers, and other key constituents. CMHI-funded systems of care build on the individual strengths of participating children, youth, and families to address their service needs.

The program has grown since its inception in fiscal year (FY) 1993 from initial funding of $4.9 million to $121.3 million in FY 2010. This brings the total investment to nearly $1.5 billion as of FY 2010, 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 E for descriptions of all national evaluation studies). These include descriptive, longitudinal, system-level, cost, and special studies.

The 2010 *Annual Report to Congress* describes

- the system of care approach, in particular the CMHI
- the characteristics, outcomes, and service experiences of the children, youth, and families receiving services through the CMHI;
- the implementation of the system of care philosophy;
- the sustainability efforts of CMHI communities.

A glossary of terms is included in Appendix A. The 2010 *Annual Report to Congress* presents findings based on the national evaluation of 59 communities whose CMHI funding began in one of the years between FY 2002 and FY 2006. Each community is funded for a six- year period; due to the rolling data collection of the national evaluation, at the time this report was prepared, data collection was not yet completed in communities initially funded in FYs 2005 and 2006.

Descriptive data were collected from intake records for 28,274 children and youth enrolled in these communities. Longitudinal data were collected from 8,937 caregivers and 5,382 youth aged 11 and older. The report also includes descriptive data on 753 children and youth served in the 18 communities funded in FY 2008.

Description of Children, Youth, and Their Families at Entry into the CMHI

CMHI-funded communities serve a diverse group of traditionally underserved children and youth:

- CMHI children and youth were more likely to be male (62.7 percent compared to 51.2 percent nationally).
- Nearly all children and youth served in CMHI grant communities (93.0 percent) were in the custody of a parent or other relative; however, only about one-quarter (26.8 percent) were in the legal custody of both biological parents, as compared to 69.4 percent in the U.S. population.
- More than one-half of the children and youth (57.2 percent) were living in poverty.

Caregivers reported that, before entering systems of care, 27.4 percent of children and youth had run away at least once, 21.7

percent had experienced physical abuse, 15.3 percent had been sexually abused, 15.3 percent had a history of drug or alcohol problems, and 11.6 percent had attempted suicide. More than one-half (53.8 percent) of children and youth experienced one or more of these risk factors prior to intake.

Children and youth exhibited a range of behavioral and emotional symptoms when entering systems of care:

- Conduct- or delinquency-related problems (57.0%)
- Hyperactive and attention-related problems (38.5%)
- Depression-related problems (35.0%)
- School performance problems (33.1%)
- Adjustment-related problems (32.1%)
- Anxiety-related problems (28.9%)
- Suicide-related problems (including ideation, attempt, self-injury) (16.6%)

In addition, children and youth served in CMHI-funded systems of care had a wide range of clinical diagnoses assigned by professionals:

- Mood disorders (35.7%)
- Attention-Deficit/Hyperactivity Disorder (32.3%)
- Oppositional Defiant Disorder (23.3%)
- Adjustment Disorders (13.8%)

Outcomes of Children, Youth, and Families

Children, youth, and their families were followed from entry into the CMHI, at 6 month intervals, for a period of 24 months. Steady improvements were found across this time interval and at 24 months after enrollment in system of care services, children and youth demonstrated a variety of improved clinical and functional outcomes. According to caregiver reports, more than one-third (38.6 percent) of children and youth showed a decrease in all types of behavioral and emotional symptoms between intake and 12 months, and 48.7 percent showed improvement between intake and 24 months.[c] [*]

Self-reported anxiety symptoms decreased for 24.2 percent of youth from intake to 12 months, and for 30.2 percent of youth from intake to 24 months.[c] Youths' self-reported symptoms of depression also improved over time. At 12 months, 16.5 percent of youth experienced improved depressive symptoms, and 23.6 percent experienced improvement at 24 months.[c] About one-third of youth had thought about suicide in the 6 months before entering system of care services. Only about 14 percent reported thoughts of suicide from 18 to 24 months after service intake.[c]

Children and youth also showed substantial improvements in various aspects of home and community functioning 24 months after enrollment in the CMHI:

- The proportion of children and youth with scores above the clinical level for functional impairment decreased steadily from 80.7 percent at intake to 63.7 percent at 24 months.[c]
- The proportion of children and youth who attended school regularly (of those who attended school at all) increased from 83.0 percent of children and youth to 90.1 percent.[c]
- The proportion of caregivers who reported that their child missed school at least once a month in the past 6 months, due to his/her behavioral or emotional problems decreased from 76.6 percent to 65.3 percent.[b]
- Good school performance, defined as achieving an average grade of A, B, or C in the 6 months prior to the interview,

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[*] Significance levels are indicated in this report as [a], [b], [c], and [d], where [a] $p < .05$, [b] $p < .01$, [c] $p < .001$, and [d] ns.

also improved from 63.4 percent to 75.7 percent.[c]

- The percentage of children and youth who were suspended or expelled in the 6 months prior to each interview decreased from 44.4 percent to 29.5 percent.[c]
- The percentage of children and youth who were in a single living situation, deemed to be a positive outcome, rather than in multiple living situations during the previous 6 months increased from 70.5 percent to 80.8 percent.[c]
- Being arrested (as reported by youth aged 11 and older) in the previous 6 months decreased from 17.5 percent to 8.0 percent.[c]
- The proportion of youth engaging in one or more delinquent behaviors (as reported by youth aged 11 and older) in the previous 6 months decreased from 76.6 percent to 44.5 percent.[c]

Caregivers experienced improved outcomes, as well:

- More than one-third (36.2 percent) of caregivers reported decreased strain from intake to 12 months, and nearly one-half (44.8 percent) reported decreased strain from intake to 24 months.[c]
- Caregivers who were employed at intake reported missing an average of 6.2 days of work in the previous 6 months due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months, and to 2.8 days at 24 months.[c]

Special Studies of Outcomes of Children and Youth

In an effort to assist communities, providers, and families in providing the most effective mental health services and interventions, two special studies were completed. These studies provided information about factors associated with better child outcomes:

- Youth who participated in their own treatment planning meetings reported having greater improvement in behavioral and emotional strengths between intake and 6 months into services than youth who did not participate in their treatment planning meetings.[c]
- Children and youth whose medications were prescribed by mental health care providers had more behavioral and emotional symptoms at intake and at 6 months than children and youth whose medications were prescribed by primary care providers.[c] However, the symptoms of all children and youth prescribed medication improved at the same rate.[c]

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 mental health services, including assessment and evaluation services; medication monitoring; individual, group, and family therapy; support services, such as case management; caregiver or family support; and respite care. Most types of mental health services were used less frequently over time. In particular, families received psychological assessments, crisis stabilization, inpatient hospitalization, and family therapy services less frequently between their 12- and 24-month interviews than between intake and their 12-month interview. Similarly, many types of support services were used less frequently over time, particularly case management, a behavioral/therapeutic aide, residential therapeutic camp, family support, therapeutic foster care, and receiving flexible funds for appropriate expenses.

System-level cost savings were realized through reduced out-of-home service use and fewer arrests. The decrease in the use of inpatient hospitalization translates into an estimated total decrease in inpatient hospitalization costs within the CMHI of more than $18 million. The decrease in juvenile arrests translates into an estimated total decrease in juvenile arrest costs within the CMHI of more than $6 million.

System Change and Sustainability

CMHI-funded communities must be able to implement system change in accordance with system of care principles. They are also expected to sustain that change when their Federal funding ends. The degree to which communities develop and implement infrastructure and service delivery systems according to system of care principles is assessed at the beginning, middle, and end of their funding period. The scores from these assessments indicate an increase from the beginning to the middle of funding for every principle within both domains, demonstrating that communities were successful in implementing the system of care principles during the first half of their funding. In both domains, communities received the highest average rating on the family-driven principle. Principles needing additional focus include the interagency, individualized, and cultural competence principles.

Community staff were surveyed about the availability of services in their communities. The services reported as being most available were case management, outpatient individual counseling, and diagnostic assessments/evaluations. The total number of evidence-based treatments (EBTs) being implemented increased from communities' second to fourth year of funding, indicating that the communities are implementing more EBTs as their systems of care develop. Interviews with community staff and caregivers revealed several facilitators of EBT implementation, including staff buy-in for particular EBTs, support by upper-level decision-makers, and adequate resources to support staff training and supervision.

Community representatives rated the extent to which factors affecting system of care sustainability after the end of CMHI funding were present in the community, and their impacts on sustainability. They reported that interagency relationships, ongoing administrative leadership for their systems of care, the inclusion of constituents at all levels, and the provision of ongoing training had the most positive impacts on their systems of care sustainability. Change in the larger economic climate and State financial support, as well as change in elected officials, were reported as having the most negative impact on system of care sustainability.

Caregiver and Youth Assessments of the Effectiveness of Systems of Care

Measuring the satisfaction of caregivers fulfills/responds to the authorizing legislation's mandate to have caregivers assess the effectiveness of systems of care. In general, caregivers and youth reported being satisfied with the services they received across all four 6-month follow-up interviews. In addition, 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, on average. Notably, caregivers receiving information about a particular aspect of their child's treatment were more satisfied with the services provided than caregivers not receiving the same information. Caregivers receiving information about a particular aspect of their child's treatment were also more satisfied with the service outcomes than caregivers not receiving the same information.

Summary

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

- reach many children and youth typically underserved by the mental health system;
- improve outcomes for children and youth;
- enhance family outcomes;
- expand the availability of effective supports and services;
- continue to implement and maintain fidelity to system of care principles;
- save money by reducing residential treatment and juvenile justice services; and
- incorporate principles that have a positive impact on sustainability.

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

Program Overview

Introduction

The Comprehensive Community Mental Health Services for Children and Their Families Program (the Children's Mental Health Initiative) is a cooperative agreement program administered by the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services. The Children's Mental Health Initiative (CMHI) provides funds to public entities to promote the transformation of the mental health care system that serves children and youth (aged 0–21) diagnosed with a serious emotional disturbance and their families. Funding is provided for the development and implementation of comprehensive and coordinated systems of care in a variety of geographical settings, such as States and U.S. territories, counties, local communities, and American Indian/Alaska Native Tribal nations.

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.

Children and youth with serious emotional disturbance face challenges in many aspects of their daily lives. They are at greater risk for substance abuse 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 emotional disturbance earn lower grade point averages, miss more days of school, are retained at grade more than students with other disabilities, and have higher dropout rates (Clark, Deschenes, Sieler, Green, White, & Sondheimer, 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research by Wagner, Kutash, Duchnowski, Epstein, and Sumi (2005) further supports assertions for poor long-term outcomes for these children and adolescents, indicating a significant correlation between childhood emotional disorders and problems in adulthood. Services that exist to address these issues are often inconsistent; they are often provided by a variety of professionals who work in diverse, relatively independent, and loosely coordinated public and private facilities, agencies, and systems. Therefore, families are challenged with obtaining services, and children and youth are left at risk for difficulties in school and/or in the community (National Research Council and Institute of Medicine, 2009.

Childhood emotional and behavioral disorders are the most costly of all chronic illnesses in children and youth (Soni, 2009; Roemer, 2011). It is estimated that 20 percent of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, and this costs the public $247 billion annually (National Research Council and Institutes of Medicine, 2009). Of children and youth in need of mental health services, 75–80 percent of these youth do not receive services (Kataoka, Zhang, & Wells, 2002). The Children's Mental Health Initiative has addressed these issues by providing quality, cost effective services that have been demonstrated to improve the lives of children and youth with serious mental health conditions and their families.

The ultimate goal of the CMHI is to improve child, youth, and family outcomes. In order to accomplish this, the CMHI aims to change the infrastructure and delivery of mental health services in communities by increasing coordination among their child-serving agencies; improving access to and quality of services; and reducing out-of-home placements for children. CMHI-funded systems of care are intended to build on the individual strengths of the children, youth, and families being served. Systems of care also promote cultural and linguistic competence.

Between FY 1993 and 2000, CMHI funds were provided by a grant mechanism, after which changes to the authorizing legislation required that cooperative agreements be awarded. Numerous types of entities may apply, including State governments; governmental units within political subdivisions of a State (e.g., county, city, town); the District of Columbia; Indian Tribes or tribal organizations; and U.S. territories. The cooperative agreements are currently funded on a matching basis over a 6-year period. During the first 3 years of the agreement, each grantee must provide matching local funding of $1 for every $3 of Federal funding provided. In the fourth year, there is a dollar-to-dollar match. During the fifth and sixth years, the Federal contribution is $1 for every $2 spent by the funded community.

Since its inception, the funding has supported increased capacity for services and improved service provision in 173 communities in all 50 States, the District of Columbia, Puerto Rico, Guam, and 22 American Indian/Alaska Native communities. The funding for the program was $4.9 million at its inception in FY 1993 and was $121.3 million in FY 2010. The cumulative investment through FY 2010 has been $1.5 billion.

The legislation authorizing the CMHI mandates an annual national evaluation of the initiative to describe, monitor, and chronicle its progress (Public Law 102–321). The national evaluation assesses the outcomes of funded communities and provides an opportunity for recommendations for administrative and legislative initiatives as the Secretary determines to be appropriate.

This report to Congress presents findings primarily derived from the national evaluation of the 59 communities initially awarded funding in each of FYs 2002–2006. This report also includes limited findings derived from the national evaluation of 18 communities funded in FY 2008. The report presents information on 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. A glossary of terms is included in Appendix A.

SAMHSA's 8 Strategic Initiatives

In order to continue its work in advancing and protecting the Nation's health, SAMHSA has identified and is pursuing 8 Strategic Initiatives. This report presents findings relevant to four initiatives that are applicable to the national evaluation: Data, Outcomes, and Quality; Recovery Support; Trauma and Justice; and Health Reform. See Appendix B for a more detailed description of SAMHSA's 8 Strategic Initiatives.

System of Care Philosophy and Goals

The CMHI was shaped by several Federal and State initiatives, beginning with the Child and Adolescent Service System Program (CASSP) (see Stroul & Friedman, 1986, for a comprehensive discussion of the program's background). CASSP was a national effort designed to help States and communities build comprehensive, community-based systems of care that were youth 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.

Underlying the system of care philosophy is the belief that services should be both comprehensive and coordinated among public and private providers, consumers, and other key constituents. When this system is in place, it is anticipated that services and supports will (1) be effective; (2) build on the strengths of each child and caregiver; and (3) address each person's unique physical, emotional, social, cultural, intellectual, and linguistic needs. The system of care philosophy revolves around the following eight principles that state 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.

With the system of care philosophy and principles as the theoretical underpinning for the CMHI, the following goals were developed for CMHI-funded communities:

- Expand community capacity to serve children and youth with serious emotional disturbance and their families.
- Provide a broad array of accessible, clinically effective, and fiscally accountable services, treatments, and supports.
- Promote broad-based, sustainable systemic change inclusive of policy reform and infrastructure development across the country, including in U.S. territories and tribal organizations.
- Create care management teams to implement an individualized service plan for each child.
- Deliver culturally and linguistically competent services with a special emphasis on racial, ethnic, linguistically diverse, and other underrepresented, underserved, or invisible cultural groups.
- Encourage and facilitate the full participation of children, youth, and families in service planning; in the development, evaluation, and sustainability of local services and supports; and in overall system change activities.

Characteristics of Communities Receiving CMHI Funding

Communities initially funded between FY 1993 and FY 2003 have completed their funding cycles. Communities funded in FYs 2004–2006 are in their later years of funding. Communities funded in FYs 2008 and 2009 are in their start-up years of funding; FY 2010 communities started their funding in October 2010. A complete list of CMHI-funded communities is provided in Appendix C.

CMHI-funded communities are characterized by different populations of focus, representing diversity in racial and ethnic groups, underserved groups, language, and age. For example, languages spoken in the CMHI communities include Creole, Cantonese, French, Filipino, Portuguese, Spanish, Vietnamese, and a variety of American Indian languages.

Many communities had established elements of systems of care prior to their CMHI funding, and some communities received their funding to expand existing system of care services to underserved populations. For example, Placer County, California, received its funding specifically to expand its existing system of care (developed with county funds) to American Indian and Hispanic/Latino children, youth, and families.

Some communities focus their CMHI-funded services on specific populations. These include children or youth of specific ages (e.g., children aged birth to 8, transition-age youth), or those with a specific service need (e.g., at risk for homelessness or out-of-home placement, involvement with juvenile justice or child welfare, or with co-occurring mental health and substance use disorders). Several communities focus their efforts on reaching out to underserved populations such as African-American; American Indian/Alaska Native; Hispanic/Latino; or Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S) children and youth and their families.

Communities are located across the country, and vary in size, population density, and population focus. The largest service areas are the islands of Guam and Puerto Rico, and States such as Idaho and Oklahoma. Urban CMHI communities such as Los Angeles County, California, and Harris County, Texas, address the needs of diverse populations that span large and densely populated geographic areas. Others—such as three counties in Maine—encompass both urban and rural service areas. Some are single counties or parishes, or smaller communities of metropolitan areas. Still others are completely rural, such as Maury County, Tennessee, and face unique challenges in providing access to services.

National Evaluation of the CMHI[1]

Authorizing Legislation

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.

The national evaluation was mandated as part of the legislation that created the CMHI, and is an important component of the CMHI. All communities agree to participate in the national evaluation as part of their funding agreement with SAMHSA. The national evaluation has been designed to provide information on the following: (1) mental health and functional outcomes of children, youth, and their families; (2) services received by children, youth, and families; (3) the implementation and sustainability of systems of care; and (4) critical and emerging issues in children's mental health. For example, the national evaluation examines the extent to which communities provide the services mandated by the authorizing legislation, and the extent to which they integrate the system of care philosophy and goals.

Findings from the national evaluation have informed service delivery and treatment, program funding decisions, and have resulted in modifications to existing U.S.

mental health policies related to children and youth nationally. In addition, findings have provided SAMHSA with data for monitoring CMHI performance and have provided evidence of CMHI achievements.

The CMHI national evaluation is also instrumental in helping SAMHSA to monitor and evaluate its agency performance toward achieving its strategic initiatives in the arenas of: data, outcomes and quality; housing and homelessness; trauma and justice; and health care reform.

SAMHSA Strategic Initiative

Data, Outcomes, and Quality—Demonstrating Results

The national evaluation developed a *CQI Progress Report* (see Appendix D) to

- assist communities in pursuing data-driven continuous quality improvement (CQI), document program performance at the community and national levels;
- provide information to support communities in conducting planned and ongoing program assessments that result in data-driven decisions related to program quality and improvement;
- present performance data in five domains: (a) system-level outcomes, (b) child and family outcomes, (c) satisfaction with services, (d) family and youth involvement, and (e) cultural and linguistic competence.

The national evaluation data are used to demonstrate improvements in program outcomes, including Government Performance and Results Act (GPRA) indicators. The CMHI GPRA measures are also reported in Appendix D.

Methodology

The 2010 *Annual Report to Congress* presents findings based on the national evaluation of 59 communities whose CMHI funding began in one of the years between FY 2002 and FY 2006. Each community is funded for a six-year period, and families are enrolled in treatment and the national evaluation on a continuing basis; enrollment into the national evaluation ends during funding year 5 so that follow-up interviews can be conducted before the end of funding (see Table 1). Therefore, at the time this report was prepared, data collection was not yet completed in communities initially funded in FYs 2005 and 2006.

Table 1. Data Collection Schedule

Longitudinal Data Collection Year	Initial Year of Funding					
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2008
FY 2004	X					
FY 2005	X	X				
FY 2006	X	X	X			
FY 2007	X	X	X	X		
FY 2008	X	X	X	X	X	
FY 2009		X	X	X	X	
FY 2010			X	X	X	X
FY 2011				X	X	X
FY 2012					X	X
FY 2013						X
FY 2014						X

Most findings presented in the report are based on analyses of data from youth or caregivers who completed all four follow-up interviews; therefore, sample sizes might vary across analyses.

The data analyzed for this report come from the national evaluation studies, described in Appendix E. These data were collected from intake records, from interviews with caregivers, from interviews with youth, and from interviews with various community staff. Appendix F describes the specific instruments used.

The data analyzed for this report represent children and youth who received services between October 1, 2003 and June 30, 2010. Descriptive data were collected from the records of 28,274 children and youth enrolled in these services. Longitudinal data were collected from a sample of 8,937 caregivers and 5,382 youth who participated in the Longitudinal Child and Family Outcome Study. 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.

Caregivers reported information about their children and their families' experiences in systems of care; youth responded for themselves, where feasible. Many findings are based on interviews conducted at 6-month intervals (i.e., at intake and at 6, 12, 18, 24 months after intake).[2] Outcomes reported for children, youth, and families are based on analyses of data from youth or caregivers who completed all four follow-up interviews.[3] Denominators for the analyses may vary, because not all respondents completed all interview items. Findings not based on four follow-up interviews will be noted in the text, tables, and figures.

All findings discussed in this report were statistically significant at the $p < .05$ level (although many findings were statistically significant with even smaller p-values). Appendix G provides a description of the statistical methods used in these analyses.

Description of Children, Youth, and Their Families Served in FY 2002–2006 Communities at Entry into the CMHI

This section presents a summary description of selected characteristics of children, youth, and their families at entry into services – their demographics, life experiences, and their mental health challenges. Appendix H contains detailed demographic and enrollment information by site and by time interval.

Demographics

The demographic characteristics of children and youth differed from those of the general population (see Table 2).[4] In comparison to those of similar age nationally, CMHI children and youth were more likely to be male (62.7 percent compared to 51.2 percent nationally), and to be younger than 16 years old (81.0 percent compared to 68.8 percent). The proportion of American Indian/Alaska Native children and youth in the CMHI was more than three times greater than in the general population (4.3 percent compared to 0.9 percent). Similarly, the proportion of African-American children and youth was much greater than in the general population (23.5 percent compared to 14.6 percent).[5] The CMHI population reflects the CMHI goal to reach populations that often have limited access to mental health services. The proportion of Hispanic and Latino children and youth was about the same as the U.S. population as a whole.

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

Gender, Age, and Race/Ethnicity	CMHI Communities Funded FYs 2002–2006	U.S. Population 2006[a]
Gender	*n* = 28,274	
Male	62.7%	51.2%
Female	37.3%	48.8%
Age	*n* = 28,159	
0–5 years	13.6%	26.0%
6–11 years	30.1%	25.0%
12–15 years	37.3%	17.8%
16–22 years	19.0%	31.2%
Race/Ethnicity	*n* = 27,939	
American Indian or Alaska Native	4.3%	0.9%
Asian	1.2%	3.9%
Black or African-American	23.5%	14.6%
Native Hawaiian or other Pacific Islander	1.3%	0.2%
White	41.6%	57.7%
Hispanic/Latino	23.3%	20.2%
Multi-Racial	4.4%	2.5%
Other	0.3%	—

[a] These estimates correspond with the midpoint of 2003–2010, the years that grant communities are receiving funding.

Nearly all children and youth served in CMHI grant communities (93.0 percent) were in the custody of a parent or other relative. However, only about one-quarter (26.8 percent) were in the legal custody of both biological parents, as compared to 69.4 percent in the U.S. population.[6] About one-half (48.6 percent) were in the care of their mothers only. The remaining 24.6 percent were in the custody of other family members (e.g., biological father, grandparents, or siblings), adoptive parents or friends, or were wards of the State. More than one-half of the children and youth (57.2 percent) were living in poverty.[7] A large proportion of caregivers (44.8 percent) reported that they had not been employed during the 6 months prior to their child's entry into services.[8] However, only 101 caregivers (0.4 percent) reported that they and their child were homeless.

Children's and Youths' Adverse Experiences

Caregivers reported that, before entering systems of care, 27.4 percent of children and youth had run away at least once, 21.7 percent had experienced physical abuse, 15.3 percent had been sexually abused, 15.3 percent had a history of drug or alcohol problems, and 11.6 percent had attempted suicide. More than one-half (53.8 percent) of children and youth experienced one or more of these risk factors prior to intake.

Almost one-half (46.2 percent) of children and youth had been exposed to domestic violence, and approximately one-third (34.1percent) lived in a household where someone had been convicted of a crime.

Most children and youth (85.2 percent) had biological family members with some type of mental illness, including drug and alcohol problems. Approximately 69.9 percent of caregivers reported that their child had a biological family member who had been diagnosed with depression or shown signs of depression and 47.1 percent reported that their child had a biological family member with another type of mental illness. In addition, 60.8 percent of children and youth were reported to have a biological family member who had a drinking or drug problem.

SAMHSA Strategic Initiative

Trauma and Justice

The types of trauma experienced by children and youth included experiencing physical or sexual abuse, being exposed to domestic violence, or living in a household with an adult who has been convicted of a crime, who has a drug or alcohol problem, or who has a mental illness.

- Children and youth experienced, on average, about 2.2 of these types of trauma prior to intake, with nearly one-fourth (23.5 percent) having experienced four or more types.

  Overall, the more types of trauma a child or youth experienced, the more clinical impairment and fewer behavioral and emotional strengths the child or youth exhibited.

  Further, youth with more types of trauma reported having more depression and anxiety symptoms.

School Attendance

Almost 70 percent (69.6 percent) of children and youth in school at entry into CMHI were usually absent at least once a month in the 6 months prior to beginning services. More than 90 percent of children and youth (92.9 percent) were in school or preschool in the 6 months prior to beginning services.

Mental Health Challenges of Children and Youth at Entry into the CMHI

Children and youth entered systems of care with a range of behavioral and emotional symptoms, and met the criteria for a range of clinical diagnoses assigned by professionals.

Conduct- or delinquency-related problems were identified as presenting problems for more than one-half (57.0 percent) of the children and youth. Children and youth also presented with hyperactive and attention-related problems (38.0 percent), depression-related problems (35.0 percent), school performance problems (33.1 percent), adjustment-related problems (32.1 percent), anxiety-related problems (28.9 percent), and suicide ideation and attempts (16.6 percent).

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 Edition (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 *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM–IV*; American Psychiatric Association, 1994) can be used for children and youth of all ages. Clinical diagnoses of children and youth at intake are presented in Appendix I (Table I–1).

The most common DC:0–3R diagnoses were adjustment disorders (20.4 percent), sensory stimulation-seeking/impulsive disorder (16.7 percent), anxiety disorders (13.9 percent), and hypersensitivity (10.8 percent).[9] In addition, the most common *DSM–IV* diagnoses were mood disorders (35.7 percent), attention-deficit/hyperactivity disorder (32.3 percent), oppositional defiant disorder (23.3 percent), and adjustment disorders (13.8 percent).[10]

Description of Children and Youth Served in FY 2008 Communities at Entry into the CMHI

In addition to the descriptive data summarized above, for children who were served in communities receiving their funding in FYs 2002–2006, some preliminary data are available from the 18 communities initially funded in FY 2008. The characteristics of the 753 children and youth for whom data were available at the time of this report are described below. See Appendix H (Table H–5) for more detail.

More than two-thirds (67.1 percent) of the children and youth were male. About one-quarter (27.5 percent) were between the ages of 0 and 5 years, and about half (48.4 percent) were 6–15 years old. Most were White (60.4 percent), 15 percent were Hispanic (15.8 percent), and 13.3 percent were African-American.

Conduct or delinquency-related problems were identified as presenting problems for more than one-half (55.1 percent) of the children and youth. Children and youth also presented with problems related to hyperactivity and attention (49.0 percent), school performance (38.0 percent), anxiety (34.2 percent), depression (34.0 percent), adjustment (31.9 percent), and attempted or contemplated suicide (18.8 percent).

The most common *DSM–IV* clinical diagnoses assigned by mental health clinicians were attention-deficit/hyperactivity disorder (40.3 percent), mood disorders (38.3 percent), oppositional defiant disorder (18.6 percent), and adjustment disorders (11.9 percent).

SAMHSA Strategic Initiative

Health Reform

Insurance Status at Intake

The types of health insurance in which children and youth were enrolled in the 6 months prior to intake included:

- Medicaid (74.1 percent)
- private health insurance (19.1 percent)
- their States' Child Health Insurance Program (4.1 percent)

Out-of-Pocket Costs

Six months after intake, caregivers were asked about their out-of-pocket expenses for the first 6 months of services:

- between $0 and $50 (30.0 percent)
- between $51 and $250 dollars (42.2 percent)
- between $251 and $500 (15.8 percent)
- more than $500 (12.0 percent

Summary of Characteristics of Children and Youth at Entry into the CMHI

Most children and youth were male, came from ethnically diverse populations, and came from families that were more likely to live at or below the poverty level than above the poverty level.

Most of the children served had one or more experiences in their lives that are associated with greater risk for mental health challenges, such as physical or sexual abuse or a history of drug or alcohol problems. Almost one-half of the children and youth lived in family situations that put them at greater risk for later mental health challenges (e.g., exposure to domestic violence).

Children and youth who experienced more different types of trauma in the 6 months prior to intake experienced greater clinical and functional impairment than those who experienced fewer types of trauma.

More than one-half of the children and youth exhibited conduct- or delinquency-related problems at entry into the system of care.

The most common clinical diagnoses assigned to children and youth entering the system of care were mood disorders, attention-deficit/hyperactivity disorder, oppositional defiant disorder, and adjustment disorders.

Outcomes of Children, Youth, and Families

System of care services aim to improve a wide range of outcomes for children and youth, including their mental health and other health outcomes; community, home, and school functioning; living situations; and juvenile justice outcomes. Another goal is to enhance the strengths of the children and youth. Improved caregiver outcomes are an additional focus of system of care services.

Mental Health Outcomes of Children and Youth After Entry into the CMHI

This subsection examines changes over time (at 6 month intervals) in children's and youths' mental and emotional health after entry into system of care services.

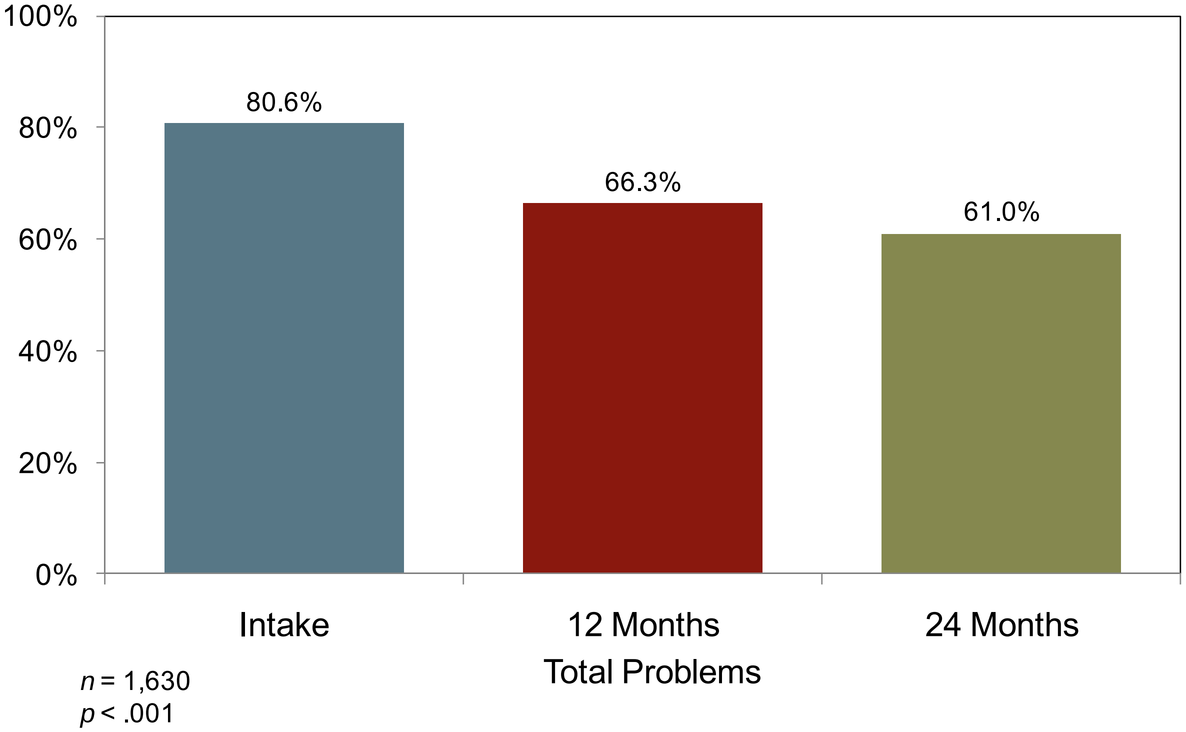
Behavioral and Emotional Symptoms

The behavioral and emotional symptoms of children and youth aged 1–18 were examined using a combination of the scores from the Child Behavior Checklist/1½–5 (CBCL 1½–5; Achenbach & Rescorla, 2000) and the Child Behavior Checklist/6–18 (CBCL 6–18; Achenbach & Rescorla, 2001), which measure behavioral and emotional problems in children and youth. A Total Problems score was computed, as were scores for two broadband subscales—Internalizing and Externalizing symptoms. Internalizing behavioral symptoms include, for example, feeling fearful or refusing to talk—symptoms which may not be apparent to others, whereas externalizing behavioral symptoms include recognizable behaviors, such as breaking rules, cruelty, and bullying.

According to caregiver reports, more than one-third (38.6 percent) of children and youth showed a decrease in all types of behavioral and emotional symptoms between intake and 12 months, and 48.7 percent showed improvement between intake and 24 months.[11,c,†] Further, the percentage of children and youth with Total Problems scores above the clinical range declined from 80.6 percent at intake to 66.3 percent at 12 months and 61.0 percent at 24 months (Figure 1).[12,c] Between intake and 24 months, 32.3 percent of children and youth showed improved Internalizing scores,[c] and the proportion with scores in the clinical range decreased from 64.7 percent to 44.1 percent[c] (Appendix J, Figure J–1). Similarly, 38.7 percent of children and youth demonstrated improved Externalizing scores,[c] with the proportion of children and youth with scores in the clinical level decreasing from 79.6 percent to 59.7 percent.[c]

[†] Significance levels are indicated in this report as [a], [b], [c], and [d], where [a] $p < .05$, [b] $p < .01$, [c] $p < .001$, and [d] ns.

Figure 1: Percentages of Children and Youth with Clinical Levels of Behavioral and Emotional Problems Communities Funded in 2002–2006



Anxiety and Depression Symptoms

Youth provided information about their anxiety symptoms using the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). In addition, youth reported their depressive symptoms using the Reynolds Adolescent Depression Scale, 2nd edition (RADS–2; Reynolds, 1986).

Self-reported anxiety symptoms decreased for 24.2 percent of youth from intake to 12 months, and for 30.2 percent of youth from intake to 24 months.[c] The proportion of youth reporting clinical levels of anxiety symptoms decreased over time from 33.7 percent at intake to 25.5 percent and 23.2 percent at 12 and 24 months, respectively (see Appendix J, Figure J–3).[13,c]

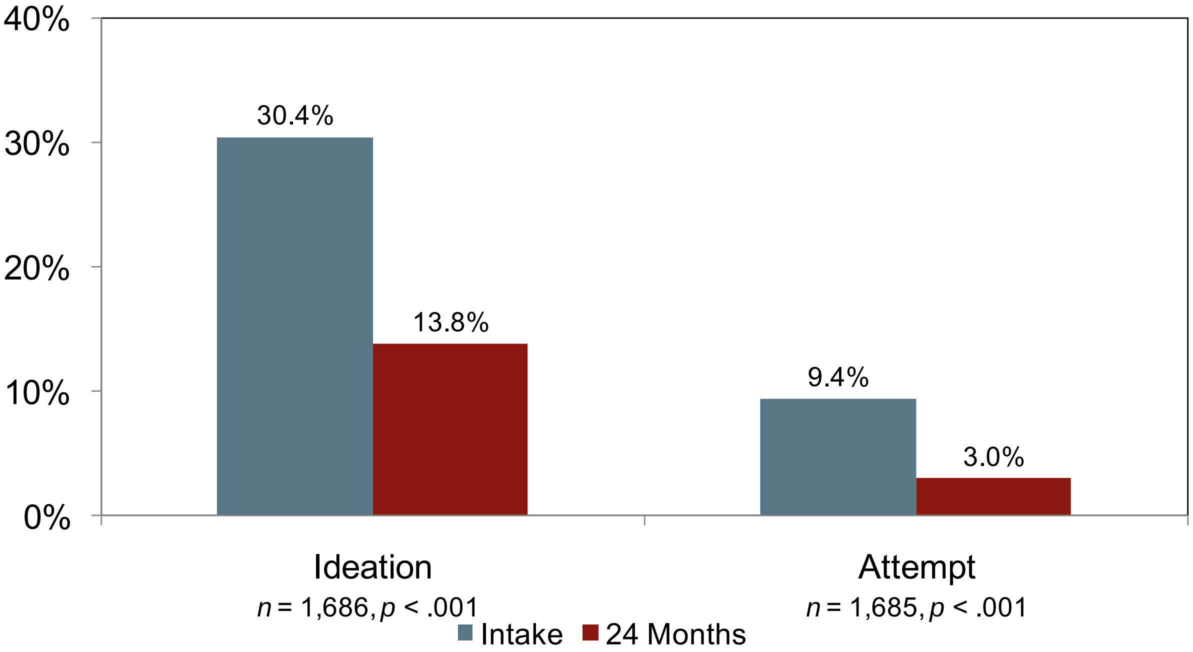
Youths' self-reported symptoms of depression also improved over time. At 12 months, 16.5 percent of youth experienced improved depressive symptoms, and 23.6 percent experienced improvement at 24 months.[,c] The percentage of youth with clinical levels of depressive symptoms decreased from 24.1 percent at intake to 16.7 and 13.4 percents at 12 and 24 months, respectively (see Appendix J, Figure J–3).[c]

Youth with anxiety or depression levels in the clinical range exhibited smaller rates of improvement than youth with levels not in the clinical range.

Suicidal Ideation and Attempts

About one-third of youth had thought about suicide in the 6 months before entering system of care services. Only about 14 percent reported thoughts of suicide from 18 to 24 months after service intake (see Figure 2).[c] Similarly, youth suicide attempts for these 6-month periods fell by more than two thirds, from 9.4 percent to 3.0 percent.[c]

Figure 2: Percentages of Youth with Suicidal Ideation and Attempts Communities Funded in 2002–2006



Functional Outcomes of Children and Youth After Entry into the CMHI

This subsection examines the change over time (in 6-month intervals after intake into system of care services) in outcomes measuring home and community functioning, such as school performance and juvenile justice involvement.

Functional Impairment

The Columbia Impairment Scale (CIS; Bird et al., 1993) provides a global measure of functional impairment of children and youth aged 3 and older. The CIS assesses basic areas of functioning problems commonly encountered in children and youth, such as relationships with other people, behavioral problems, and negative emotions.

An examination of changes over time revealed that the percentage of children and youth who improved in overall functioning increased from 19.8 percent between intake and 12 months to 26.1 percent between intake and 24 months.[c] The percentages of children and youth with scores above a prescribed clinical level also were examined at three points in time (see Appendix J, Figure J–2).[14] The proportion of children and youth with scores above the clinical level for functional impairment decreased steadily from 80.7 percent at intake to 63.7 percent at 24 months.[c]

Educational Outcomes

Regular school attendance, defined as attending school at least 80 percent of the time during the previous 6 months, improved. The proportion of children and youth who attended school regularly (of those who attended school at all) increased from 83.0 percent of children and youth at intake to 90.1 percent at 24 months (see Appendix J, Figure J–4).[c] In addition, the proportion of caregivers who reported that their child missed school at least once a month in the last 6 months due to his/her behavioral or emotional problems decreased from 76.6 percent at intake to 65.3 percent at 24 months.[b] Similarly, the percentage of caregivers who reported that their child's attendance in a daycare or afterschool program was affected by his/her behavioral or emotional problems in the past 6 months, decreased from 32.2 percent at intake to 19.5 percent at 12 months.[15,c]

Good school performance, defined as achieving an average grade of A, B, or C in the 6 months prior to the interview, also improved. The percentage of children and youth with good school performance increased from 63.4 percent at intake to 75.7 percent at 24 months (see Appendix J, Figure J–4).[c] The percentage of children and youth who were suspended or expelled in the 6 months prior to each interview decreased from 44.4 percent at intake to 29.5 percent at 24 months.[c]

The proportion of children and youth with an individualized education plan (IEP) increased slightly from 53.7 percent at intake to 60.8 percent at 24 months.[c]

Living Situations

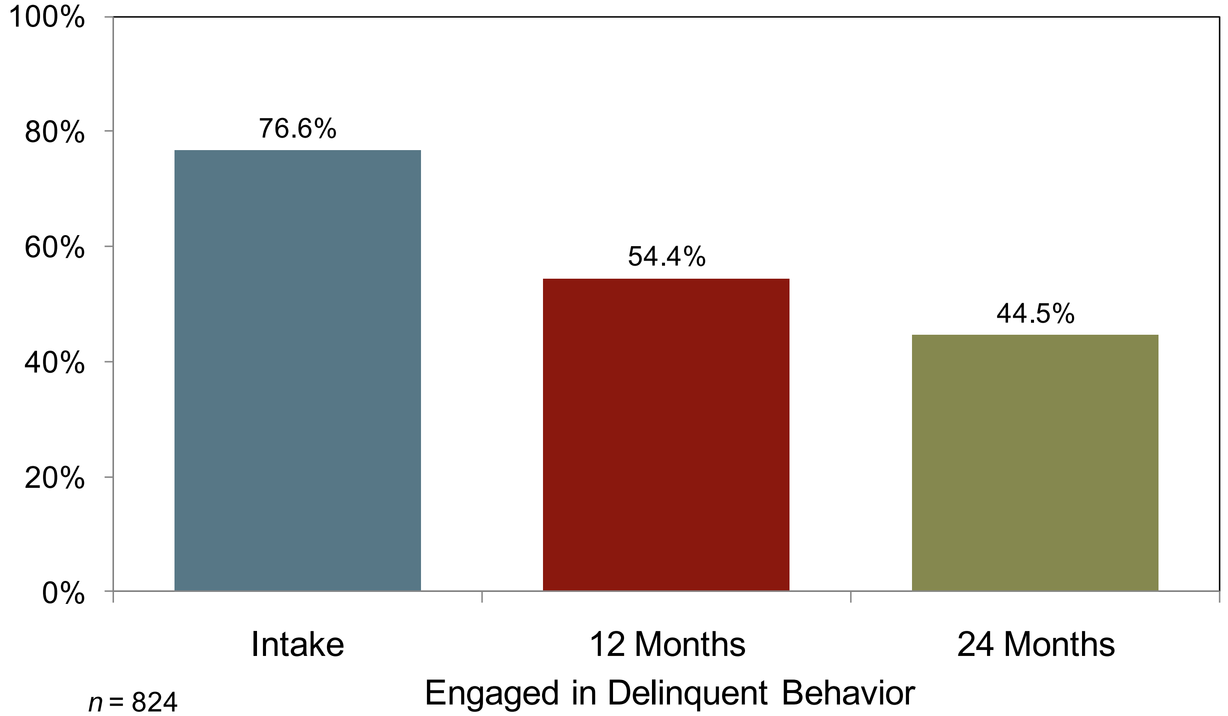
Caregivers were asked about all of the places in which their child or youth had lived in the 6 months prior to each interview. The percentage of children and youth who were in a single living situation, deemed to be a positive outcome, rather than in multiple living situations during the previous 6 months increased from 70.5 percent at intake to 80.8 percent at 24 months.[c]

Juvenile Justice Outcomes

Youth were asked about their involvement with law enforcement in the 6 months prior to each interview. The percentage who reported being questioned by the police decreased from 19.6 percent at intake to 12.0 percent at 24 months. The proportion of youth who reported having been on probation in the previous 6 months decreased (from 19.3 percent at intake to 13.4 percent at 24 months).[c] Further, 17.5 percent reported having been arrested in the 6 months prior to intake, but only 8.0 percent reported being arrested in the 6 months prior to their 24-month interview.[c]

Youth were also asked about their involvement in various delinquent behaviors in the 6 months prior to each interview. These behaviors include, but are not limited to, stealing from a store, traffic citations, physical fights, breaking into a house or building, and forcing someone to have sex against his/her will. The proportion of youth engaging in one or more of these delinquent behaviors decreased from 76.6 percent at intake to 44.5 percent at 24 months (see Figure 3).[c]

Figure 3: Change in Youths' Engagement in Delinquent Behaviors Communities Funded in 2002–2006



n = 824
p < .001

Other Health Outcomes After Entry into the CMHI

Many children and youth also had chronic medical problems (e.g., asthma, diabetes, migraines), increasing their needs for primary healthcare and affecting their daily lives. Almost one-half (43.2 percent) had chronic health problems at intake, and this percentage stayed fairly consistent (40.8 percent at 24 months).[d] At intake, caregivers reported that the regular activities of 45.4 percent of these children and youth were disrupted due to their health problems. By 24 months after intake, the proportion of caregivers reporting disruptions in their child's activities due to chronic health problems decreased, with 34.8 percent reporting such disruptions.[a]

Child and Youth Strengths After Entry into the CMHI

In addition to assessing challenges experienced by children and youth, the national evaluation examined several factors contributing to the strengths and well-being of children and youth participating in the systems of care.

Children's and youths' 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. Caregivers reported a significant increase in their child's strengths from intake to 24 months; approximately one-third (33.1 percent) of youth exhibited improvement in a score summarizing their behavioral and emotional strengths at 12 months and 38.0 percent exhibited improvement in this summary score at 24 months (see Appendix J, Figure J–5).[c] Youth perceived their own scores (summarizing their strengths) to be lower than their caregivers' scores; 26.5 percent of youth reported improvement at 12 months, and 31.3 percent reported improvement at 24 months.[c]

SAMHSA Strategic Initiative

Recovery Support

Many aspects of CMHI services support the recovery and resilience of children and youth:

- One of the system of care principles calls for service plans to be strengths based.
- CMHI grant communities serve children as young as under one year old, and there is a growing number of grant communities that are focusing their services on young children
- Children's and youths' strengths increase after their entry into the CMHI.

Caregiver Outcomes After Entry into the CMHI

Caregivers and families of children and youth with mental health challenges experience stressors that may impact their functioning which, in turn, can impact their children and youth. This subsection examines changes in caregiver outcomes.

Caregiver Strain

The national evaluation assessed caregiver stress using the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1998). It 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-third (36.2 percent) of caregivers reported decreased global strain from intake to 12 months, and nearly one-half (44.8 percent) reported decreased global strain from intake to 24 months (see Appendix J, Figure J–6).[c] Some caregivers (7.9 percent) reported decreased subjective externalizing strain between intake and 12 months; 11.8 percent reported decreased subjective externalizing strain between intake and 24 months.[c] Almost one-quarter of caregivers (21.9 percent) reported that their subjective internalizing strain had decreased between intake and 12 months and 31.4 percent reported it had decreased between intake and 24 months.[c] Caregivers also reported decreased objective strain from intake to 12 months (32.1 percent), as well as from intake to 24 months (38.8 percent).[c]

Caregiver Employment

An important goal of the system of care approach is to improve the lives of families of children and youth with serious emotional issues, including improving caregivers' abilities to work productively. Caregivers who were employed at intake reported missing an average of 6.2 days of work in the previous 6 months due to their child's behavioral or emotional problems. This decreased to 4.0 days at 12 months, and to 2.8 days at 24 months.[c]

Summary of Outcomes of Children, Youth, and Families After Entry into the CMHI

- Substantial proportions of children and youth showed improved emotional and behavioral symptoms and functioning, and decreased symptoms of depression and anxiety.
- There was a significant decrease in the proportion of children and youth who thought about or attempted suicide.
- Many children and youth demonstrated improved educational outcomes, such as improved attendance and improved grades. Children and youth also experienced fewer suspensions and expulsions, on average.
- Children and youth experienced more stable living situations.
- Large proportions of youth reported a decrease in engaging in delinquent behavior, as well as decreased law enforcement involvement, such as being questioned by police, being arrested, or being on probation.
- Many children and youth experienced fewer disruptions due to chronic health problems, demonstrating the critical connection between physical and mental health.
- Many children and youth experienced a gain in behavioral and emotional strengths over time.
- Large proportions of caregivers experienced less strain, and missed fewer days of work due to their child's emotional or behavioral problems.

Special Studies of Outcomes of Children and Youth

In an effort to assist communities, providers, and families in providing the most effective mental health services and interventions, two special studies were completed.

Youths' Participation in Their Own Treatment Planning

The national evaluation compared the emotional and behavioral strengths of youth aged 11 and older who did (77.3 percent) and did not (22.7 percent) participate in their own treatment planning meetings. Youths' behavioral and emotional strengths were measured using both the youth and caregiver versions of the Behavioral Emotional Rating Scale (BERS-2). Youth who participated in their own treatment planning meetings reported having greater improvement in strengths between intake and 6 months into services than youth who did not participate in their treatment planning meetings (see Appendix J, Figure J–7).[b]

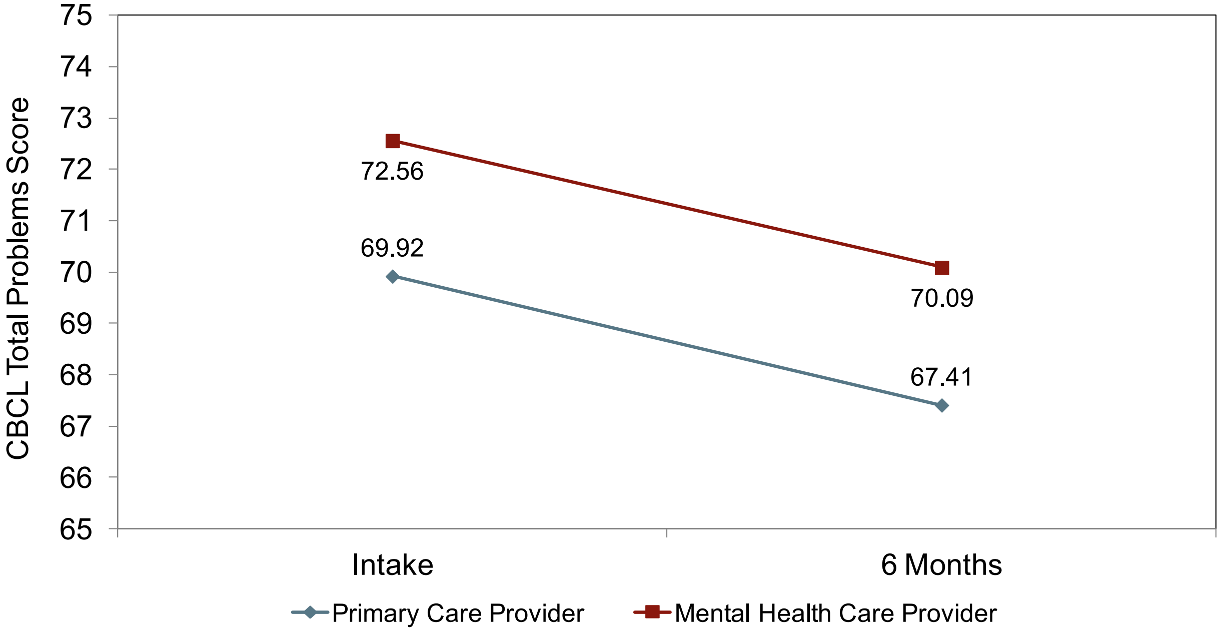
Type of Provider Prescribing Medications for Emotional and Behavioral Symptoms

The national evaluation compared emotional and behavioral symptoms of children and youth 6-18 years old (using the CBCL 6-18) whose medications to reduce these symptoms were prescribed by different types of health care providers. At entry into services, slightly more than one-half of these children and youth (52.6 percent) were taking at least one medication for their emotional or behavioral symptoms; the overwhelming majority (85.7 percent) had their medications prescribed by mental health care providers.[16] The remainder (14.3 percent) had their medications prescribed by primary care providers.

Children and youth whose medications were prescribed by mental health care providers had more behavioral and emotional symptoms at intake and at 6 months than children and youth whose medications were prescribed by primary care providers (Figure 4).[c] However, the symptoms of all children and youth prescribed medication improved at the same rate. These findings were similar for children and youth with internalizing or externalizing symptoms.

Children and youth whose medications were prescribed by mental health care providers were more likely to be female, were older, had more *DSM–IV* diagnoses, took more types of medications, and received more types of services than those whose medications were prescribed by primary care providers.

Figure 4: Medication-Prescribing Provider Type and Behavioral and Emotional Symptoms at Intake and 6 Months
Communities Funded in 2002–2006



n = 2,516
Within Subjects X Time: *F* = .010, *p* = .921
Between Subjects X Time: *F* = 43.000, *p* < .001

Summary of Special Studies of Outcomes of Children and Youth

- Youth who participated in their own treatment planning meetings tended to report more improved behavioral and emotional strengths than those who did not participate in treatment planning.
- Children and youth whose psychotropic medications were prescribed by mental health care providers or primary care providers were very likely to experience similar rates of improved behavioral and emotional symptoms over the first 6 months of services.

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 mental health services, including assessment and evaluation services; medication monitoring; individual, group, and family therapy; support services, such as case management; caregiver or family support; and respite care. The national evaluation examined the sources of referrals to system of care services, types of services used, utilization patterns, and associated costs. This section summarizes individual-level service use. Broader system-level service availability is addressed in the next section.

Referrals and Involvement in Service Planning

Families can be referred for system of care services by any number of child-serving agencies in the community. They can also refer themselves to these services.

Over one-fourth (26.8 percent) of the referrals to system of care services were made by mental health agencies.[17] Other referrals were made by schools (20.1 percent), the child welfare system and family courts (15.8 percent), caregivers or youth as self-referrals (14.1 percent), the juvenile justice system (11.2 percent), and various other sources (12.0 percent).

Many staff from these community agencies participated in the preparation of children's system of care service plans. Families' case managers or service coordinators were most likely to have participated in developing their system of care service plans (74.7 percent of plans). Mental health staff members participated in more than half (51.7 percent) of the families' service planning meetings. Education (15.8 percent), child welfare (11.0 percent), juvenile justice (8.1 percent), or health (4.0 percent) staff participated in far smaller proportions of service planning meetings.

Types of Mental Health and Support Services Received

During each of the interviews conducted, caregivers were asked about the types of services they and their child had received during the previous 6 months. Caregivers were also asked about the locations in which the services were received. This section summarizes services reported by caregivers as being received between intake and 12 months, as well as services reported being received between 12 and 24 months.[18]

The number of different types of services received is highest in the first 6 months in systems of care and decreases over time. On average, children and families received six types of services in the first year, and five types from 12 to 24 months after intake. The most frequently used services between intake and the 12-month interview were case management (a support service), individual therapy, and assessment or evaluation (see Table 3). Case management and individual therapy remained the most frequently used services between the 12-month and 24-month interviews. The service used third most frequently changed between the two time periods from assessment or evaluation between intake and 12 months to medication treatment monitoring between 12 and 24 months.

Caregiver or family support services were received by about half of the families during their first 24 months of involvement with systems of care; 53.5 percent received such services during their first year of involvement and 45.5 percent received such services during their second year of involvement. Informal support services were received by about two-thirds of the families during both their first and second years of involvement with systems of care (67.2 percent and 67.3 percent, respectively). Other support services received consistently by substantial percentages of families throughout their first and second years of involvement with systems of care were treatment plan-based recreational activities (57.1 and 55.0 percent, respectively), transportation (47.9 percent and 43.5 percent, respectively), and receiving flexible funds for various expenses designed to improve family functioning (42.7 percent and 35.1 percent, respectively).

Most types of mental health services were used less frequently over time (see Table 3). In particular, families received psychological assessments, crisis stabilization, inpatient hospitalization, and family therapy services less frequently between their 12- and 24-month interviews than between intake and their 12-month interview. Similarly, many types of support services were used less frequently over time, particularly case management, a behavioral/ therapeutic aide, residential therapeutic camp, family support, therapeutic foster care, and receiving flexible funds for appropriate expenses.

One of the major goals of the CMHI is to reduce restrictive out-of-home service use. The percentage of children and youth receiving inpatient hospitalization, residential therapeutic camp, or residential treatment decreased from 31.3 percent between intake and the 12-month interview to 23.7 percent between the 12- and 24-month interviews.

Caregivers reported that most (approximately 94 percent) of the services were received in mental health settings or in schools (approximately 92 percent) (see Appendix I, Table I–2). In addition, a substantial proportion of the services were received at home (approximately 80 percent), in social services or child welfare offices (approximately 50 percent), or in community settings (approximately 50 percent). Services were also reported as being received in agencies such as juvenile courts (approximately 35 percent), youth detention centers (approximately 15 percent), medical hospitals, (approximately 35 percent) or in psychiatric hospitals (approximately 25 percent).

Table 3: Caregiver Report of Services Received

Type of Service	Received Service Between: Intake and 12-Month Interviews %	Received Service Between: 12-Month and 24-Month Interviews %
Mental Health Services		
Individual therapy	89.8%	89.8%
Assessment or evaluation	82.9%	75.4%[c]
Medication treatment monitoring	76.1%	77.0%
Family therapy	57.0%	53.7%[b]
Group therapy	43.9%	45.8%
Crisis stabilization	30.2%	23.4%[c]
Inpatient hospitalization	20.2%	16.4%[c]
Residential treatment center	13.7%	14.1%
Support Services		
Case management	90.0%	83.9%[c]
Informal supports	67.2%	67.3%
Recreational activities	57.1%	55.0%
Caregiver or family support	53.5%	45.5%[b]
Transportation	47.9%	43.5%
Receipt of flexible funds for expenses	42.7%	35.1%[c]
After-school programs or child care	33.5%	30.8%
Respite care	29.9%	28.2%
Behavioral/therapeutic aide	29.4%	26.7%[c]
Family preservation	22.4%	20.0%
Day treatment	15.4%	17.8%
Vocational training	8.8%	11.2%[a]
Youth transition	7.0%	7.8%
Residential therapeutic camp or wilderness program	6.7%	4.1%[c]
Therapeutic group home	5.1%	4.5%
Independent living	4.7%	5.3%
Therapeutic foster care	3.1%	4.8%[b]

[a] Change in percentage from first time period to second time period is significant at $p < .05$ level

[b] Change in percentage from first time period to second time period is significant at $p < .01$ level

[c] Change in percentage from first time period to second time period is significant at $p < .001$ level

Service Costs

One of the intended benefits of the system of care is to reduce the use of overly restrictive, high-cost residential and inpatient services in favor of community-based services.

Cost Savings from Reduction in Inpatient Care

The average number of days spent in inpatient hospital care decreased from 1.69 days in the 6 months prior to intake to 0.90 days in the 6 months prior to the 24-month interview. This decrease of 0.79 days, on average, is consistent with the findings presented in the previous section that the percentage of children and youth in any type of inpatient care decreased over the first two years after their entry into CMHI services. The average numbers of days of inpatient care are based on data for all 2,246 children and youth whose caregivers provided information during both their intake and 24-

month interviews about whether their children and youth 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 \$2,144 in 2010 dollars.[19] When this daily rate is multiplied by the average number of days of inpatient hospitalization of children and youth in CMHI, the average estimated total cost per child for the use of inpatient hospitalization in the 6 months prior to entering the CMHI was approximately \$3,623. This cost decreased to an average estimated cost per child of \$1,930 between 18 and 24 months after entering CMHI services, representing a 46.7 percent reduction in average per child inpatient hospitalization costs (see Figure 5).

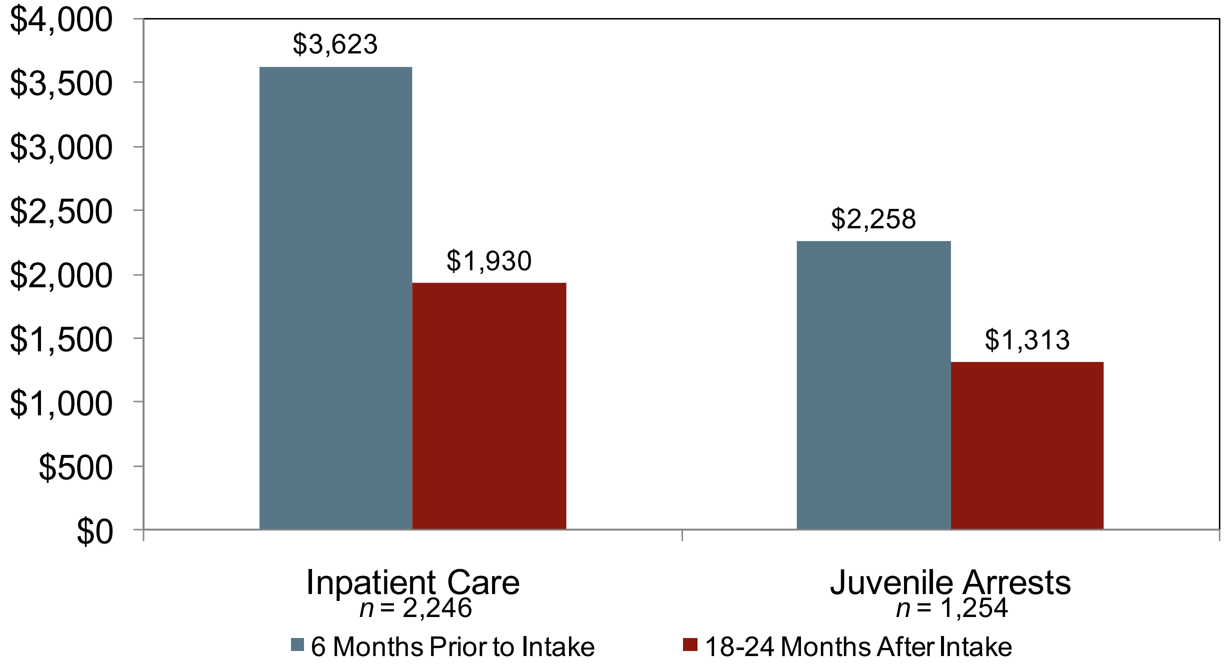
The estimated number of children and youth being served in CMHI communities in FY 2009 was 10,762. The decrease in the average number of inpatient hospitalization days, 0.79 days, is used as an estimate of the decrease in the average number of inpatient hospitalization days experienced by all 10,762 children and youth served in CMHI-funded communities in FY 2009.[20] Therefore, within CMHI the decrease in the use of inpatient hospitalization translates into an estimated total decrease in inpatient hospitalization costs of more than \$18 million (\$18,220,066).

Cost Savings from Reduction in Juvenile Arrests

The average number of arrests decreased from 0.43 in the 6 months prior to intake to 0.25 in the 6 months prior to the 24-month interview. This decrease of 0.18 arrests, on average, is consistent with the findings presented previously that the percentage of youth reporting an arrest decreased over the first two years after their entry into CMHI services. These average numbers of arrests were based on data collected from 1,254 youth aged 11 and older who provided information during both their intake and 24-month interviews related to their arrest histories.

The estimated average cost per juvenile arrest is \$5,253 in 2010 dollars.[21] When this cost per juvenile arrest is multiplied by the average number of arrests, the average estimated cost per youth due to arrest in the 6 months prior to entering the CMHI was approximately \$2,258, decreasing to an average estimated cost per youth of \$1,313 between 18 and 24 months after entering services. This represents a 41.9 percent reduction in average per child arrest costs (see Figure 5).

Figure 5: Estimated Gross Cost Savings per Child or Youth from Reduction in Inpatient Hospitalization and Juvenile Arrests



The estimated number of all youth 11 years or older served in CMHI-funded systems of care in FY 2009 was 6,715. The decrease in the average number of arrests, 0.18 arrests, for the 1,254 youth reporting arrest information is used as an estimate for the decrease in the average number of arrests experienced by all 6,715 youth 11 years or older served in CMHI-funded communities in FY 2009.[22] Therefore, within CMHI the decrease in juvenile arrests translates into an estimated total decrease in juvenile arrest costs of more than $6 million ($6,345,675).

Summary of Service Use and Costs

- The most commonly used services were case management, individual therapy, assessment or evaluation, and medication monitoring.
- Most types of services were used less frequently over time during the first two years after children and youth entered CMHI systems of care. Most services were provided in mental health settings or schools.
- Children and youth received fewer restrictive out-of-home services over the first two years of service use, on average.
- There are substantial estimated total decreases in inpatient hospital care costs and costs due to arrests.

CMHI-funded communities must be able to implement system change in accordance with system of care principles. They are also expected to sustain that change when their Federal funding ends.

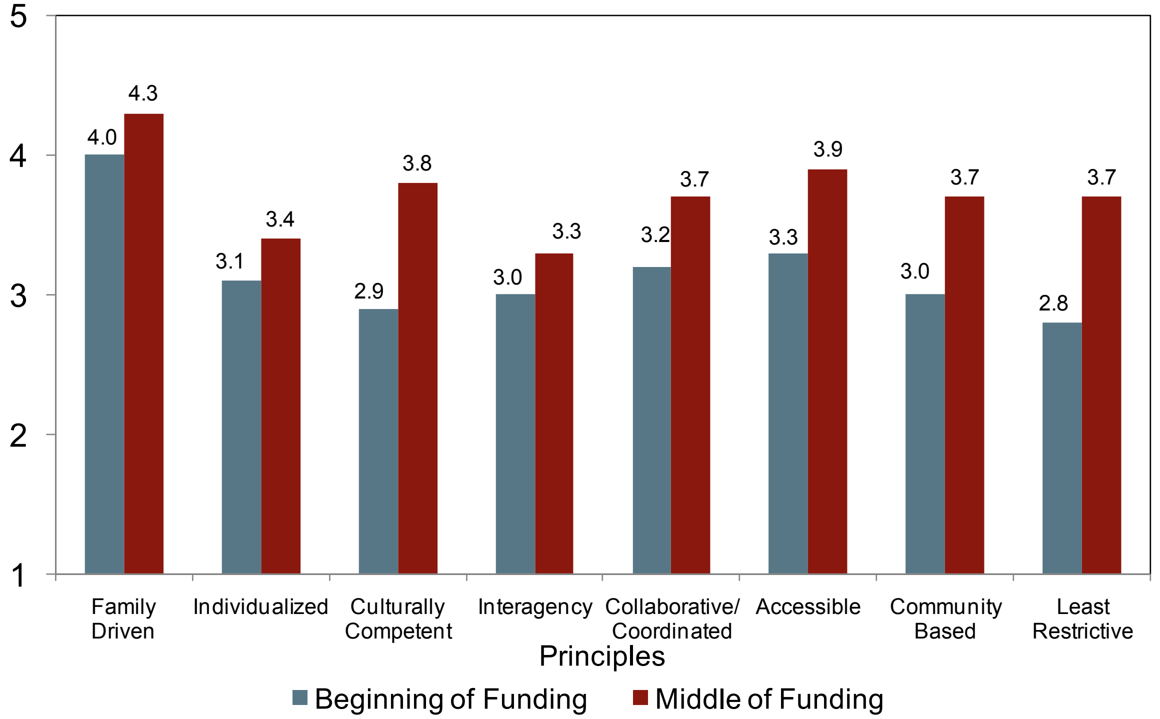
Implementation of System of Care Principles

The degree to which communities develop and implement infrastructure and service delivery systems according to system of care principles is assessed at the beginning, middle, and end of their funding period. Communities funded in FYs 2005 and 2006 had only been assessed at the beginning and middle[23] of their funding at the time of this report. Rating scores based on the information provided by community staff were computed for these two domains. [24] Figures 6 and 7 present average infrastructure and service delivery domain ratings, respectively, for the extent to which the eight system of care principles (described in section 1 of this report) had been implemented within these communities.

The scores in both domains increased from the beginning to the middle of funding for every principle, demonstrating that communities were successful in implementing the system of care principles during the first half of their funding.

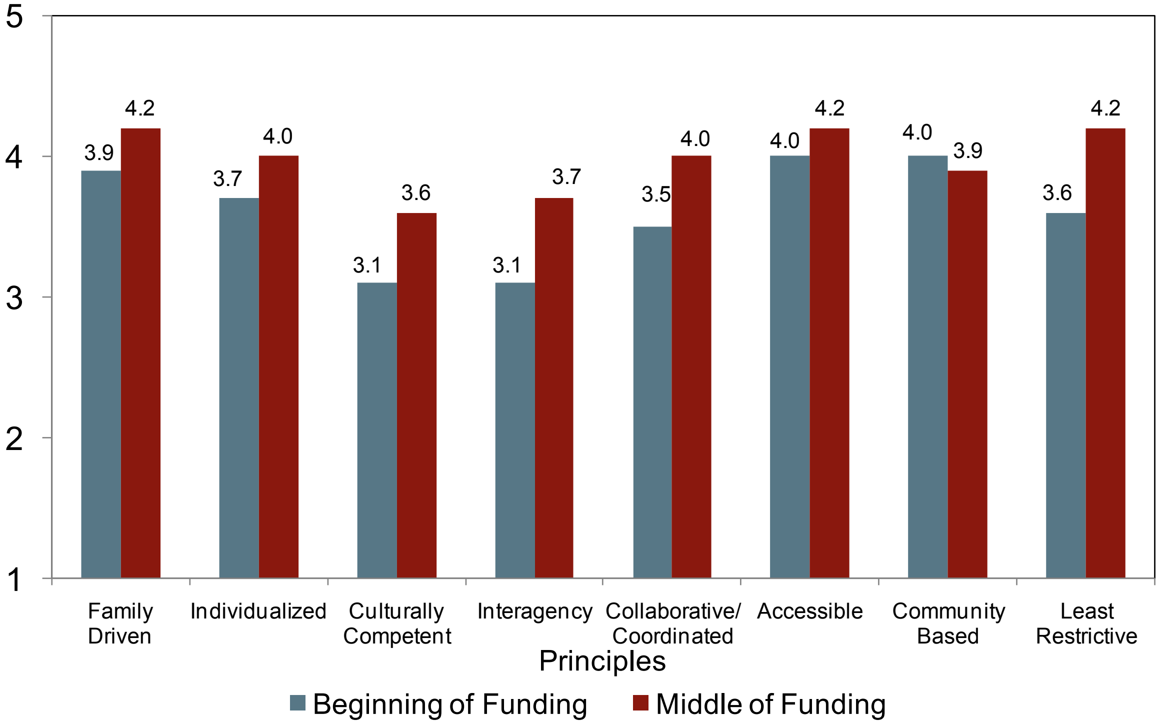
In the infrastructure domain, communities received the highest average rating at both time points for the family-driven principle (4.0 and 4.3, respectively). In contrast, the lowest average ratings at the second time point were received for the interagency (3.3) and the individualized care (3.4) principles. In the service delivery domain, the highest average ratings at both time points were received on the family-driven (3.9 and 4.2, respectively) and the accessible (4.0 and 4.2, respectively) principles. The lowest average service delivery ratings at both time points were for the culturally competent (3.1 and 3.6, respectively) and interagency (3.1 and 3.7, respectively) principles.

Figure 6: Average Infrastructure Ratings for Communities Funded in 2005 and 2006, Beginning and Middle of Funding



n = 30

Figure 7: Average Service Delivery Ratings for Communities Funded in 2005 and 2006, Beginning and Middle of Funding



n = 30

Successes and Challenges in Implementing Interagency Collaboration

Examples of ways in which communities implemented the interagency and collaboration/coordination principles and examples of challenges communities faced are described in Appendix I (Table I–3).

In order to enhance interagency collaboration, some communities placed mental health staff onsite in other child-serving agencies and other communities established governing bodies that included cross-agency representation from multiple publicly funded child-serving agencies. The referral patterns presented in the previous chapter also indicate that communities are successfully implementing interagency collaboration.

In some communities, challenges remained. Some communities found it difficult to incorporate multiple agencies into the quality monitoring and evaluation processes. A further challenge communities experienced was changing administrative processes so they could be used by multiple agencies.

Services Available in CMHI-Funded Communities

Staff in grant communities funded in FYs 2002, 2003, 2004, and 2005 were surveyed at the beginning of their funding about the availability of services in their communities at any time during the first half of their communities' funding. The services reported as being most available were case management, outpatient individual counseling, and diagnostic assessments/evaluations. Services reported as being least available were transition-to-adult services, independent living, and vocational services (probably because these services were only needed for transition-age youth).

The Use of Evidence-Based Treatments

Communities receiving CMHI funding are expected to deliver evidence-based practices to the greatest extent possible. Evidence-based practices can be described as effective interventions that have been shown by research studies to produce positive child and family outcomes.[25] Within the broader class of evidence-based practices are evidence-based treatments (EBTs), which are clinical treatments that follow a particular protocol. Staff reported estimates of the number of EBTs being implemented near the beginning and middle of their communities' funding. The total number of EBTs implemented in all 59 communities funded in FYs 2002–2006 increased over the course of their funding, indicating that the communities implemented more EBTs as their systems of care developed.

In addition, the total number of EBTs implemented in communities funded in FYs 2005 and 2006 was higher than among communities funded in FYs 2002–2004. Over the past decade there has been increasing emphasis on the use of EBTs, and ongoing development of the infrastructure at the State and local levels to facilitate their use. The increase seen in the use of EBTs among the communities may reflect these trends.

Interviews with community staff and caregivers revealed several factors that contributed to EBT implementation, including staff buy-in for particular EBTs, support by upper-level decision-makers, and adequate resources to support staff training and supervision. However, staff buy-in, upper management support, and adequate resources are often not available in communities, which can present challenges to implementing EBTs. Other barriers to implementation included inflexible payment systems, and staff turnover.

Sustainability of Communities Funded in FY 2002–FY 2005

Community representatives rated, at several points during their grant funding, the extent to which factors affecting system of care sustainability after the end of CMHI funding were present in the community. The same representatives also rated the impacts of these factors on efforts to prepare for sustainability. The findings below are based on the survey completed by 51 communities funded in FYs 2002–2005, in the middle of their funding period.

Sustainability factors reported on by community staff included partnerships among constituents, leadership, and resources available. Community representatives reported that interagency relationships, ongoing administrative leadership for their systems of care, the inclusion of constituents at all levels, and the provision of ongoing training were most likely to be present in their communities at any time during the first half of their funding. The factors affecting sustainability that were reported to be least present, were state and local financial support for maintaining the system of care, and change in elected or appointed officials.

Interagency relationships, the inclusion of constituents at all levels, and ongoing training had the most positive impacts on sustainability planning of CMHI systems of care. Change in the larger economic climate and State financial support, as well as change in elected officials, were reported as having the most negative impact on system of care sustainability planning.

Summary of System Change and Sustainability

- CMHI-funded communities were increasingly successful in implementing system of care principles over the course of the first four years of their funding.
- Interagency collaboration was evidenced by the large numbers of referrals from non-mental health service agencies. However, these agencies were less involved in treatment planning than in referring.
- Various types of services became more available in CMHI-funded communities over the course of their funding, indicating that their systems were changing to provide needed services.
- Although CMHI-funded communities were implementing an increasing number of evidence-based treatments as their systems of care developed over the first four years of their funding, there were still significant challenges to implementation, including inflexible payment systems and staff turnover.
- Community staff reported the presence of numerous factors that might contribute to sustainability after the CMHI funding cycle, including stable leadership, well-established interagency relationships, and the provision of ongoing training. The factors that were reported as being present least often related primarily to funding for sustaining systems of care.

Caregiver and Youth Assessments of the Effectiveness of Systems of Care

Satisfaction of Caregivers and Youth with Services

Measuring the satisfaction of caregivers fulfills/responds to the authorizing legislation's mandate to have caregivers assess the effectiveness of systems of care. Caregivers and youth aged 11 years and older were asked about their levels of general satisfaction with the CMHI system of care services they received. Caregivers were also asked about several specific aspects of their service experience: access to services, the quality of the services received, participation in their child's care decisions, care outcomes, and the cultural sensitivity of their providers. In general, caregivers and youth reported being satisfied with the services they received across all four 6-month follow-up interviews.

Caregivers' overall satisfaction with services received an average rating of 4.0, on a scale from 1 to 5 where 5 is most satisfied, across all four follow-up interviews. Youths' average overall satisfaction rating was also 4.0. Average caregiver ratings across all four interviews for the various aspects of services ranged from 3.6 (regarding outcomes of treatment) to 4.5 (regarding the cultural sensitivity of service provision). For youth, average ratings ranged from 3.8 (regarding participation in treatment) to 4.3 (regarding the cultural sensitivity of services). Interestingly, youth rated their satisfaction with the quality of their services and their participation in their own care decisions (4.0 and 3.7, respectively) lower than caregivers did (4.1 and 4.2, respectively), and rated their satisfaction with their care outcomes (3.9) higher than caregivers did (3.6).

Caregivers were also asked whether they would come back to system of care services if their child needed help again, and whether they would recommend these services to other families who needed help. The responses to both items were overwhelmingly positive. Approximately 90 percent of caregivers reported that they would probably or absolutely return to system of care services, and approximately 92 percent reported they would probably or absolutely recommend these services to someone else.

Cultural Competence of Service Experience

The system of care philosophy includes providing services that are culturally and linguistically competent.[26] Caregivers were asked during each interview, starting with the 6-month follow-up interview, how important it was to include their cultural traditions, beliefs, and practices into service planning and provision. Caregivers indicated consistently in all interviews that it was moderately important to them, on average. It was less important to them (only ―somewhat" important, on average) to have a provider of the same racial or ethnic group as themselves. Each caregiver was also asked during these interviews the extent to which their child's primary behavioral health care provider acted in a culturally competent manner. Caregivers indicated consistently that these 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, on average.

Receiving Information about Services

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. The findings presented here are based on responses from communities funded in FYs 2005 and 2006.[27]

It appears that 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 receiving information about a particular aspect of their child's treatment were more satisfied with the services provided than caregivers not receiving the same information (see Appendix I, Table I–4). Caregivers receiving information about a particular aspect of their child's treatment were also more satisfied with the service outcomes than caregivers not receiving the same information.

Summary of Caregiver and Youth Assessments of the Effectiveness of Systems of Care

- Caregivers tended to be very satisfied with the services received by their children. Similarly, youth were very satisfied with all aspects of the services they received; they were slightly less satisfied with their own involvement in their care decisions.
- Almost all caregivers would return to system of care services if they needed help in the future and would recommend those services to other families in need.
- Most caregivers and youth found their service providers to be culturally competent, and were very satisfied with the cultural sensitivity of their care.
- The more informed caregivers were about the treatment their child was receiving, the more satisfied they tended to be with the services received.

Summary

This report to Congress provides critical information about the Comprehensive Community Mental Health Services for Children and their Families Program (CMHI), including the characteristics of children, youth, and families as they enter the CMHI; the outcomes attained for children and youth, and their caregivers and families after entry into the CMHI; their CMHI service use and service experience; how well communities have implemented system of care principles, particularly interagency collaboration; the sustainability of systems of care; and caregiver and youth satisfaction with services. Data from the national evaluation demonstrate that funded systems of care:

- **Reach and provide services to many children and youth typically underserved by the mental health system.** Children and youth served were from ethnically diverse populations and from families affected by poverty and complex issues such as domestic violence, sexual and physical abuse, and family histories of mental health and substance use challenges.

- **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, and more stable living situations.

- **Enhance family outcomes.** Caregivers' levels of strain associated with caring for their children and youth 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, evidence-based treatments, and case management services.

- **Implement and maintain fidelity to the principles of family-driven, youth-guided, individualized services.** The data from the system of care assessment demonstrated that communities were working in partnership with youth and families at both the system and service levels, including the development of individualized service plans.

- **Save money by reducing the amount spent on residential treatment and juvenile justice services.** There was a 46.7 percent decrease in the estimated average per child inpatient hospitalization costs during the first 2 years of services. In addition, there was a 41.9 percent decrease in the estimated average per youth arrest costs during the first 2 years of services.

- **Incorporate processes and resources that have a positive impact on sustainability.** Community staff rated interagency partnerships and collaboration as having the most positive impact on sustainability. This factor was reported to be one of the most likely to be present in the middle of their funding cycle.

The national evaluation and this report to Congress have addressed the authorizing legislation's mandate to assess the effectiveness of the systems of care with regard to outcomes for children, youth, and families served by the CMHI. The report examined the use of hospitalization and other institutional settings, described the role and importance of interagency collaboration, and summarized parental assessments of the effectiveness of systems of care. Further, this report provided a description of how communities are carrying out the goal of the cooperative agreements by providing the types of services outlined in the legislation using an individualized, culturally and linguistically competent, and collaborative approach.

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[1] In addition to participating in and collecting data for the national evaluation, each community is required to conduct a local-level evaluation of its CMHI-funded program. The local-level's evaluations include data collected by the national evaluation, but also include information collected by communities, on indicators of interest.

[2] Interviews for the national evaluation are not equivalent to services.

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

[4] Gender and age data taken from United States Department of Health and Human Services (US 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 2000–2007 (Vintage 2007) bridged-race postcensal population estimates, on CDC WONDER On-line Database for the year 2006. Accessed August 11, 2009 at http://wonder.cdc.gov/bridged-race-v2007.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: www.census.gov/popest/national/asrh/2005_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.

[5] Race/Ethnicity estimates for the United States population are based on those ages 0–17 years rather than 0–22 years.

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[6] 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/cps2010.html.Accessed December 1, 2010.

[7] Poverty level is based on the Department of Health and Human Services poverty guidelines, which are available for the 50 States and Washington, DC, at http://aspe.hhs.gov/poverty/.

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

[9] Based on the DC:0–3R, Axis I.

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

[11] The Reliable Change Index (RCI) is a relative measure that compares a child's or caregiver's scores at two different points in time and indicates whether a change in score shows significant improvement, worsening, or stability.

[12] Total Problem scores and both Internalizing and Externalizing subscale scores 64 or above are in the clinical range.

[13] A total score greater than 60 indicates a high level of impairment on the RCMAS. A score of 61 or higher on the RADS–2 indicates a clinical level of depression.

[14] Global Impairment scores of 15 or above are considered in the clinical range.

[15] This analysis was carried out to 12 months instead of 24 months, as the number of caregiver responses reduced greatly when including caregivers who responded at all 5 time points.

[16] —Mental health care providers" include general psychiatrists, child psychiatrists, and other providers specified that included neuropsychiatrists, psychiatrist assistants, psychologists, child behavioral specialists, and licensed counselors.

[17] The State- or county-level mental health agency, or a private mental health provider, is generally the CMHI-funded entity.

[18] This section only describes whether services were received. It does not refer to the intensity of those services.

[19] 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 4, 2010).

[20] The smaller sample used to estimate the decrease of 0.79 days is generally representative of the full sample of children and youth served.

[21] 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 4, 2010).

[22] The smaller sample used to estimate the decrease of 0.18 arrests is generally representative of the full sample of children and youth served.

[23] These reports were gathered during the first and second assessments of the System of Care Assessment study.

[24] The scores on this scale range from 1 to 5, with 5 representing the highest degree of implementation.

[25] 2005 RFA, p. 10.

[26] Cross, Bazron, Dennis, & Isaacs (1989) describe cultural competence as systemic and personal actions that allow effective helping behaviors with diverse groups. Goode and Jones (2006) describe linguistic competence as a similarly pervasive group of behaviors that facilitate communication with diverse groups.

[27] Caregiver satisfaction items were asked beginning in FY 2005, so no data was available for communities funded in FY 2004.

Appendices

Appendix A

Glossary of Terms

Accessible services: services that are affordable, located nearby, and open during evenings and weekends. Staff is sensitive to and incorporates individual and cultural values. Staff is also 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, service delivery and involve systematically consumers, key constituencies and communities.

Evidence-based practice: a *decision-making process* that integrates the best available research, clinician expertise, and client characteristics.

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

Evidence-based treatments: *mental health 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.

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 2010 runs from October 1, 2009 through September 30, 2010.

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, 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 competency 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 level: based on Department of Health and Human Services poverty guidelines, which are available for the 50 States.

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

Serious emotional disturbance: defined by the CMHI program as

- an emotional, socio-emotional, behavioral or mental disorder diagnosable under the DSM-IV 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 in the family, 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 one year or, on the basis of diagnosis, severity, or multiagency intervention, expected to last longer than one 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 a serious emotional disturbance and their families.

Transition-age: youth transitioning from adolescence to adulthood, aged 14 and older in the *2010 Annual Report to Congress*.

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.

Appendix B

SAMHSA's 8 Strategic Initiatives

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

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.

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.

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 barriers to social inclusion.

Health Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act) that make health insurance coverage more affordable for individuals, families, and the owners of small businesses. The Affordable Care Act is one aspect of a broader movement toward a reformed behavioral health system.

Health Information Technology

Ensuring that 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).

Data, Outcomes, and Quality

Realizing an integrated data strategy that informs policy and measures program impact, leading to improved quality of services and outcomes for individuals, families, and communities.

Public Awareness and Support

Public Awareness and Support —Increasing the understanding of mental and substance use disorders 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 C

System of Care Communities of the Comprehensive Community Mental Health Services for Children and Their Families Program, 1993–2009

Project Name	Catchment Area	State
Phase I (grants awarded in 1993 and 1994)		
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	California
Hawaii 'Ohana Project	Wai'anae Coast and Leeward Oahu	Hawaii
Community Wraparound Initiative	Lyons, Riverside, and Proviso Townships	Illinois
COMCARE	Sedgwick County	Kansas
KanFocus	13 southeastern counties	Kansas
Wings for Children and Families	Piscataquis, Hancock, Penobscot, and Washington Counties	Maine
East Baltimore Mental Health Partnership	East Baltimore, Maryland	Maryland
K'é Project	Navajo Nation	Arizona, New Mexico, Utah
Olympia (formerly Doña Ana County Child and Adolescent Collaborative)	Doña Ana County	New Mexico
Families Reaching in Ever New Directions (FRIENDS)	Mott Haven	New York
Pitt-Edgecombe-Nash Public-Academic Liaison Project (PEN-PAL)	Pitt, Edgecombe, and Nash Counties	North Carolina
Partnerships Project	Minot, Bismarck, and Fargo regions	North Dakota
Stark County Family Council and Southern Consortium	Stark County and 10 southeastern counties	Ohio
New Opportunities	Lane County	Oregon
South Philadelphia Family Partnership Project	South Philadelphia	Pennsylvania
Project REACH Rhode Island	Statewide	Rhode Island
The Village Project	Charleston and Dorchester Counties	South Carolina
City of Alexandria System of Care	City of Alexandria	Virginia
ACCESS	Statewide	Vermont
Wraparound Milwaukee	Milwaukee County	Wisconsin

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

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

Project Name	Catchment Area	State
Phase IV (cooperative agreements awarded in 2002, 2003, and 2004)		
Ch'eghutsen' A System of Care	Fairbanks Native Association	Alaska
Glenn County Children's System of Care	Glenn County	California
La Familia Sana	Monterey County	California
OASIS (Obtaining and Sustaining Independent Success)	Sacramento County	California
San Francisco Children's System of Care	San Francisco	California
Urban Trails	Oakland	California
Project BLOOM	El Paso, Fremont, and Mesa Counties, and the City of Aurora	Colorado
Partnership for Kids (PARK) Project	Statewide	Connecticut
D.C. Children Inspired Now Gain Strength (D.C. CINGS)	Districtwide	Washington, District of Columbia
One Community Partnership	Broward County	Florida
I'Famagu'onta (Our Children)	Territorywide	Guam
Building on Each Other's Strengths	Statewide	Idaho
System of Care Chicago	Chicago	Illinois
Kentuckians Encouraging Youth to Succeed (KEYS)	Boone, Campbell, Carroll, Gallatin Grant, Kenton, Owen, and Pendleton Counties	Kentucky
Louisiana Youth Enhanced Services for Children's Mental Health (LA–YES)	Jefferson, Orleans, Plaquemines, St. Bernard, and St. Tammany Parishes	Louisiana
Show Me Kids	Barry, Christian, Green, Lawrence, Stone, and Taney Counties	Missouri
Transitions	St. Louis County and City	Missouri
Kids Integrated Delivery System for Montana (KIDS fm)	Statewide and Crow Indian Nation	Montana
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	New York
Tapestry	Cuyahoga County	Ohio
Choctaw Nation CARES	Choctaw Nation of Oklahoma	Oklahoma
Great Plains Systems of Care	Beckham, Canadian, Kay, Oklahoma, and Tulsa Counties	Oklahoma
Columbia River Wraparound	Gilliam, Hood River, Sherman, and Wasco Counties	Oregon
Puerto Rico Mental Health Initiative for Children	Llorens Torres Housing Project in San Juan, Municipality of Gurabo	Puerto Rico
YouthNet	Chester, Lancaster, and York Counties and Catawba Indian Nation	South Carolina
Border Children's Mental Health Collaborative	El Paso County	Texas
Community Solutions	Fort Worth	Texas

Project Name	Catchment Area	State
Phase V (cooperative agreements awarded in 2005 and 2006)		
Sewa Uusim/Flower Children, Our Hope, Our Light, Our Future	Pascua Yaqui Tribe of Arizona	Arizona
ACTION for Kids (Arkansas Collaborating to Improve Our Network)	Craighead, Lee, Mississippi, and Phillips Counties	Arkansas
Connecting Circles of Care	Butte County	California
Seven Generations System of Care	Los Angeles County	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	California
Building Blocks for Brighter Beginnings	New London County	Connecticut
Sarasota Partnership for Children's Mental Health	Sarasota County	Florida
Project Hoʻomohala (Transition to Adulthood)	Honolulu	Hawaii
McHenry County Family CARE (Child/Adolescent Recovery Experience)	McHenry County	Illinois
Community Circle of Care	10 northeastern counties	Iowa
THRIVE: A Trauma-Informed System of Care for Children with Serious Emotional Disturbance in Maine	Androscoggin, Franklin, and Oxford Counties	Maine
Central Massachusetts Communities of Care	Worcester County (excluding the City of Worcester)	Massachusetts
Impact	Ingham County	Michigan
Kalamazoo Wraps	Kalamazoo County	Michigan
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	Minnesota
CommUNITY Cares	Forrest, Lamar, and Marion Counties	Mississippi
Circle of H.O.P.E. (Home, Opportunities, Parents & Providers, Empowerment)	Andrew and Buchanan Counties	Missouri
Blackfeet Po'Ka System of Care	Blackfeet Reservation	Montana
Monroe County Achieving Culturally Competent and Effective Services and Supports (Monroe County ACCESS)	Monroe County	New York
MeckCARES	Mecklenburg County	North Carolina
Wraparound Oregon: Early Childhood	Multnomah County	Oregon
Starting Early Together (SET)	Allegheny County	Pennsylvania
Beaver County's System of Care: Optimizing Resources, Education and Supports (BC-SCORES)	Beaver County	Pennsylvania

Project Name	Catchment Area	State
Phase V (cooperative agreements awarded in 2005 and 2006) (continued)		
Rhode Island Positive Education Partnership	Statewide	Rhode Island
Tiwahe Wakan (Families as Sacred)	Yankton Sioux Reservation	South Dakota
Mule Town Family Network	Maury County	Tennessee
Systems of Hope	Harris County	Texas
Wyoming Support, Access, Growth, and Empowerment (SAGE) Initiative	Statewide	Wyoming
Phase VI (cooperative agreements awarded in 2008)		
Delaware's B.E.S.T. (Bringing Evidence-based System-of-Care & Treatment) for Young Children and Their Families	Statewide	Delaware
KidsNet Northwest	Bartow, Dade, Floyd, Haralson, Paulding, Polk, and Walker Counties	Georgia
One Community, One Family	8 southeastern counties	Indiana
Kentucky SEED (System to Enhance Early Development)	Statewide	Kentucky
MD CARES (Maryland Crisis and At Risk for Escalation Diversion Services)	Baltimore City	Maryland
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	New York
Alamance Alliance for Children and Families	Alamance County	North Carolina
Protecting the Future	Muscogee (Creek) Nation	Oklahoma
Oklahoma System of Care Statewide Initiative (OSOCSI)	Statewide	Oklahoma
Nak-Nu-Wit	Clackamas, Multnomah, and Washington Counties, Oregon, and Clark County, Washington	Oregon, Washington
JustCare Family Network, A System of Care for Shelby County	Shelby County	Tennessee
Hand in Hand: Planting Seeds for Healthy Families	Hood, Johnson, Palo Pinto, Parker, and Tarrant Counties	Texas
Rural Children's Initiative	11 Panhandle counties	Texas
Mental Health Services for Transition-Aged Youth	Statewide	Vermont
Lummi System of Care Initiative	Lummi Nation	Washington
Yakima Valley Youth and Family Coalition	Yakima County	Washington

Project Name	Catchment Area	State
Communities Funded in 2009		
East Central Children's Health Collaborative (ECCHCO) Project	Bulloch, Macon, and Pike Counties	Alabama
Early Connections	Alameda County	California
Urban Trails San Francisco	San Francisco	California
Families and Communities Empower for Success	Miami-Dade County	Florida
Wraparound Orange System of Care	Orange County	Florida
Project Kariñu	Territorywide	Guam
Project Kealahou—A New Pathway for Girls	Central Oahu, Windward Oahu, and East Honolulu	Hawaii
Madison CARES	Madison County	Idaho
ACCESS Initiative	Champaign County	Illinois
Project Connect	Gallatin, Saline, and White Counties	Illinois
RURAL Crisis and At Risk for Escalation Diversion Services (CARES)	9 Eastern Shore counties	Maryland
Massachusetts Young Children's Health Interventions for Learning and Development (MYCHILD)	Boston	Massachusetts
Community Family Partnership (CFP)	Kent County	Michigan
Mississippi Transitional Outreach Program	Statewide except for Hinds, Forrest, Lamar, and Marion Counties	Mississippi
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
ON CARE	Onondaga County	New York
FAST TRAC	Clermont County	Ohio
Journey to Successful Living (Journey)	Hamilton County	Ohio
Pennsylvania System of Care Partnership	15 counties	Pennsylvania
K-Town Youth Empowerment Network (K-Town)	Knox County	Tennessee

Appendix D

Performance Measurement

GPRA Program Indicators for FY 2009

GPRA Program Indicators	Actual Performance
(1) Increase in number of children receiving services FY 2009 Target: 13,051	10,762
(2) Increase in percentage of children attending school 75% or more of time after 12 months FY 2009 Target: 86.3%	89.2%
(3) Increase in percentage of children with no law enforcement contacts at 6 months FY 2009 Target: 71.7%	69.5%
(4) Decrease average number of days in inpatient facilities among children served in systems of care at 6 months FY 2009 Target: -2.00 days	-0.12 days
(5) Decrease in inpatient care costs per 1,000 children served FY 2009 Target: $2,376,000	$160,000

CQI Progress Report—Aggregate for Communities Funded in 2002–2004

COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate, July 2010

Date Services Started: **Oct-03**
Number Enrolled in the Descriptive Study: **19178**
Number Enrolled in the Outcome Study: **4752**

	ACTUALS		CHANGE		INDEX		
	Performance Mark[1]	Raw Score	Previous Raw Score	Change from Previous Report	Benchmark[2]	Max Points	Actual Points
TOTAL SITE SCORE						**100.00**	**82.56**
System-Level Outcomes							
Service Accessibility							
1. Number of Children Served (with descriptive data)	Top 25%	18,469	18,308	↑	n/a	.	.
2. Linguistic Competency Rate	25% to 50%	91.2%	91.2%	↔	91.7%	n/a	0.00
3. Agency Involvement Rate–Service Provision	25% to 50%	75.0%	74.9%	↑	92.9%	3.50	2.82
4. Caregiver Satisfaction Rate–Access to Services	25% to 50%	4.24	4.24	↔	4.42	3.67	3.52
5. Timeliness of Services (average days)*	25% to 50%	15.10	15.12	↑	10.18	1.36	0.92
Service Quality							
6. Agency Involvement Rate–Treatment Planning	25% to 50%	29.0%	29.1%	↓	64.1%	3.00	1.36
7. Informal Supports Rate	50% to 75%	35.0%	35.0%	↔	51.4%	1.55	1.06
8. Caregiver Satisfaction Rate–Quality of Services	25% to 50%	4.02	4.02	↔	4.13	3.94	3.83
9. Youth Satisfaction Rate–Quality of Services	25% to 50%	3.92	3.92	↔	4.02	3.83	3.73
10. Caregiver Satisfaction Rate–Outcomes	25% to 50%	3.53	3.53	↔	3.61	3.86	3.77
11. Youth Satisfaction Rate–Outcomes	25% to 50%	3.86	3.86	↔	3.92	4.04	3.98
Service Appropriateness							
12. Individualized Education Plan (IEP) Development (% at 6 months)[3,4]	25% to 50%	54.4%	54.4%	↔	55.9%	n/a	n/a
13. Substance Use Treatment Rate	50% to 75%	58.8%	58.8%	↔	67.8%	3.25	2.82
System-Level Outcomes Subtotal						*32.00*	*27.81*
Child and Family Outcomes							
Caregiver Report							
Child Level							
14a. School Enrollment Rate[3]	25% to 50%	95.6%	95.6%	↔	97.8%	n/a	n/a
14b. School Enrollment Rate (Preschool)	Lowest 25%	95.9%	95.9%	↔	n/a	n/a	n/a
15a. School Attendance Rate (80% of the time)	25% to 50%	79.5%	79.5%	↔	84.4%	3.68	3.47
15b. Daycare or Afterschool Attendance Rate	25% to 50%	73.7%	73.8%	↓	n/a	n/a	n/a
16. School Performance Improvement Rate (intake to 6 months)	50% to 75%	36.0%	36.0%	↔	39.8%	2.20	1.99
17. Stability in Living Situation Rate (intake to 6 months)	50% to 75%	77.2%	77.2%	↔	86.2%	2.85	2.55
18. Inpatient Hospitalization Days per Youth (intake to 6 months)*	25% to 50%	4.73	4.74	↑	0.78	2.75	0.45
19. Suicide Attempt Reduction Rate–Caregiver Report**	25% to 50%	-41.0%	-41.0%	↔	-43.8%	3.90	3.65
20a. Emotional and Behavioral Problem Improvement Rate–Ages 6–18 Years (intake to 6 months)	50% to 75%	29.2%	29.2%	↔	35.0%	3.27	2.73
20b. Emotional and Behavioral Problem Improvement Rate–Ages 1½–5 Years (intake to 6 months)	50% to 75%	31.7%	31.7%	↔	n/a	n/a	n/a

CQI Progress Report—Aggregate for Communities Funded in 2002–2004 (continued)

COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM
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National Aggregate, July 2010

Date Services Started: **Oct-03**
Number Enrolled in the Descriptive Study: **19178**
Number Enrolled in the Outcome Study: **4752**

	ACTUALS		CHANGE		INDEX		
	Performance Mark[1]	Raw Score	Previous Raw Score	Change from Previous Report	Benchmark[2]	Max Points	Actual Points
Family Level							
21. Average Reduction in Employment Days Lost (intake to 6 months)*	50% to 75%	-2.37	-2.38	↓	-3.98	3.58	2.13
22. Family Functioning Improvement Rate (intake to 6 months)	25% to 50%	3.5%	3.5%	↔	5.8%	3.32	2.00
23. Caregiver Strain Improvement Rate (intake to 6 months)	25% to 50%	28.7%	28.7%	↔	33.8%	3.34	2.84
Youth Report							
24. Youth No Arrest Rate (intake to 6 months)	50% to 75%	7.6%	7.6%	↔	21.0%	3.78	1.37
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)** [4]	50% to 75%	-51.2%	-51.2%	↔	-100.0%	3.74	1.91
26. Anxiety Improvement Rate (intake to 6 months)	50% to 75%	17.5%	17.5%	↔	12.6%	2.95	2.95
27. Depression Improvement Rate (intake to 6 months)	50% to 75%	14.1%	14.1%	↔	22.9%	2.64	1.63
Child and Family Outcomes Subtotal						*42.00*	*29.68*
Satisfaction of Services							
28. Caregiver Overall Satisfaction	50% to 75%	4.04	4.04	↔	4.09	3.00	2.96
29. Youth Overall Satisfaction	50% to 75%	3.92	3.92	↔	3.98	3.00	2.96
Satisfaction with Services Subtotal						*6.00*	*5.92*
Family and Youth Involvement							
30. Caregiver Satisfaction Rate–Participation	25% to 50%	4.16	4.16	↔	4.30	3.06	2.96
31. Youth Satisfaction Rate–Participation	50% to 75%	3.63	3.63	↔	3.72	2.98	2.91
32. Caregiver and Other Family Involvement in Service Plan	25% to 50%	92.3%	92.2%	↑	100.0%	3.97	3.66
33. Youth Involvement in Service Plan	25% to 50%	84.6%	84.6%	↔	89.7%	3.99	3.76
Family and Youth Involvement Subtotal						*14.00*	*13.29*
Cultural and Linguistic Competency							
34. Caregiver Satisfaction Rate–Cultural Competency	25% to 50%	4.46	4.46	↔	4.61	3.00	2.90
35. Youth Satisfaction Rate–Cultural Competency	50% to 75%	4.26	4.26	↔	4.31	3.00	2.96
Cultural Competency Subtotal						*6.00*	*5.87*
Evidence-based Practice (to be developed)		**TBD**			**TBD**	**TBD**	
Evidence-based Practice Subtotal							

[1] Performance Mark represents the quartile where the raw score falls compared to other cohort scores..
[2] The benchmark represents the 75th percentile score from the April 2006 CQI Progress Report.
[3] Indicator reported for information purposes only and was not included in the PCA. Therefore, raw score does not contribute to the domain score.
[4] The calculation was modified on the Dec 2006 report to reflect % of cases with an IEP at 6 months and should be interpreted locally.
* 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 Funded in 2002–2004 (continued)

Number Table & Standard Deviation Table

National Aggregate, July 2010

CQI Progress Report Indicator	National**	# of Sites***	National std dev	Data Source
1. Number of children served (with descriptive data)	18,469	29	691.86	EDIF****
2. Linguistic Competency Rate	317	11	0.06	Caregiver
3. Agency Involvement Rate–Service Provision	2,948	26	0.13	Caregiver
4. Caregiver Satisfaction Rate–Access to Services	2,835	26	0.25	Caregiver
5. Timeliness of Services (average days)	13,060	28	10.36	EDIF****
6. Agency Involvement Rate–Treatment Planning	11,197	29	0.25	EDIF****
7. Informal Supports Rate	2,935	26	0.18	Caregiver
8. Caregiver Satisfaction Rate–Quality of Services	2,836	26	0.30	Caregiver
9. Youth Satisfaction Rate–Quality of Services	1,696	23	0.17	Youth
10. Caregiver Satisfaction Rate–Outcomes	2,827	26	0.31	Caregiver
11. Youth Satisfaction Rate–Outcomes	1,695	23	0.15	Youth
12. Individualized Education Plan (IEP) Development (% at 6 months)	2,488	26	0.17	Caregiver
13. Substance Use Treatment Rate	277	13	0.18	Caregiver
14a. School Enrollment Rate	3,196	26	0.04	Caregiver
14b. School Enrollment Rate (Preschool)	122	2	0.03	Caregiver
15a. School Attendance Rate (80% of the time)	2,832	26	0.07	Caregiver
15b. Daycare or Afterschool Attendance Rate	498	19	0.11	Caregiver
16. School Performance Improvement Rate (intake to 6 months)	1,948	24	0.08	Caregiver
17. Stability in Living Situation Rate (intake to 6 months)	3,225	26	0.13	Caregiver
18. Inpatient Hospitalization Days per Youth (intake to 6 months)	3,222	22	9.48	Caregiver
19. Suicide Attempt Reduction Rate–Caregiver Report	3,089	18	1.30	Caregiver
20a. Emotional and Behavioral Problem Improvement Rate–Ages 6–18 Years (intake to 6 months)	2,781	25	0.10	Caregiver
20b. Emotional and Behavioral Problem Improvement Rate–Ages 1½–5 Years (intake to 6 months)	202	4	0.12	Caregiver
21. Average Reduction in Employment Days Lost (intake to 6 months)	1,366	23	2.33	Caregiver
22. Family Functioning Improvement Rate (intake to 6 months)	3,138	26	0.04	Caregiver
23. Caregiver Strain Improvement Rate (intake to 6 months)	3,061	26	0.06	Caregiver
24. Youth No Arrest Rate (intake to 6 months)	1,726	22	0.12	Youth
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)	1,725	13	0.30	Youth
26. Anxiety Improvement Rate (intake to 6 months)	1,723	23	0.04	Youth
27. Depression Improvement Rate (intake to 6 months)	1,731	23	0.05	Youth
28. Caregiver Overall Satisfaction	2,835	26	0.36	Caregiver
29. Youth Overall Satisfaction	1,695	23	0.15	Youth
30. Caregiver Satisfaction Rate–Participation	2,835	26	0.26	Caregiver
31. Youth Satisfaction Rate–Participation	1,697	23	0.24	Youth
32. Caregiver and Other Family Involvement in Service Plan	11,324	29	0.10	EDIF****
33. Youth Involvement in Service Plan	7,339	27	0.15	EDIF****
34. Caregiver Satisfaction Rate–Cultural Competency	2,781	26	0.17	Caregiver
35. Youth Satisfaction Rate–Cultural Competency	1,669	23	0.16	Youth

* Number of cases per indicator at the site level. ** Number of cases per indicator at the national level, i.e., across all cases in the national evaluation dataset.

*** Number of sites (among 27 in cohort) with a raw score reported, i.e., complete data to generate the indicator.

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

CQI Progress Report—Aggregate for Communities 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, 2010

Date Services Started: **Aug-06**
Number Enrolled in the Descriptive Study: **9,721**
Number Enrolled in the Outcome Study: **4,365**

	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	8,515	9,396		929	n/a	Community defined
2. Linguistic Competency Rate	Score Improved	87.9%	88.9%		95.2%	94.7%	Closer to 100% better
3. Agency Involvement Rate–Service Provision	Score Worsened	77.7%	77.6%		76.8%	85.9%	Closer to 100% better
4. Caregiver Satisfaction Rate–Access to Services	Score Improved	4.24	4.25		4.31	4.38	Closer to 5 better
5. Timeliness of Services (average days)*	Score Improved	15.31	14.64		8.73	6.00	Lower # better
Service Quality							
6. Agency Involvement Rate–Treatment Planning	Score Worsened	33.4%	33.1%		29.2%	54.6%	Closer to 100% better
7. Informal Supports Rate	Score Improved	39.6%	40.0%		42.6%	51.8%	Closer to 100% better
8. Caregiver Satisfaction Rate–Quality of Services	Score Improved	4.00	4.01		4.03	4.18	Closer to 5 better
9. Youth Satisfaction Rate–Quality of Services	Score Improved	3.88	3.90		3.97	4.02	Closer to 5 better
10. Caregiver Satisfaction Rate–Outcomes	No Change	3.52	3.52		3.53	3.77	Closer to 5 better
11. Youth Satisfaction Rate–Outcomes	Score Improved	3.83	3.84		3.89	3.97	Closer to 5 better
Service Appropriateness							
12. Individualized Education Plan (IEP) Development (% at 6 months)	Score Worsened	58.6%	57.6%		51.8%	67.2%	Community defined
13. Substance Use Treatment Rate	No Change	58.8%	58.8%		59.4%	73.1%	Closer to 100% better
Child and Family Outcomes							
Caregiver Report							
Child Level							
14a. School Enrollment Rate	Score Improved	95.8%	95.9%		96.3%	99.8%	Closer to 100% better
14b. School Enrollment Rate (Preschool)	Score Worsened	97.6%	97.3%		93.3%	100.0%	Closer to 100% better
15a. School Attendance Rate (80% of the time)	Score Worsened	81.5%	81.2%		79.7%	87.2%	Closer to 100% better
15b. Daycare or Afterschool Care Program Attendance Rate	No Change	79.0%	79.0%		79.2%	81.4%	Closer to 100% better
16. School Performance Improvement Rate (intake to 6 months)	Score Worsened	34.9%	33.2%		23.9%	39.1%	Closer to 100% better
17. Stability in Living Situation Rate (intake to 6 months)	Score Improved	79.3%	79.5%		80.9%	84.7%	Closer to 100% better
18. Inpatient Hospitalization Days per Child (intake to 6 months)*	Score Improved	2.96	2.88		2.38	0.80	Lower # better
19. Suicide Attempt Reduction Rate–Caregiver Report**	Score Improved	-43.6%	-45.5%		-55.6%	-50.0%	More negative % better
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	Score Improved	27.8%	28.1%		29.8%	33.6%	Closer to 100% better
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	Score Improved	32.7%	33.5%		41.7%	35.6%	Closer to 100% better
20c. Socialization or Communication Problem Improvement Rate (intake to 6 months)	Score Worsened	24.0%	23.0%		21.0%	33.5%	Closer to 100% better

CQI Progress Report—Aggregate for Communities 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, 2010

Date Services Started: **Aug-06**
Number Enrolled in the Descriptive Study: 9**,721**
Number Enrolled in the Outcome Study: **4,365**

	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)							
Family Level							
21. Average Reduction in Employment Days Lost (intake to 6 months)**	Score Worsened	-1.52	-1.47		-1.16	-2.92	More negative # better
22. Family Functioning Improvement Rate (intake to 6 months)	No Change	2.7%	2.7%		3.1%	5.7%	Higher % better
23. Caregiver Strain Improvement Rate (intake to 6 months)	Score Improved	25.4%	25.7%		27.5%	32.1%	Closer to 100% better
Youth Report							
24. Youth No Arrest Rate (intake to 6 months)	Score Improved	4.7%	5.6%		10.5%	17.6%	Higher % better
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)**	Score Improved	-25.4%	-34.2%		-76.9%	-50.0%	More negative % better
26. Anxiety Improvement Rate (intake to 6 months)	Score Worsened	17.3%	17.2%		16.6%	18.5%	Closer to 100% better
27. Depression Improvement Rate (intake to 6 months)	Score Improved	10.1%	11.0%		16.3%	14.3%	Closer to 100% better
Satisfaction with Services							
28. Caregiver Overall Satisfaction	Score Improved	4.00	4.01		4.03	4.16	Closer to 5 better
29. Youth Overall Satisfaction	Score Improved	3.91	3.92		3.99	4.00	Closer to 5 better
Family and Youth Involvement							
30. Caregiver Satisfaction Rate–Participation	No Change	4.24	4.24		4.27	4.30	Closer to 5 better
31. Youth Satisfaction Rate–Participation	Score Improved	3.64	3.66		3.72	3.73	Closer to 5 better
32. Caregiver and Other Family Involvement in Service Plan	No Change	96.9%	96.9%		96.7%	99.4%	Closer to 100% better
33. Youth Involvement in Service Plan	No Change	88.7%	88.7%		88.9%	94.8%	Closer to 100% better
Cultural and Linguistic Competency							
34. Caregiver Satisfaction Rate–Cultural Competency	No Change	4.44	4.44		4.47	4.56	Closer to 5 better
35. Youth Satisfaction Rate–Cultural Competency	Score Improved	4.23	4.25		4.35	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 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)	9,396	30	230.45	1,929	EDIF**
2. Linguistic Competency Rate	153	5	0.14	21	Caregiver
3. Agency Involvement Rate–Service Provision	2,332	29	0.16	323	Caregiver
4. Caregiver Satisfaction Rate–Access to Services	2,222	29	0.22	314	Caregiver
5. Timeliness of Services (average days)	7,812	30	13.57	855	EDIF**
6. Agency Involvement Rate–Treatment Planning	7,098	30	0.22	742	EDIF**
7. Informal Supports Rate	2,341	29	0.19	324	Caregiver
8. Caregiver Satisfaction Rate–Quality of Services	2,229	29	0.28	314	Caregiver
9. Youth Satisfaction Rate–Quality of Services	1,194	22	0.27	173	Youth
10. Caregiver Satisfaction Rate–Outcomes	2,221	29	0.30	311	Caregiver
11. Youth Satisfaction Rate–Outcomes	1,190	22	0.23	171	Youth
12. Increase in Individualized Education Plan (IEP) Development (intake to 6 months)	1,957	29	0.16	276	Caregiver
13. Substance Use Treatment Rate	226	10	0.19	32	Caregiver
14a. School Enrollment Rate	2,425	29	0.07	324	Caregiver
14b. School Enrollment Rate (Preschool)	221	6	0.03	15	Caregiver
15a. School Attendance Rate (80% of the time)	2,210	29	0.10	305	Caregiver
15b. Daycare or Afterschool Care Program Attendance Rate	434	17	0.14	53	Caregiver
16. School Performance Improvement Rate (intake to 6 months)	1,269	24	0.09	197	Caregiver
17. Stability in Living Situation Rate (intake to 6 months)	2,497	29	0.13	335	Caregiver
18. Inpatient Hospitalization Days per Child (intake to 6 months)	2,497	29	4.00	336	Caregiver
19. Suicide Attempt Reduction Rate–Caregiver Report	2,466	20	0.75	331	Caregiver
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	1,971	26	0.07	282	Caregiver
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	424	8	0.05	36	Caregiver
20c. Socialization or Communication Problem Improvement Rate (intake to 6 months)	441	7	0.11	42	Caregiver
21. Average Reduction in Employment Days Lost (intake to 6 months)	1,116	26	3.40	149	Caregiver
22. Family Functioning Improvement Rate (intake to 6 months)	2,484	29	0.03	343	Caregiver
23. Caregiver Strain Improvement Rate (intake to 6 months)	2,443	29	0.08	335	Caregiver
24. Youth No Arrest Rate (intake to 6 months)	1,239	22	0.12	174	Youth
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)	1,226	19	0.56	176	Youth
26. Anxiety Improvement Rate (intake to 6 months)	1,208	22	0.09	169	Youth
27. Depression Improvement Rate (intake to 6 months)	1,237	22	0.04	172	Youth
28. Caregiver Overall Satisfaction	2,229	29	0.22	314	Caregiver
29. Youth Overall Satisfaction	1,191	22	0.22	172	Youth
30. Caregiver Satisfaction Rate–Participation	2,228	29	0.20	314	Caregiver
31. Youth Satisfaction Rate–Participation	1,191	22	0.28	173	Youth
32. Caregiver and Other Family Involvement in Service Plan	7,339	30	0.09	784	EDIF**
33. Youth Involvement in Service Plan	4,436	24	0.19	514	EDIF**
34. Caregiver Satisfaction Rate–Cultural Competency	2,173	28	0.14	311	Caregiver
35. Youth Satisfaction Rate–Cultural Competency	1,170	22	0.18	171	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.

Appendix E

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. Please refer to Appendix F for a list of descriptive data collected in the study.

Longitudinal Child and Family Outcome Study

The primary purpose of the Outcome Study is to assess changes over time among children and families participating in system of care services. Outcome data collected from caregivers included the child's clinical and social functioning, behavioral and emotional strengths, restrictiveness of living situation, educational performance, and satisfaction with services. Assessments of family functioning, family resources, and caregiver strain also were obtained from caregivers. In addition, youth 11 years or older reported on their own delinquent behaviors, behavioral and emotional problems, history of substance use, perceptions of family functioning, and service satisfaction. Standardized and nonstandardized instruments typical in the field of children's mental health services were used to collect these data. Please see Appendix F 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 (case manager), and initial efforts to plan additional services.
- Have a caregiver who legally can grant consent to participate in the evaluation (can grant consent for treatment), or a legal custodian who will grant consent for

the child and the child's primary caregiver to participate in the Outcome Study.

- Have a caregiver who can provide the information requested and is capable of completing a data collection interview (e.g., no severe cognitive impairment).
- 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 Outcome Study, examines whether clients experience services according to system of care principles. Because efforts to develop a system infrastructure that supports service delivery and embodies system of care principles may not succeed at changing how services are provided directly to children and families, the study assesses intervention fidelity, satisfaction with services, cultural competence, 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 F 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 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 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).

In conducting the Services and Costs Study, the national evaluation provides training to communities and conducts a survey of their management information system and technology capabilities during their first year of funding. This is followed by further training and technical assistance through workshops, Webinars, and conference calls.

This study relies on data that communities can provide from their existing management information systems. Because communities vary widely in the completeness, quality, and availability of usable services and costs data, the analysis of services and costs data is tailored to individual communities.

System of Care Assessment

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

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

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 funding 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 stakeholders in graduated sites and those nearing graduation. Hard copies of the survey in English and Spanish are available upon request. Four stakeholders 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 Added to the National Evaluation Active in FY 2010

Evidence-Based Practice 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 funded in 2005–2006. The EBP Study includes a multi-level, mixed-method approach to the collection of information from multiple respondent groups within and across communities. Data from two substudies are described in this report: (1) Family and Youth Experiences Substudy and (2) Evidence-Based Treatment Implementation Factors Substudy.

Family and Youth Experiences Substudy (FYES)

Data for the FYES are collected from participants in the Longitudinal Child and Family Outcome Study at all communities initially funded in 2005–2006 regarding their participation in and experience with EBP. 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 at follow-up data collection points every 6 months.

Evidence-Based Treatment Implementation Factors Substudy (EBT IFS)

The EBT IFS examines factors related to implementing EBTs for children and youth, including associated facilitators and challenges. The *EBT IFS* involved 38 individual telephone interviews with key stakeholders in 21 grant communities; these interviews were conducted between February and July 2010.

Appendix F

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, delinquent 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.

Measures

- **Demographics, medications, chronic illnesses—**Caregiver Information Questionnaire (CIQ) and Youth Information Questionnaire (YIQ)
- **Caregiver strain—**Caregiver Strain Questionnaire (CGSQ; Brannan et al., 1998)
- **Child and youth behavior—**Child Behavior Checklist 1½–5 (CBCL/1½–5; Achenbach & Rescorla, 2000) and Child Behavior Checklist 6–18 (CBCL/6–18; Achenbach & Rescorla, 2001)
- **Child development—**Vineland Screener 0–Under 3 (VS1), Vineland Screener 3–5, (VS2), and Vineland Screener 6–12 (VS3) (Sparrow et al., 1993)
- **Child and youth social functioning—**Columbia Impairment Scale (CIS; Bird et al., 1993)
- **Child and youth strengths—**Behavioral and Emotional Rating Scale–2: Parent Rating Scale (BERS–2C; Epstein, 2004) and Behavioral and Emotional Rating Scale–2: Youth Rating Scale (BERS–2Y; Epstein, 2004)
- **Cultural competence of services—**Cultural Competence and Service Provision Questionnaire (CCSP)
- **Delinquent behaviors—**Delinquency Survey–Revised (DS–R)
- **Educational indicators—**Education Questionnaire–Revised (EQ–R)
- **Family functioning—**Family Life Questionnaire (FLQ)
- **Satisfaction with services—**Youth Services Survey (YSS; Brunk et al., 2000); Youth Services Survey for Families (YSS–F; Brunk et al., 2000)
- **Service use information—**Multi-Sector Service Contacts–Revised (MSSC–R)
- **Stability of living situations—**Living Situations Questionnaire (LSQ)
- **Substance abuse—**Substance Use Survey–Revised (SUS–R) and GAIN Quick–R Substance Problem Scale (GAIN)
- **Youth anxiety—**Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978)
- **Youth depression—**Reynold's Adolescent Depression Scale–Second Edition (RADS–2; Reynolds, 1986)

Descriptions of the Measures

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

The BERS–2C is administered to caregivers of children participating in the Outcome

Study. The 57-item checklist measures children's behavioral and emotional strengths in six different areas: interpersonal strength, family involvement, intrapersonal strength, school functioning, affective strength, and career strength. Caregivers may respond based on a 4-point scale: (0) *not at all like your child*, (1) *not much like your child*, (2) *like your child*, and (3) *very much like your child.*

Several analyses reported in the BERS–2 Examiner's Manual, 2nd Edition, indicated that the BERS–2C demonstrates adequate reliability. Coefficient alphas are reported for each BERS–2C subscale across 12 different age intervals in the BERS–2 Examiner's Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .80 to .93. The average for the strength index across the 12 age intervals was .97. Two studies reported in the BERS–2 Examiner's Manual, 2nd Edition examined the test–retest reliability of the BERS–2C. In the first study, test–retest correlation coefficients for the BERS–2C subscales ranged from .80 to .94. The coefficient for the strength index was .90. In the second study, test–retest correlation coefficients for the BERS–2C subscales ranged from .88 to .92, while the coefficient for the strength index was .87. All of these coefficients are in the very large range (Hopkins, 2002). Finally, inter-rater reliabilities between parent and student ratings on each of the subscales ranged from .50 to .63, while the inter-rater reliability on the Strength Index was .54.

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

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

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

Several analyses reported in the BERS–2 Examiner's Manual, 2nd Edition indicated that the BERS–2Y demonstrates adequate reliability. Coefficient alphas are reported for each BERS–2Y subscale across six different age intervals in the BERS–2 Examiner's Manual, 2nd Edition. The average coefficient for the six subscales collapsed across the age intervals ranged from .79 to .88, while the average for the strength index across the six age intervals was .95. Test–retest correlation coefficients for the BERS–2Y subscales ranged from .84 to .91, while the coefficient for the strength index was .91. Finally, inter-rater reliabilities between parent and student ratings on each of the subscales ranged from .50 to .63, while the inter-rater reliability on the strength index was .54.

Several analyses reported in the BERS–2 Examiner's Manual, 2nd Edition indicated that the BERS–2Y demonstrates adequate validity. Concerning construct-identification validity, confirmatory factor analysis supports the factor structure of the five core subscales used in calculating the Strength Index (Epstein, 2004). In addition, correlations between the BERS–2Y standard scores and the Youth Self-Report (Achenbach, 1991) total problems score, broadband syndrome scores, narrow-band syndrome scores, competence scores, and total competence score were in the expected direction, demonstrating criterion-prediction validity. Finally, correlations between the BERS–2Y standard scores and the Total Social Skills scale of the Social Skills Rating System, Student Form (Gresham & Elliot, 1990) were in the hypothesized direction (i.e., positive), further evidencing criterion-prediction validity.

Caregiver Information Questionnaire (CIQ)

The CIQ is administered to all caregivers of children participating in the Longitudinal Child and Family Outcome Study. There are caregiver and staff-as-caregiver versions, as well as an intake version and follow-up versions that are administered every 6 months for up to 36 months.

The CIQ was developed to capture uniform demographic data about caregivers to whom the national evaluation instruments are being administered. The intake version of the CIQ that caregivers respond to contains 39 items with subparts that describe the child and family. These items gather information on demographic characteristics, child and family risk factors, family composition, legal custody of the child, the child's mental and physical health service use history, caregiver employment status, attitudes about coercion in receiving services, and the child's presenting problem(s). The staff-as-caregiver version contains a reduced number of items, since some questions items can or should be posed to staff-as-caregivers. The follow-up versions of the CIQ contained a reduced number of items because some questions are not repeated at follow-up.

Caregiver Strain Questionnaire (CGSQ)

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

The CGSQ has demonstrated good reliability and validity. Confirmatory factor analysis supported the existence of three related dimensions of caregiver strain. The three subscales on the CGSQ (Objective Strain, Subjective Externalizing Strain, Subjective Internalizing Strain) demonstrated adequate internal consistency (Brannan & Heflinger, 2000; Heflinger, Northrup, Sonnichsen, & Brannan, 1998).

Preliminary analysis of national evaluation data collected from communities initially funded in 2002–03 shows good internal consistency for the three subscales. The Cronbach's alphas are .92 for objective strain, .67 for subjective internalizing strain, and .82 for subjective externalizing strain.

Child Behavioral Checklist/1½–5 (CBCL/1½–5)

The CBCL/1½–5 is administered to caregivers of children participating in the Outcome Study. It measures behavioral and emotional problems in children aged 1½–5. The CBCL/1½–5 includes three main sections. For the national evaluation, caregivers are required only to complete the behavioral and emotional problems section. In this section, caregivers report on 99 problem items by indicating the degree to which each statement (e.g., Cruel to animals) describes their child. Response options are the same for all items in this section: (0) *not true*, (1) *somewhat or sometimes true*, and (2) *very true or often true*.

Using a national normative sample and large clinical samples as norms, the checklist produces seven narrow-band syndrome T-scores: emotionally reactive, anxious/depressed, somatic complaints, withdrawn, sleep problems, attention problems, and aggressive behavior; two broadband syndrome T-scores: internalizing and externalizing; and a total problems T-score.

Reported test–retest reliabilities for the seven narrow-band scales were between .68 and .92. The test–retest reliabilities for the Internalizing and Total Problems scales were both .90, while the Externalizing scale had a test–retest reliability of .87. The average test–retest reliability across all scales was .85. Finally, the CBCL/1½–5 demonstrates adequate content, criterion-related, and construct validity using a variety of techniques (Achenbach & Rescorla, 2000).

Child Behavioral Checklist/6–18 (CBCL/6–18)

The CBCL/6–18 is administered to caregivers of children and youth participating in the Longitudinal Child and Family Outcome Study. The CBCL/6–18 is designed to provide a standardized measure of behavioral and emotional problems among children aged 6–18. The CBCL/6–18 has been widely used in children's mental health services to assess social competence, behaviors, and feelings. It elicits a rich and detailed description of behaviors and symptoms that provides more information than diagnosis alone provides. The CBCL/6–18 contains three main sections. For the national evaluation, caregivers are required only to complete the social competence section and the behavioral and emotional problem section. The social competence section collects information related to involvement in organizations, sports, peer relations, and school performance (e.g., "About how many times a week does your child do things with any friends outside of regular school hours?"). Response options for this section vary.

The behavioral and emotional problem section contains 113 items and documents the presence of various problems and symptoms (e.g., argumentativeness, withdrawal, aggression). Response options are the same for all items in this section: (0) *not true*, (1) *somewhat or sometimes true*, and (2) *very true or often true*.

The checklist produces a total problems T-score; two broadband syndrome T-scores; eight narrowband syndrome T-scores; competence T-scores in activities, social situations, and school; and a total competence T-score. The social competence items are scored to provide a more strengths-based perspective, but should be interpreted cautiously due to cultural biases and a response format that often leads to incomplete data (Drotar, Stein, & Perrin, 1995).

Achenbach and Rescorla (2001) have reported a variety of information regarding internal consistency, test–retest reliability, construct validity, and criterion-related validity. Good internal consistency was found for the Internalizing, Externalizing, and Total Problems scales (alpha ≥ .90). The CBCL/6–18 demonstrated good test–retest reliability after 8 days (Pearson *r* at or above .80 for all scales). Moderate to strong correlation with the Connor Parent Rating Scale–Revised and the Behavior Assessment System for Children (BASC) Scales (Pearson *r* coefficients ranged from .34 to .89) supported the construct validity of the CBCL/6–18.

The CBCL/6–18 was, for most items and scales, capable of discriminating between children referred to clinics for needed mental health services and those youth not referred (Achenbach & Rescorla, 2001). A variety of other studies have also shown good criterion-related or discriminant validity (e.g., Barkley, 1988; McConaughy, 1993). Inter-observer agreement was evident in a meta-analysis of 119 studies that used the CBCL/6–18. In 269 separate samples, statistically significant correlations (using Pearson *r*) were found among ratings completed by parents, mental health workers, teachers, peers, observers, and adolescents themselves (Achenbach, McConaughey, & Howell, 1987).

The instrument has been nationally normed on a proportionally representative sample of children across income and racial/ethnic groups. Racial/ethnic differences in total and subscale scores of the CBCL/6–18 disappeared when controlling for socioeconomic status, suggesting a lack of instrument bias related to racial/ethnic differences.

Columbia Impairment Scale (CIS)

The CIS evaluates level of impairment in four basic areas of functioning and provides a global measure of impairment. The CIS lists 13 problems commonly encountered by youth. Within each of the four functioning areas (interpersonal relations, functioning in job or schoolwork, use of leisure time, and broad psychopathological domains), caregivers rate the extent to which each item is a problem for his/her child, using a 4-point scale: (0) *no problem* to (4) *a very big problem*. Response options 1, 2, and 3 indicate the extent to which a particular item is of *some problem*; 3 indicates a greater level of impairment and 1 indicates a lower level of impairment.

Reliability and validity were measured on a sample from an ethnically, geographically, and socioeconomically diverse population ranging in age from 9 to 17 (n = 121) and a demographically comparable sample of clinical subjects (n = 61). Validity was determined by comparing scores from the CIS with those from the clinician-scored Children's Global Assessment Scale (CGAS), with a correlation of -0.73 between the CIS and CGAS (scales for the two measures move in opposite directions). There was high internal consistency across the four conceptual domains measured by the CIS (range .43 to .77), and the measure was able to discriminate between clinical and community subjects ($p < .001$). The CIS has good test–retest reliability, with an intraclass correlation coefficient = .89.

Cultural Competence and Service Provision Questionnaire (CCSP)

The CCSP is comprised of 16 items that assess the importance and inclusion of culture in services provided to the child. The first three items of the CCSP assess the caregivers' ratings of the importance of their providers' understanding and inclusion of culture in their service provision on a scale from 1 = *not at all important* to 5 = *extremely important*. The remaining 13 items measure the frequency with which service providers incorporate their understanding of culture in their practices on a scale from 1 = *never* to 5 = *always*.

Preliminary reliability information for the CCSP indicate that internal consistency is acceptable for the importance subscale (Cronbach's alpha = .757) and the provider practices subscale (Cronbach's alpha = .879). Further empirical assessment of the CCSP's reliability and validity will be conducted when additional data have been received.

Delinquency Survey–Revised (DS–R)

The DS–R gathers information reported by youth about their contacts with law enforcement and other delinquent behavior. The questionnaire consists of 29 questions that assess the youth's destructive and violent behavior toward others in the community and contact with law enforcement, including involvement with criminal offenses, arrests, and probation.

Analysis of 149 completed DS–Rs submitted by communities initially funded in 2002–03 revealed high internal consistency on DS–R items measuring the frequency and type of delinquent behavior in the past 6 months (Cronbach's alpha = .86).

Education Questionnaire–Revised (EQ–R)

The EQ–R was developed to collect, from caregivers, information on their child's educational status. The EQ–R contains 15 questions with subparts covering topics including school attendance, grade level, school achievement, alternative or special school and classroom placements, and reasons for having an Individualized Education Plan (IEP). Additional questions also provide information on overall academic performance and whether the child has been suspended or expelled from school.

As a method for collecting descriptive information, conventional assessments of reliability and validity are not appropriate for the EQ–R. However, review and refinement of the measure were conducted for communities initially funded in 2002–2004 and 2005–2006, building on the questionnaire used in the evaluation with communities initially funded in 1993–1994, 1997–1998, and 1999–2000, and feedback from communities.

Family Life Questionnaire (FLQ)

The FLQ consists of 10 statements about activities the family may do together and how the family interacts. This questionnaire was designed to assess aspects of family life that may change as a result of changes in children's functional impairment.

Preliminary analysis of national evaluation data from communities initially funded in 2002 and 2003 revealed high internal consistency (Cronbach's alpha = .85). Further, subscales of the CGSQ were found to correlate negatively with the FLQ items as expected, suggesting the measure has discriminant validity.

GAIN Quick–R: Substance Problem Scale (GAIN)

The GAIN “documents participant-reported problems associated with the use and abuse of and dependence on drugs and alcohol” (Titus & Dennis, 2005, p. 11). This questionnaire is drawn from the Global Appraisal of Individual Needs–Quick (GAIN–Q, http://www.chestnut.org/LI/gain/GAIN_Q/index.html). There is one screener item and 16 core items. Youth are asked to respond *no* or *yes* to each item. The 16 core items parallel those used to obtain a *DSM–IV* diagnosis of substance use. Although typically used to assess issues present during the past 12 months, the GAIN will assess issues that occurred in the past 6 months, the timeframe used throughout the national evaluation.

The overall alpha coefficient reported by Titus and Dennis (2005) for the 16 core items of the GAIN for adolescents (using a 12-month timeframe) is .82. Two subscales result from the 16 core GAIN items: the nine-item Substance Use and Abuse Index (SAUI–9) and the seven-item Substance Dependence Index (SDI–7). The alpha coefficients for these indices are .63 and .75, respectively.

Living Situations Questionnaire (LSQ)

The Living Situations Questionnaire (LSQ) is a modified version of the restrictiveness of living situations questionnaire (ROLES; Hawkins, Almeida, Fabry, & Reitz, 1992). The LSQ documents the physical setting in which youth lived during a 6-month time period and with whom the child was living in that setting. Information gathered from the LSQ can be used to create the same living situation categories assessed in the ROLES, which was developed to operationalize and assess the restrictiveness of children’s living situations.

No formal reliability and validity information is available on the LSQ or the ROLES; however, expected relationships have been found between levels of restrictiveness, as assessed with the ROLES, and programmatic variables. The ROLES was used to document changes in the restrictiveness of placements over time as a quality assurance indicator for children in foster care (Thomlison, 1993) and as a process outcome for a therapeutic case management program for children with severe emotional disturbance (Bruns, Burchard, & Yoe, 1995).

Multi-Sector Service Contacts–Revised (MSSC–R)

The MSSC–R was developed to record caregivers’ reports of services used in multiple child-serving sectors. Development of the MSSC–R followed from previous efforts in the field of mental health services research to collect caregiver reports of service use. The MSSC–R provides standard descriptions of types of services, but the names of the services as well as the service settings should be customized for each site. The standard descriptions allow cross-site comparisons, and the use of local service and agency names, those familiar to caregivers, improves the reporting of service contacts. The MSSC–R captures the different locations a child and/or family may have received any of the services in the 6-month period prior to the interview and whether each of the locations is convenient to the child and/or family. In addition, for each specific service asked, the MSSC–R records how much of each service type was received and how well the service meets the needs of the child and/or family. The MSSC–R also contains two questions related to the caregiver’s service experience.

Information from the MSSC–R will be compared to communities’ fiscal management information systems to check the accuracy with which services provided in the mental health sector are reported by caregivers. Based on reliability analysis of the national evaluation data collected from communities initially funded in 1997–98, Cronbach's alpha coefficient was .98 for the service items that asked about whether a child received a service in the previous 6 months.

Revised Children's Manifest Anxiety Scale (RCMAS)

The RCMAS (Reynolds & Richmond, 1978) assesses the level and nature of anxiety experienced by children and youth aged 6–19. It examines both the source and the cause of stress in a person's life. The scale can also be used to identify the relationship between anxiety and performance in other aspects of the child's or youth's life. The RCMAS contains 37 items. Each item is a statement that embodies a feeling or action that reflects an aspect of anxiety. The instrument includes questions about what the youth worries about, how often the youth worries, and how the youth feels, physiologically, as a result of his/her worry. Youth respond to each description with either *yes* or *no*.

Internal consistency; long-term reliability; and concurrent, convergent, and divergent validity have been demonstrated. Reynolds and Richmond (1978) reported that the items on the RCMAS yield a Kuder-Richardson (KR) reliability estimate of .83, demonstrating internal consistency. A cross-validation assessment conducted with 167 middle- and high-school-age children yielded a KR reliability estimate of .85. Comparable internal consistency was also demonstrated with kindergarten-age children. The measure has been shown to have high short-term (i.e., retesting at 1 and 5 weeks) test–retest reliability (Pearson correlations from .60 to .88, significant at $p \leq .01$), and fairly high long-term (i.e., retest at 9 months) test-retest reliability ($r = .68$).

The RCMAS is highly correlated with the trait measure of anxiety, STAIC ($r = .85$, $p \leq .05$). A study by Mattison, Bagnato, and Brubaker (1988) showed that the RCMAS is able to discriminate between children with a *DSM–III* anxiety disorder and other *DSM–III* psychiatric diagnoses.

Reynolds Adolescent Depression Scale–2nd Edition (RADS–2)

The RADS–2 (Reynolds, 1986) measures adolescent depression and is comprised of four subscales: dysphoric mood, anhedonia/negative affect, negative self-evaluation, and somatic complaints. The RADS–2 contains 30 items that state a feeling. Youth rate how often each statement describes how they feel using a 4-point scale: (1) *almost never*, (2) *hardly ever*, (3) *sometimes*, and (4) *most of the time*. Questions include feelings of happiness, sadness, fear, anxiety, loneliness, anger, and love.

Validity of the RADS–2 has been examined with respect to content validity, criterion-related validity, construct validity (convergent, discriminant, and factorial), and clinical validity (Krefetz, Steer, Gulab, & Beck, 2002; Reynolds & Mazza, 1998). Reliability and validity studies included a school-based sample of over 9,000 adolescents and a clinical sample of 297 adolescents with *DSM–III–R* or *DSM–IV* diagnoses who were evaluated in both school and clinical settings. Reynolds (1986) examined the reliability and validity of the RADS–2 in a sample of 89 young adolescents from an inner-city school. The study found an internal consistency reliability of .91 on the initial assessment and .93 for the retest. The test–retest reliability of the RADS–2 was .87. The

RADS–2 was able to discriminate depressed and non-depressed adolescents, with a sensitivity rate of 89 percent and specificity of 90 percent, and an overall correct classification of 90 percent. Total scores for the RADS–2 have a correlation of .84 with the Beck Depression Inventory ($p < .001$) and .76 with the Hamilton Depression Rating Scale.

Substance Use Survey–Revised (SUS–R)

The SUS–R assesses youth's report of their substance use for alcohol, tobacco, and other drugs. The first set of questions measure a youth's alcohol use, including history and frequency of drinking behaviors, and cigarette use. The next set of questions focuses on the youth's illegal substance use. Youth are asked whether they ever used the substance, how old they were when they first tried the substance, how long it has been since they last used the substance, and frequency of use during the past 30 days. The remaining questions assess youths' use of prescription drugs without a physician's prescription and abuse of nonprescription or over-the-counter drugs.

Conventional assessments of reliability and validity are not appropriate for the SUS–R.

Vineland Screener 0–Under 3 (VS1), 3–5 (VS2), 6–12 (VS3)

The Vineland Screener (Sparrow et al., 1993) is a developmental assessment. There are multiple versions of the Vineland Screener, each targeting a narrow age range and including assessment items that are appropriate for the development of children within that age range. The national evaluation uses three age-specific versions of the screener: 0 to under 3 years (VS1), 3 to under 6 years (VS2), and 6 to under 12 years (VS3).

The VS1 and VS2 assess development within four domains: communication, daily living skills, socialization, and motor skills. Both of these screeners have 60 items (15 items per domain). The VS3 includes all of the domains that are in the VS1 and VS2 except for motor skills, and has a total of 45 items. For each item, the interviewer indicates how often the child does the behavior, with the scoring referring to the information probed for rather than the initial question. Scoring options include *Yes, usually*; *Sometimes, partially*; *No, never*; *No opportunity*; and *Don't know*.

The Vineland normative data were obtained from a representative national sample matched to the 1980 census on the basis of gender, race/ethnicity, community size, region of the country, and parents' educational level. This sample of 536 children was also used to derive the norms for the Vineland Screener (Canino, Costello, & Angold, 1999; Coll, Buckner, Brooks, Weinreb, & Bassuk, 1998).

The Vineland Screener is highly correlated with the in-depth Vineland Survey Form, with correlations of at least 0.89 (range: 0.87–0.98) on each domain and the composite score. The instrument has inter-rater reliability of $\alpha = 0.98$ among lay interviewers.

Youth Information Questionnaire (YIQ)

The YIQ contains 25 items that capture a range of issues and information that are important for understanding many facets of the youth's life. The YIQ includes questions about the youth's acculturation, employment, peer relationships, presenting problems, suicidality, and neighborhood safety. A subset of 18 YIQ items (i.e., those data elements that may change over time) will also be asked at each follow-up data collection point (e.g., 6 months, 12 months, 18 months, etc.).

As a method for collecting descriptive information, conventional assessments of reliability and validity are not appropriate for the YIQ. However, data collected with the YIQ will be compared to descriptive data provided by the caregivers to check for consistency**.**

Youth Services Survey (YSS)

The YSS (Brunk et al., 2000) contains 21 items scored on a 5-point scale and one open-ended question. The measure assesses perceptions of service across five domains: access, participation in treatment, cultural sensitivity, satisfaction, and outcomes.

Based on reliability analysis of the State Indicator Pilot Project, which evaluated data from Colorado, Kentucky, Oklahoma, Texas, Virginia, and the District of Columbia, Cronbach's alpha for the domain measuring access to services is .71, participation in treatment is .82, cultural sensitivity of staff is .90, satisfaction with services is .94, and perceived outcome of service is .86.

Youth Services Survey for Families (YSS–F)

The YSS–F (Brunk et al., 2000) contains 21 items scored on a 5-point scale and one open-ended question. The measure assesses perceptions of service across five domains: access, participation in treatment, cultural sensitivity, satisfaction, and outcomes.

Based on reliability analysis of the State Indicator Pilot Project, which evaluated data from Colorado, Kentucky, Oklahoma, Texas, Virginia, and the District of Columbia, Cronbach's alpha for the domain measuring access to services is .73, participation in treatment is .77, cultural sensitivity of staff is .91, satisfaction with services is .94, and perceived outcome of service is .91.

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 anytime 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 contains four service system components that form the columns of the table. The domains are infrastructure and service delivery. The infrastructure domain is comprised of four components that address governance, management and operations, service array, and evaluation and quality monitoring. The service delivery domain is comprised of four components that address entry into services, service planning, service provision, and case review. Definitions of the components are provided in Table F–1.

Table F–1: 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.
Quality Monitoring	Quality management conducted by the system that tracks the integration of process assessment and outcome measurement, and the use of continuous feedback loops to improve service delivery.
Service Delivery	
Entry into Service System	The processes and activities associated with children and families' initial contact with the service system, including eligibility determination.
Service Planning	The identification of services for children and families through initial development as well as periodic updating of initial service plans.
Service Provision	The processes and activities related to the ongoing receipt of and participation in services.
Case Review Structure	The process used to review the care of children at risk of out-of-home or out-of-community placement. For those already in such placements, there may be routine monitoring to determine whether that setting is still appropriate, or to plan transition to services in the community or back to the home. This process may also include review of challenging cases to resolve difficult problems that could not be resolved by other means. Key to the case review process is that the persons involved have the authority to make service decisions, including transitions to and from restrictive or out-of-community placements.

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

Table F–2: Definition of System of Care Principles

Principle	Definition
Family Focused (Communities Funded in 2002–2004)	The recognition that (a) the ecological context of the family is central to the care of all children; (b) families are important contributors to and equal partners in any effort to serve children; and (c) all system and service processes should be planned to maximize family involvement.
Family Focused (Communities Funded in 2005–2006)	The recognition that (a) the ecological context of the family is central to the care of all children; (b) families are primary decision makers and equal partners in all efforts to serve children; and (c) all system and service processes should be planned to maximize family involvement and decision making.
Individualized (Communities Funded in 2002–2004)	The provision of care that is expressly child centered, addresses child-specific needs, and recognizes and incorporates child-specific strengths.
Individualized/Youth Guided (Communities Funded in 2005–2006)	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; and 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.
Culturally Competent	Sensitivity and responsiveness to, and acknowledgment of, the inherent value of differences related to race, religion, language, national origin, gender, socioeconomic background, and community-specific characteristics.
Interagency	The involvement and partnership of core agencies in multiple child-serving sectors, including child welfare, health, juvenile justice, education, and mental health.
Collaborative/ Coordinated	Professionals working together in a complementary manner to avoid duplication of services, eliminate gaps in care, and facilitate child and family movement through the service system.
Accessible	The minimizing of barriers to services in terms of physical location, convenience of scheduling, and financial constraints.
Community Based	The provision of services within close geographical proximity to the targeted community.
Least Restrictive	The provision of services in settings that maximize freedom of choice and movement, and that present opportunities to interact in normative environments (e.g., school and family).

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

Reliability and Validity

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.

Data Analysis Methods

The quantitative data are determined from items linked to framework indicators. Site visitors rate these items on a 5-point scale, with 1 being the lowest and 5 the highest possible rating. For each interview, items are rated using only information reported by that specific informant and are based on standard criteria. Mean ratings are derived from ratings of the system of care assessment protocols. This information reveals how systems of care develop or are developing vis-à-vis system of care principles.

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

Appendix G

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 H

Descriptive and Outcome Data Tables

Methods and Study Sample

The Longitudinal Child and Family Outcome Study of CMHI-funded communities assessed children and their families every 6 months, for up to 36 months, regardless of whether the children continued to receive services through system of care programs. This allowed comparison of clinical and functional outcomes for all children who participated in the Outcome Study, regardless of whether they remained in or exited system of care services. These figures may vary slightly for communities funded to serve smaller numbers of children (e.g., funding in some communities may be directed primarily toward infrastructure development, or the number of children meeting service criteria for serious emotional disturbance may be lower). While in most communities all willing families need to be recruited into the Outcome Study, in some larger communities, sampling strategies may need to be employed to select a sufficient number of families at random from the pool of children who enter the system of care program. Sample size in analyses conducted in this report fluctuates due to differences in enrollment and data completion rates across communities. Table H–1 presents study enrollment and data completion rates through June 30, 2010 for each community initially funded in 2002–2006.

Demographic Characteristics, Clinical Status, and Child and Family Outcomes

Table H–2 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 2002–2006.

Baseline child and youth history and family characteristics are shown in Table H–3 for children, youth, and families enrolled in communities initially funded in 2002–2006.

Information on child, youth, and family clinical and functional outcome indicators at intake, 6 months, 12 months, 18 months, and 24 months are presented for children, youth, and families enrolled in communities initially funded in 2002–2006 in Table H–4. Information on clinical and functional outcomes at each data collection point does not represent changes over time. Rather, the information provides *descriptive* information on these outcomes at each data collection point. Some children, youth, and families may not have data collected across all data collection points.

Table H–5 presents detailed information on the baseline child and youth demographics of children and youth enrolled in communities initially funded in 2008.

Table H–1: Study Enrollment and Program Interview Completion for Communities Funded in 2002–2006 as of June 2010

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
55	52	4	4	3	2	2	2	0	1	1	1	0	0	0	25.0	33.3	50.0	0.0	0.0	
56	340	114	114	113	107	93	66	55	78	52	33	22	15	7	68.4	46.0	30.8	23.7	22.7	12.7
57	3,358	223	223	201	175	139	85	53	137	93	75	61	8	0	61.4	46.3	42.9	43.9	9.4	0.0
58	393	110	110	110	110	101	85	70	104	101	103	95	80	66	94.5	91.8	93.6	94.1	94.1	94.3
59	72	25	25						12						48.0					
60	660	113	105	81	65	57	40	24	65	40	39	29	18	14	61.9	49.4	60.0	50.9	45.0	58.3
61	504	170	170	142	96	71	49	22	126	91	57	39	26	7	74.1	64.1	59.4	54.9	53.1	31.8
62	287	186	178	160	143	117	105	65	140	121	106	78	60	42	78.7	75.6	74.1	66.7	57.1	64.6
63	362																			
64	481	261	261	261	246	234	204	156	188	149	110	93	66	47	72.0	57.1	44.7	39.7	32.4	30.1
65	358	168	167	156	131	121	95	76	136	116	95	83	54	39	81.4	74.4	72.5	68.6	56.8	51.3
66	323	102	102	94	88	79	62	44	41	22	21	9	6	3	40.2	23.4	23.9	11.4	9.7	6.8
67	371	180	180	178	169	140	110	61	141	116	93	71	48	30	78.3	65.2	55.0	50.7	43.6	49.2
68	498	229	219	206	121	95	74	50	119	76	32	19	6	3	54.3	36.9	26.4	20.0	8.1	6.0
69	838	250	250	217	206	151	97	68	194	167	144	87	55	38	77.6	77.0	69.9	57.6	56.7	55.9
70	258	113	112	104	95	88	88	73	93	77	63	53	42	36	83.0	74.0	66.3	60.2	47.7	49.3
71	711	295	279	212	186	158	135	79	213	141	106	89	64	32	76.3	66.5	57.0	56.3	47.4	40.5
72	851	316	316	316	316	300	266	224	270	252	239	222	192	173	85.4	79.7	75.6	74.0	72.2	77.2
73	274	50	50	50	47	41	32	24	25	16	14	3	5	1	50.0	32.0	29.8	7.3	15.6	4.2
74	2,162	305	305	289	246	194	157	105	186	167	107	84	64	39	61.0	57.8	43.5	43.3	40.8	37.1
75	227	115	115	115	115	103	90	77	98	81	77	63	49	41	85.2	70.4	67.0	61.2	54.4	53.2
76	346	51	51	47	33	17	9	4	32	15	10	6	3	0	62.7	31.9	30.3	35.3	33.3	0.0
77	347	146	146	146	146	146	137	122	56	48	19	8	0	0	38.4	32.9	13.0	5.5	0.0	0.0
78	143	84	51	42	24	24	24	24	35	16	0	3	5	3	68.6	38.1	0.0	12.5	20.8	12.5
79	443	280	280	280	257	219	171	121	244	227	204	158	125	86	87.1	81.1	79.4	72.1	73.1	71.1

Table H–1: Study Enrollment and Program Interview Completion for Communities Funded in 2002–2006 as of June 2010 (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
80	519	176	176	176	148	130	94	68	86	68	39	29	15	9	48.9	38.6	26.4	22.3	16.0	13.2
81	312	168	166	156	110	61	26	12	126	94	64	35	13	5	75.9	60.3	58.2	57.4	50.0	41.7
82	1,758	238	238	238	238	220	188	147	169	146	113	85	58	37	71.0	61.3	47.5	38.6	30.9	25.2
83	1,930	280	280	280	276	221	172	143	241	229	189	150	117	87	86.1	81.8	68.5	67.9	68.0	60.8
100	224	103	91	81	62	47	35	26	50	32	29	18	11	9	54.9	39.5	46.8	38.3	31.4	34.6
101	176	93	86	66	46	41	32	26	67	42	35	21	18	14	77.9	63.6	76.1	51.2	56.3	53.8
102	327	74	73	67	59	48	19	4	43	33	28	18	6	0	58.9	49.3	47.5	37.5	31.6	0.0
103	388	256	231	201	170	133	94	37	114	71	45	23	18	4	49.4	35.3	26.5	17.3	19.1	10.8
104	424	114	103	83	52	19	4	0	56	25	6	1	0	0	54.4	30.1	11.5	5.3	0.0	
105	191	150	123	99	81	66	55	24	109	78	60	48	34	12	88.6	78.8	74.1	72.7	61.8	50.0
106	455	215	201	166	115	93	65	30	142	91	57	35	22	10	70.6	54.8	49.6	37.6	33.8	33.3
107	131	55	52	39	27	20	16	12	32	24	11	9	4	0	61.5	61.5	40.7	45.0	25.0	0.0
108	719	159	141	114	88	86	64	32	49	24	24	23	8	4	34.8	21.1	27.3	26.7	12.5	12.5
109	164	111	93	76	64	50	13	5	59	39	24	17	5	1	63.4	51.3	37.5	34.0	38.5	20.0
110	440	228	217	195	167	131	82	16	165	138	112	72	40	0	76.0	70.8	67.1	55.0	48.8	0.0
111	433	233	187	157	122	98	63	42	130	83	67	43	23	14	69.5	52.9	54.9	43.9	36.5	33.3
112	298	225	205	176	144	118	87	49	143	102	75	50	35	13	69.8	58.0	52.1	42.4	40.2	26.5
113	478	289	257	217	152	111	49	16	195	151	96	71	26	9	75.9	69.6	63.2	64.0	53.1	56.3
114	81	49	49	46	41	29	21	5	40	39	26	21	9	1	81.6	84.8	63.4	72.4	42.9	20.0
115	1,062	225	206	161	101	74	41	4	127	66	51	31	9	0	61.7	41.0	50.5	41.9	22.0	0.0
116	562	299	281	234	188	143	111	61	195	133	111	78	53	20	69.4	56.8	59.0	54.5	47.7	32.8
117	93	67	63	56	52	42	29	15	52	42	37	25	16	8	82.5	75.0	71.2	59.5	55.2	53.3
118	134	95	85	71	58	34	15	0	67	53	39	19	6	0	78.8	74.6	67.2	55.9	40.0	
119	214	83	65	54	36	23	9	0	44	30	20	9	3	0	67.7	55.6	55.6	39.1	33.3	

Table H–1: Study Enrollment and Program Interview Completion for Communities Funded in 2002–2006 as of June 2010 (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
120	308	132	123	115	103	78	44	31	80	61	42	34	23	8	65.0	53.0	40.8	43.6	52.3	25.8
121	84	32	30	30	23	14	7	0	19	11	6	3	0	0	63.3	36.7	26.1	21.4	0.0	
122	269	188	170	141	112	87	53	28	129	90	69	55	33	19	75.9	63.8	61.6	63.2	62.3	67.9
123	158	82	78	72	61	54	46	36	52	31	25	19	14	7	66.7	43.1	41.0	35.2	30.4	19.4
124	60	39	39	39	35	23	16	7	27	18	11	5	1	0	69.2	46.2	31.4	21.7	6.3	0.0
125	70	0	0	0	0	0	0	0	0	0	0	0	0	0						
126	477	133	113	85	34	0	0	0	57	14	0	0	0	0	50.4	16.5	0.0			
127	228	77	75	61	38	24	2	0	52	42	22	6	0	0	69.3	68.9	57.9	25.0	0.0	
128	244	153	125	84	55	38	10	0	70	51	30	22	0	0	56.0	60.7	54.5	57.9	0.0	
129	351	223	156	47	27	16	2	0	140	41	25	13	2	0	89.7	87.2	92.6	81.3	100.0	
Aggregated Number[f]	28,421	8,934	8,366	7,406	6,209	5,062	3,747	2,473	5,849	4,377	3,336	2,463	1,613	998	69.9	59.1	53.7	48.7	43.0	40.4

[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. During FY 2006 two sites were defunded. Those sites contributed about 400 children to the baseline descriptive sample and about 20 children to the baseline outcome sample. Data from the two sites are not included in the aggregated number for eligible for interview, completed interview, and interview completion rate at each assessment point.

Table H–2: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006

Communities Funded in 2002–2006			
	Overall Sample (*n* = 28,421)	**Descriptive Sample (*n* = 19,484)**	**Outcome Sample (*n* = 8,937)**
Gender	(*n* = 28,274)	(*n* = 19,426)	(*n* = 8,848)
Male	62.7%	61.7%	64.8%
Female	37.3%	38.3%	35.2%
Age in Years	(*n* = 28,159)	(*n* = 19,322)	(*n* = 8,837)
Mean (*SD*)	11.4 (4.5)	11.4 (4.6)	11.2 (4.4)
0–5 Years	13.6%	13.2%	14.5%
6–11 Years	30.1%	29.7%	31.0%
12–15 Years	37.3%	36.9%	38.4%
16 Years or Older	19.0%	20.3%	16.1%
Race and Ethnicity	(*n* = 27,939)	(*n* = 19,161)	(*n* = 8,778)
American Indian or Alaska Native Alone	4.3%	4.5%	3.7%
Asian Alone	1.2%	1.4%	1.0%
Black or African American Alone	23.5%	22.5%	25.8%
Native Hawaiian or Other Pacific Islander Alone	1.3%	1.1%	1.7%
White Alone	41.6%	41.7%	41.4%
Of Hispanic Origin	23.3%	24.6%	20.6%
Multiracial	4.4%	3.9%	5.6%
Other, Single Race	0.3%	0.4%	0.2%
Participating in Service Plan Development[a]	(*n* = 18,203)	(*n* = 11,283)	(*n* = 6,920)
Caregiver	90.9%	88.6%	94.7%
Child	76.9%	79.9%	72.0%
Other Family Member	31.2%	31.6%	30.6%
Case Manager	74.7%	74.5%	74.9%
Therapist	34.1%	30.5%	39.9%
Other Mental Health Staff	17.6%	16.7%	19.1%
Education Staff	15.8%	14.5%	17.8%
Child Welfare Staff	11.0%	11.9%	9.5%
Juvenile Justice	8.1%	8.0%	8.1%
Health Staff	4.0%	4.5%	3.1%
Family Advocate	20.7%	18.5%	24.4%
Other Participant	19.0%	17.6%	21.2%

Table H–2: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006			
	Overall Sample (*n* = 28,421)	**Descriptive Sample (*n* = 19,484)**	**Outcome Sample (*n* = 8,937)**
Referral Sources	(*n* = 27,897)	(*n* = 19,215)	(*n* = 8,682)
Corrections	0.5%	0.5%	0.4%
Juvenile Court	4.9%	4.6%	5.6%
Probation	5.8%	6.4%	4.4%
School	20.1%	19.8%	20.7%
Mental Health agency, clinic, provider	26.8%	25.4%	29.9%
Physical Health Care agency, clinic, provider	2.0%	2.0%	1.9%
Child Welfare	15.2%	17.4%	10.4%
Substance abuse agency, clinic, provider	0.6%	0.5%	0.8%
Family court	0.6%	0.6%	0.5%
Caregiver	11.6%	10.9%	13.3%
Self (youth referred himself or herself)	2.5%	2.7%	1.9%
Other	9.0%	8.8%	9.5%
Early Care: Early Head Start Program	0.1%	0.0%	0.2%
Early Care: Head Start Program	0.1%	0.0%	0.2%
Early Care: Early Intervention (Part C)	0.1%	0.0%	0.2%
Early Care: Preschool Special Education Program (Part B)	0.0%	0.0%	0.1%
Other Early Care and Education Programs/Providers	0.1%	0.0%	0.1%
Early Care: Other	0.0%	0.0%	0.1%
Agency Involvement[a]	(*n* = 28,302)	(*n* = 19,452)	(*n* = 8,850)
Corrections	1.8%	1.8%	1.9%
Juvenile Court	12.4%	11.6%	14.1%
Probation	11.4%	11.3%	11.6%
School	61.6%	59.7%	65.8%
Mental Health	59.0%	54.1%	69.9%
Physical Health	16.4%	15.0%	19.4%
Child Welfare	22.4%	24.0%	19.1%
Substance Abuse Clinic	3.1%	3.0%	3.2%
Family Court	6.4%	6.9%	5.2%
Other	14.5%	14.9%	13.6%
Early Care: Early Head Start Program	0.3%	0.2%	0.7%
Early Care: Head Start Program	0.6%	0.4%	1.1%
Early Intervention	0.3%	0.2%	0.7%
Preschool Special Education Program (Part B)	0.3%	0.2%	0.7%
Other Early Care and Education Programs/Providers	0.9%	0.7%	1.3%
Early Care: Other	0.4%	0.3%	0.7%

Table H–2: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006		
	Overall Sample (*n* = 28,421)	**Descriptive Sample (*n* = 19,484)**	**Outcome Sample (*n* = 8,937)**
***DSM–IV* Axis I and II Diagnosis at Intake**[a]	(*n* = 22,951)	(*n* = 15,217)	(*n* =7,734)
Substance Use Disorders	6.5%	6.8%	5.7%
Schizophrenia and Other Psychotic Disorders	2.3%	2.3%	2.1%
Mood Disorders	35.7%	35.2%	36.7%
Autism and Other Pervasive Developmental Disorders	3.3%	2.8%	4.2%
Anxiety Disorder	8.3%	8.1%	8.7%
Adjustment Disorders	13.8%	14.4%	12.6%
Posttraumatic Stress Disorder and Acute Stress Disorder	8.5%	8.4%	8.5%
Impulse Control Disorders	2.5%	2.3%	2.9%
Oppositional Defiant Disorder	23.3%	21.6%	26.5%
Attention-Deficit/Hyperactivity Disorder (ADHD)	32.3%	29.4%	38.0%
Personality Disorders	1.1%	1.1%	1.1%
Mental Retardation	2.2%	2.3%	1.9%
Learning, Motor Skills, and Communication Disorders	3.8%	3.6%	4.1%
Conduct Disorder	5.7%	5.7%	5.6%
Disruptive Behavior Disorder	7.0%	6.4%	8.1%
Other	10.2%	11.3%	8.2%
V Code	7.4%	7.7%	7.0%
Substance-Induced Disorders	0.3%	0.3%	.3%
DC:0–3R Axis I Diagnosis at Intake[a]	(*n* = 510)	(*n* = 348)	(*n* = 162)
Posttraumatic Stress Disorder	7.8%	6.8%	8.3%
Deprivation/Maltreatment Disorder	5.5%	7.4%	4.6%
Disorders of Affect	3.3%	1.9%	4.0%
Prolonged Bereavement/Grief Reaction	1.4%	2.5%	0.9%
Anxiety Disorders	13.9%	17.9%	12.1%
Depression	2.2%	1.9%	2.3%
Mixed Disorders of Emotional Expressiveness	3.7%	1.9%	4.6%
Adjustment Disorder	20.4%	19.8%	20.7%
Regulation Disorders of Sensory Processing	5.9%	5.6%	6.0%
Hypersensitive	10.8%	8.6%	11.8%
Hyposensitive/Underresponsive	2.2%	5.6%	0.6%
Sensory Stimulation-Seeking/Impulsive	16.7%	19.1%	15.5%
Sleep Disorders	2.9%	1.9%	3.4%
Feeding Disorders	0.8%	0.0%	1.1%
Disorders of Relating and Communicating	2.9%	4.3%	2.3%
Multi-System Developmental Disorder (MSDD)	3.5%	4.9%	2.9%
Other Disorders	11.4%	6.8%	13.5%

Table H–2: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006		
	Overall Sample (*n* = 28,421)	**Descriptive Sample (*n* = 19,484)**	**Outcome Sample (*n* = 8,937)**
Presenting Problems[a]	(*n* = 26,881)	(*n* = 18,380)	(*n* = 8,501)
Suicide Ideation/Self-Injury	16.6%	16.8%	16.1%
Depression	35.0%	34.5%	36.1%
Anxiety	28.9%	28.6%	29.6%
Hyperactivity/Attention	38.5%	35.4%	45.3%
Conduct/Delinquency	57.0%	54.7%	62.0%
Substance Use	12.0%	11.8%	12.5%
Adjustment	32.1%	31.8%	32.6%
Psychotic Behaviors	5.4%	5.1%	6.0%
Pervasive Development Disability	5.0%	4.4%	6.4%
Specific Development Disability	6.0%	5.3%	7.5%
Learning Disability	13.5%	12.7%	15.2%
School Performance	33.1%	30.3%	39.1%
Eating Disorder	3.7%	4.4%	2.1%
Other	13.1%	13.1%	13.0%
Presenting Problems Relevant for Early Childhood[a b]	(*n* = 1,780)	(*n* = 829)	(*n* = 951)
Feeding problems in young children	4.9%	3.6%	6.1%
Disruptive behaviors in young children	64.7%	58.4%	70.1%
Persistent noncompliance	29.4%	27.7%	30.8%
Excessive crying/tantrums	30.9%	26.4%	34.8%
Separation problems	15.8%	15.8%	15.9%
Non-engagement with people	8.7%	8.8%	8.5%
Sleeping problems	16.2%	13.4%	18.6%
Excluded from preschool or childcare program	8.4%	8.1%	8.6%
At risk for or has failed family home placement	11.5%	9.5%	13.2%
Maltreatment (child abuse and neglect)	11.2%	12.3%	10.2%
Other problems that are related to child's health	4.2%	3.3%	4.9%
Maternal depression	13.3%	11.3%	14.9%
Maternal mental health (other than depression)	11.7%	11.3%	12.1%
Paternal mental health	6.3%	4.7%	7.7%
Other Caregiver mental health	1.3%	1.1%	1.5%
Maternal substance abuse/use	12.4%	14.8%	10.3%
Paternal substance abuse/use	10.4%	11.7%	9.3%
Other Caregiver substance abuse/use	1.0%	1.3%	0.7%
Family health problems	6.3%	5.7%	6.8%
Other parent/caregiver/family problems	17.6%	19.5%	15.9%
Housing Problems	9.4%	10.4%	8.6%
Early child: Other	11.5%	9.8%	13.0%

Table H–2: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006		
	Overall Sample (*n* = 28,421)	**Descriptive Sample (*n* = 19,484)**	**Outcome Sample (*n* = 8,937)**
Financial Resources for Services[a]	(*n* = 24,027)	(*n* = 15,947)	(*n* = 8,080)
Medicaid	73.3%	72.5%	74.9%
Child Health Insurance Program (CHIP)	4.1%	4.0%	4.4%
Supplemental Security Income (SSI)	7.8%	6.6%	10.1%
Temporary Assistance for Needy Families (TANF)	4.9%	4.0%	6.7%
Private Insurance	19.0%	19.3%	18.5%
Other Assistance	10.0%	9.2%	11.5%

[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 only asked for children younger than 9.

Table H–3: Baseline Characteristics: Child and Youth History and Family Characteristics for Communities Funded in 2002–2006

Communities Funded in 2002–2006	
	Outcome Sample (*n* = 8,937)
Custody Status	(*n* = 8,450)
Two Parents	26.8%
Biological Mother Only	48.6%
Biological Father Only	4.1%
Adoptive Parents	5.1%
Sibling(s)	0.3%
Aunt and/or Uncle	1.7%
Grandparent(s)	6.6%
Adult Friend	0.2%
Ward of the State	4.5%
Other	2.1%
Living Situation[a]	(*n* = 8,554)
Biological Parent(s)	69.3%
Adoptive Family	4.6%
Relative(s)	17.0%
Non-Family or Foster Care	8.0%
Independent	1.2%
Primary Caregiver Relationship to Child	(*n* = 7,019)
Biological Parent	79.2%
Adoptive Parent	6.3%
Foster Parent	2.8%
Live-In Partner of Parent	0.2%
Sibling	0.4%
Aunt or Uncle	2.0%
Grandparent	7.6%
Cousin	0.2%
Other Relative	0.2%
Adult Friend	0.2%
Other	0.9%
Primary Caregiver Gender	(*n* = 8,469)
Male	8.1%
Female	91.9%
Primary Caregiver Age in Years	(*n* = 8,377)
Mean (*SD*)	39.5 (10.3)
16–25 Years	4.9%
26–30 Years	14.3%
31–35 Years	20.8%
36–40 Years	20.2%
41–45 Years	15.4%
46–50 Years	10.3%
51 Years or older	14.1%

Table H–3: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006	
	Outcome Sample (*n* = 8,937)
Primary Caregiver Race and Ethnicity	(*n* = 8,440)
American Indian or Alaska Native Alone	3.6%
Asian Alone	0.8%
Black or African American Alone	24.6%
Native Hawaiian or Other Pacific Islander Alone	1.3%
White Alone	48.2%
Of Hispanic Origin	18.7%
Multiracial	2.8%
Other, Single Race	0.0%
Whether Primary Caregiver Employed[b]	(*n* = 8,339)
Yes	55.2%
No	44.8%
Whether Primary Caregiver Paid for Child's Services[b]	(*n* = 8,394)
Yes	17.6%
No	82.4%
Family Income	(*n* = 8,163)
Less Than $5,000	14.9%
$5,000–$9,9999	14.2%
$10,000–$14,000	15.1%
$15,000–$19,999	10.5%
$20,000–$24,999	10.4%
$25,000–$34,999	12.7%
$35,000–$49,999	10.6%
$50,000–$74,999	7.5%
$75,000–$99,999	2.4%
$100,000 and Over	1.7%
Family Poverty Level Status	(*n* = 7,386)
Below Poverty	57.2%
At Poverty	16.5%
Above Poverty	26.3%
Whether Child Uses Medication	(*n* = 8,451)
Yes	47.4%
No	52.6%

Table H–3: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006	
	Outcome Sample (*n* = 8,937)
Current Medications	(*n* = 3,902)
Abilify	14.5%
Adderall	17.5%
Benzodiazepine	0.4%
Carbamazepine	0.5%
Catapres	8.7%
Celexa	3.4%
Klonopin	2.2%
Concerta	15.9%
Depakote	9.7%
Desyrel	3.2%
Dexedrine	0.8%
Effexor	0.9%
Haldol	0.4%
Lexapro	3.8%
Lamictal	3.6%
Lithium	4.1%
Neurontin	0.5%
Orap	0.1%
Paxil	1.2%
Prozac	9.3%
Risperdal	18.2%
Ritalin	6.8%
Seroquel	12.5%
Strattera	8.6%
Symbiax	0.1%
Tenex	4.6%
Trileptal	4.3%
Wellbutrin	5.0%
Xanax	0.2%
Zoloft	6.7%
Zyprexa	2.1%
Other	24.1%

Table H–3: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006	
	Outcome Sample (*n* = 8,937)
Child Risk Factors	(*n* = 8,107)
None	46.2%
One or More	53.8%
Physical Abuse	21.7% (*n* = 8,184)
Sexual Abuse	15.3% (*n* = 7,959)
Running Away	27.4% (*n* = 8,424)
Attempted Suicide	11.6% (*n* = 8,385)
Substance Abuse	15.3% (*n* = 8,319
Family History of Illness	(*n* = 8,290)
Yes	85.2%
No	14.8%
Depression	69.9% (*n* = 8,101)
Other Mental Illness	47.1% (*n* = 8,048)
Alcohol or Substance Abuse	60.8% (*n* = 8,260)
Recent Caregiver History of Illness[c]	(*n* = 8,199)
Yes	46.9%
No	53.1%
Depression	41.6% (*n* = 8,271)
Other Mental Illness	14.7% (*n* = 8,289)
Alcohol or Substance Abuse	7.9% (*n* = 8,335)
Household Risk Factors	
Domestic Violence	46.2% (*n* = 8,269)
Household Member With Criminal History	34.1% (*n* = 8,278)
Household Member Depression	65.4% (*n* = 8,171)
Household Member Mental Illness	34.3% (*n* = 8,167)
Household Member Substance Abuse	45.8% (*n* = 8,270)

Table H–3: Baseline Characteristics: Child and Youth Demographic and Enrollment Information for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006	
	Outcome Sample (*n* = 8,937)
Child Substance Use History[d]	
Number of Substances	(*n* = 4,648)
None	39.6%
One	14.6%
Two	12.7%
Three	13.8%
Four or More	19.3%
Substances Used[e]	
Alcohol	75.4% (*n* = 2,804)
Cigarettes	74.7% (*n* = 2,805)
Chewing Tobacco or Snuff	13.5% (*n* = 2,802)
Marijuana	66.1% (*n* = 2,799)
Cocaine	12.1% (*n* = 2,801)
Hallucinogens	9.2% (*n* = 2,801)
PCP	2.1% (*n* = 2,801)
Ketamine	0.5% (*n* = 2,801)
MDMA (Ecstasy)	9.9% (*n* = 2,798)
GHB	0.4% (*n* = 2,800)
Inhalants	9.4% (*n* = 2,802)
Heroin	2.1% (*n* = 2,802)
Amphetamines/Stimulants	5.8% (*n* = 2,797)
Painkillers	17.5% (*n* = 2,796)
Ritalin, Adderall, Desoxyn	11.2% (*n* = 2,794)
Tranquilizers	6.3% (*n* = 2,797)
Barbiturates/Sedatives	2.1% (*n* = 2,798)
Over-the-Counter/Nonprescription Drugs	10.1% (*n* = 2,800)
Other	4.7% (*n* = 2,806)
Child Juvenile Justice Contacts[d]	
Lifetime Contacts	(*n* = 4,660)
None	43.4%
One or More	56.6%
Recent Contacts[b]	
Questioned by Police	23.5% (*n* = 4,639)
Arrested	21.9% (*n* = 4,641)
Told to Appear in Court	21.0% (*n* = 4,627)
Convicted of a Crime	11.8% (*n* = 4,640)
On Probation	26.5% (*n* = 4,645)
Sentenced to Secure Facility	11.1% (*n* = 4,634)

[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 H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006

	Communities Funded in 2002–2006						
	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	65.7 (11.1) (*n* = 1,150)	63.7 (10.8) (*n* = 637)	62.8 (10.8) (*n* = 376)	62.2 (10.8) (*n* = 200)	62.4 (11.2) (*n* = 106)	62.2 (11.5) (*n* = 46)	59.8 (9.2) (*n* = 13)
Sleep Problems	61.6 (11.9) (*n* = 1,150)	59.6 (10.9) (*n* = 637)	59.5 (11.2) (*n* = 376)	59.7 (11.0) (*n* = 200)	60 (11.8) (*n* = 106)	57.8 (10.8) (*n* = 46)	57.4 (7.8) (*n* = 13)
Withdrawn	63.7 (10.3) (*n* = 1,150)	62.3 (9.9) (*n* = 637)	61.6 (10.0) (*n* = 376)	61.5 (10.6) (*n* = 200)	59.3 (8.7) (*n* = 106)	59 (10.0) (*n* = 46)	56.8 (5.8) (*n* = 13)
Somatic Complaints	58.3 (8.6) (*n* = 1,150)	57 (7.9) (*n* = 637)	56.9 (8.5) (*n* = 376)	57.1 (8.3) (*n* = 200)	57.8 (9.1) (*n* = 106)	56.8 (9.0) (*n* = 46)	56.8 (7.6) (*n* = 13)
Anxious/Depressed	62.4 (10.5) (*n* = 1,150)	60.3 (9.9) (*n* = 637)	59.4 (9.1) (*n* = 376)	60.3 (9.6) (*n* = 200)	59.3 (8.8) (*n* = 106)	60.2 (9.9) (*n* = 46)	59.7 (7.6) (*n* = 13)
Attention Problems	63.4 (9.1) (*n* = 1,150)	62.4 (9.0) (*n* = 637)	61 (8.9) (*n* = 376)	60.2 (8.9) (*n* = 200)	60.3 (8.9) (*n* = 106)	58.8 (8.5) (*n* = 46)	58.8 (6.9) (*n* = 13)
Aggressive Problems	70.4 (13.7) (*n* = 1,150)	66.5 (12.9) (*n* = 633)	65.3 (13.2) (*n* = 371)	64 (12.5) (*n* = 197)	62.9 (12.8) (*n* = 106)	62.3 (14.6) (*n* = 45)	55.3 (4.8) (*n* = 13)
Internalizing Problems	63.9 (10.2) (*n* = 1,150)	61.3 (11.2) (*n* = 637)	60.2 (11.6) (*n* = 376)	60 (12.2) (*n* = 200)	59.4 (12.0) (*n* = 106)	58.5 (13) (*n* = 46)	58.2 (10.7) (*n* = 13)
Externalizing Problems	68.4 (12.6) (*n* = 1,150)	64.7 (12.9) (*n* = 637)	62.9 (13.6) (*n* = 376)	61.3 (13.5) (*n* = 200)	60.4 (14.0) (*n* = 106)	59 (15.1) (*n* = 46)	55.4 (6.9) (*n* = 13)
Total Problems	**67.2 (11.1)** **(*n* = 1,150)**	**63.9 (12.0)** **(*n* = 637)**	**62.5 (12.7)** **(*n* = 376)**	**61.4 (13.2)** **(*n* = 200)**	**60.5 (13.7)** **(*n* = 106)**	**59.4 (14.1)** **(*n* = 46)**	**57.4 (9.6)** **(*n* = 13)**
At/Above Clinical Level (Total Problems)	**63.9%** **(*n* = 1,150)**	**53.1%** **(*n* = 637)**	**47.6%** **(*n* = 376)**	**49.0%** **(*n* = 200)**	**47.2%** **(*n* = 106)**	**37.0%** **(*n* = 46)**	**23.1%** **(*n* = 13)**

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006							
	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	36.5 (9.4) (*n* = 7,039)	36 (9.3) (*n* = 4,776)	36.1 (9.3) (*n* = 3,655)	36.2 (9.6) (*n* = 2,840)	35.8 (9.3) (*n* = 2,091)	35.9 (9.1) (*n* = 1,377)	35.7 (9.2) (*n* = 866)
Social Competence	37.1 (9.0) (*n* = 6,879)	38 (9.0) (*n* = 4,689)	38.2 (9.0) (*n* = 3,575)	38.4 (8.9) (*n* = 2,781)	38.6 (8.7) (*n* = 2,047)	38.5 (8.6) (*n* = 1,358)	38.7 (8.9) (*n* = 846)
School Competence	36.9 (8.7) (*n* = 6,363)	37.9 (8.7) (*n* = 4,326)	38.3 (8.7) (*n* = 3,277)	38.2 (9.0) (*n* = 2,544)	38.2 (8.9) (*n* = 1,811)	38.3 (8.7) (*n* = 1,159)	38.3 (8.9) (*n* = 689)
Total Competence	31.8 (8.6) (*n* = 6,119)	32.3 (8.7) (*n* = 4,162)	32.6 (8.9) (*n* = 3,158)	32.7 (9.2) (*n* = 2,446)	32.8 (8.9) (*n* = 1,742)	32.7 (8.6) (*n* = 1,110)	33 (9.3) (*n* = 652)
Anxious/Depressed	64.9 (10.8) (*n* = 7,171)	62.6 (10.4) (*n* = 4,862)	61.7 (10.1) (*n* = 3,707)	61.2 (10.1) (*n* = 2,900)	60.7 (10.2) (*n* = 2,133)	60.3 (9.8) (*n* = 1,410)	59.8 (9.7) (*n* = 885)
Withdrawn	65.6 (10.1) (*n* = 7,171)	63.8 (9.9) (*n* = 4,862)	62.9 (9.5) (*n* = 3,707)	62.3 (9.5) (*n* = 2,900)	62 (9.5) (*n* = 2,133)	61.8 (9.3) (*n* = 1,410)	61.8 (9.4) (*n* = 885)
Somatic Complaints	61.2 (9.3) (*n* = 7,171)	59.9 (9.2) (*n* = 4,862)	59.3 (9.0) (*n* = 3,707)	59 (9.0) (*n* = 2,900)	58.8 (9.0) (*n* = 2,133)	58.3 (8.6) (*n* = 1,410)	58.3 (8.6) (*n* = 885)
Social Problems	66.2 (9.7) (*n* = 7,171)	64.7 (9.6) (*n* = 4,862)	64 (9.6) (*n* = 3,707)	63.5 (9.7) (*n* = 2,900)	63.1 (9.8) (*n* = 2,133)	62.9 (9.7) (*n* = 1,410)	62.7 (9.4) (*n* = 885)
Thought Problems	66.8 (10.0) (*n* = 7,171)	65 (10.0) (*n* = 4,862)	64 (9.9) (*n* = 3,707)	63.5 (10.0) (*n* = 2,900)	63.2 (10.1) (*n* = 2,133)	62.9 (9.8) (*n* = 1,410)	62.3 (9.9) (*n* = 885)
Attention Problems	68 (10.9) (*n* = 7,171)	66 (10.6) (*n* = 4,862)	65 (10.4) (*n* = 3,707)	64.4 (10.3) (*n* = 2,900)	63.9 (10.3) (*n* = 2,133)	63.5 (10.0) (*n* = 1,410)	63.3 (10.0) (*n* = 885)
Rule-Breaking Behavior	67.3 (9.0) (*n* = 7,171)	65.6 (9.0) (*n* = 4,862)	64.7 (9.0) (*n* = 3,707)	64.1 (8.9) (*n* = 2,900)	63.9 (9.0) (*n* = 2,133)	64 (9.2) (*n* = 1,410)	63.9 (9.5) (*n* = 885)
Aggressive Behavior	71.8 (12.3) (*n* = 7,171)	69.3 (12.1) (*n* = 4,862)	68.1 (12.1) (*n* = 3,707)	67.3 (12.0) (*n* = 2,900)	66.6 (11.9) (*n* = 2,133)	66.8 (12.0) (*n* = 1,410)	66 (12.0) (*n* = 885)
Internalizing	65.1 (10.2) (*n* = 7,171)	62.7 (10.7) (*n* = 4,862)	61.4 (11.1) (*n* = 3,707)	60.8 (11.3) (*n* = 2,900)	60.1 (11.8) (*n* = 2,133)	59.7 (11.4) (*n* = 1,410)	59.2 (11.7) (*n* = 885)
Externalizing	69.4 (9.7) (*n* = 7,171)	67.3 (10.2) (*n* = 4,862)	66.2 (10.5) (*n* = 3,707)	65.4 (10.7) (*n* = 2,900)	64.8 (11.0) (*n* = 2,133)	64.9 (11.2) (*n* = 1,410)	64.4 (11.5) (*n* = 885)
Total Problems	69.2 (9.3) (*n* = 7,171)	66.9 (10.0) (*n* = 4,862)	65.7 (10.4) (*n* = 3,707)	64.8 (11.0) (*n* = 2,900)	64.1 (11.6) (*n* = 2,133)	63.9 (11.5) (*n* = 1,410)	63.4 (11.8) (*n* = 885)
At/Above Clinical Level (Total Problems)	76.9% (*n* = 7,171)	68.6% (*n* = 4,862)	64.6% (*n* = 3,707)	61.4% (*n* = 2,900)	60.2% (*n* = 2,133)	59.5% (*n* = 1,410)	58.4% (*n* = 885)

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006							
	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* = 7,500)	8 (3.3) (*n* = 5,097)	8.2 (3.3) (*n* = 3,860)	8.3 (3.4) (*n* = 2,995)	8.4 (3.4) (*n* = 2,191)	8.4 (3.4) (*n* = 1,443)	8.6 (3.5) (*n* = 908)
Interpersonal Strengths	6.6 (3.1) (*n* = 7,525)	7.1 (3.1) (*n* = 5,105)	7.3 (3.1) (*n* = 3,868)	7.5 (3.2) (*n* = 3,000)	7.7 (3.3) (*n* = 2,191)	7.6 (3.2) (*n* = 1,443)	7.8 (3.3) (*n* = 909)
School Functioning	6.5 (3.0) (*n* = 7,144)	7.1 (3.1) (*n* = 4,845)	7.2 (3.1) (*n* = 3,671)	7.4 (3.2) (*n* = 2,808)	7.3 (3.2) (*n* = 2,043)	7.4 (3.3) (*n* = 1,321)	7.5 (3.4) (*n* = 813)
Family Involvement	7.1 (2.9) (*n* = 7,535)	7.4 (2.9) (*n* = 5,106)	7.5 (2.9) (*n* = 3,863)	7.6 (3.0) (*n* = 2,998)	7.6 (3.0) (*n* = 2,185)	7.6 (3.1) (*n* = 1,442)	7.5 (3.1) (*n* = 904)
Affective Strengths	8.1 (3.1) (*n* = 7,542)	8.3 (3.1) (*n* = 5,112)	8.4 (3.1) (*n* = 3,872)	8.5 (3.0) (*n* = 3,001)	8.5 (3.1) (*n* = 2,195)	8.5 (3.1) (*n* = 1,446)	8.4 (3.1) (*n* = 908)
Career Strengths	8.8 (3.6) (*n* = 6,336)	9 (3.6) (*n* = 4,411)	9.2 (3.5) (*n* = 3,392)	9.2 (3.6) (*n* = 2,636)	9.3 (3.5) (*n* = 1,934)	9.3 (3.7) (*n* = 1,279)	9.3 (3.6) (*n* = 842)
Strengths Quotient	**80.5 (17.1) (*n* = 7,105)**	**83.4 (17.9) (*n* = 4,832)**	**84.5 (17.9) (*n* = 3,656)**	**85.4 (18.4) (*n* = 2,799)**	**85.8 (18.9) (*n* = 2,032)**	**85.7 (19) (*n* = 1,315)**	**85.6 (18.9) (*n* = 809)**
Behavioral and Emotional Rating Scale–2, Youth (BERS–2Y)							
Intrapersonal Strengths	9.3 (2.9) (*n* = 4750)	9.5 (3) (*n* = 3196)	9.5 (3) (*n* = 2483)	9.7 (3) (*n* = 2019)	9.7 (3) (*n* = 1549)	9.7 (2.9) (*n* = 1042)	9.8 (2.9) (*n* = 672)
Interpersonal Strengths	8.6 (3.3) (*n* = 4747)	9 (3.4) (*n* = 3192)	9.1 (3.3) (*n* = 2481)	9.4 (3.4) (*n* = 2018)	9.5 (3.4) (*n* = 1548)	9.6 (3.4) (*n* = 1042)	9.8 (3.4) (*n* = 672)
School Functioning	8.4 (3) (*n* = 4657)	8.8 (3) (*n* = 3107)	8.9 (3) (*n* = 2383)	9.1 (3.1) (*n* = 1905)	9 (3) (*n* = 1430)	9.2 (3) (*n* = 952)	9.4 (3.1) (*n* = 598)
Family Involvement	8.8 (2.9) (*n* = 4750)	9.1 (2.9) (*n* = 3190)	9.2 (2.9) (*n* = 2481)	9.3 (2.9) (*n* = 2016)	9.4 (3) (*n* = 1544)	9.4 (3) (*n* = 1040)	9.5 (3.1) (*n* = 671)
Affective Strengths	9.7 (3.1) (*n* = 4754)	9.9 (3) (*n* = 3195)	10 (3.1) (*n* = 2484)	10.2 (3) (*n* = 2019)	10.3 (3) (*n* = 1549)	10.4 (2.9) (*n* = 1043)	10.5 (2.9) (*n* = 672)
Career Strengths	9.6 (2.9) (*n* = 4527)	9.8 (2.8) (*n* = 3109)	9.8 (2.8) (*n* = 2418)	9.8 (2.7) (*n* = 1985)	9.8 (2.8) (*n* = 1527)	9.8 (2.8) (*n* = 1024)	9.9 (2.7) (*n* = 667)
Strengths Quotient	**92.6 (16.8) (*n* = 4647)**	**94.7 (17.2) (*n* = 3099)**	**95.5 (17.2) (*n* = 2380)**	**96.9 (17.3) (*n* = 1904)**	**97.1 (17.4) (*n* = 1426)**	**98 (17.2) (*n* = 949)**	**98.4 (17.5) (*n* = 598)**

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	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	**22.5 (10.5)** **(*n* = 8,183)**	**20.3 (10.5)** **(*n* = 5,425)**	**19.4 (10.6)** **(*n* = 4,063)**	**18.7 (10.7)** **(*n* = 3,096)**	**18.5 (10.7)** **(*n* = 2,245)**	**18.4 (10.8)** **(*n* = 1,465)**	**18.1 (11.0)** **(*n* = 913)**
At/Above Clinical Level	**75.4%**	**68.3%**	**65.6%**	**62.8%**	**62.5%**	**61.5%**	**60.6%**
Revised Children's Manifest Anxiety Scale (RCMAS)							
Worry/Oversensitivity	11.2 (3.3) (*n* = 4,736)	10.8 (3.4) (*n* = 3,191)	10.6 (3.5) (*n* = 2,466)	10.5 (3.6) (*n* = 2,004)	10.3 (3.5) (*n* = 1,554)	10.3 (3.6) (*n* = 1,045)	10 (3.6) (*n* = 673)
Social Concerns/Concentration	10.3 (3.5) (*n* = 4,734)	9.9 (3.5) (*n* = 3,185)	9.6 (3.5) (*n* = 2,463)	9.5 (3.5) (*n* = 2,001)	9.3 (3.4) (*n* = 1,553)	9.4 (3.6) (*n* = 1,044)	9.2 (3.5) (*n* = 672)
Physiological Anxiety	11.0 (3.2) (*n* = 4,526)	10.4 (3.2) (*n* = 3,026)	10.3 (3.3) (*n* = 2,328)	10.0 (3.3) (*n* = 1,880)	9.9 (3.4) (*n* = 1,442)	9.8 (3.4) (*n* = 966)	9.5 (3.4) (*n* = 609)
Total Anxiety	**54.6 (11.8)** **(*n* = 4,716)**	**52.9 (12.2)** **(*n* = 3,171)**	**52.0 (12.8)** **(*n* = 2,454)**	**51.3 (12.9)** **(*n* = 1,997)**	**50.4 (12.5)** **(*n* = 1,549)**	**50.5 (13.1)** **(*n* = 1,042)**	**49.5 (13.2)** **(*n* = 671)**
At/Above Clinical Level (Total Anxiety)	**31.3%** **(*n* = 4,716)**	**26.0%** **(*n* = 3,171)**	**24.9%** **(*n* = 2,454)**	**24.0%** **(*n* = 1,997)**	**21.8%** **(*n* = 1,549)**	**23.4%** **(*n* = 1,042)**	**22.5%** **(*n* = 671)**
Reynolds Adolescent Depression Scale–2 (RADS–2)							
Dysphoric Mood	50.6 (10.9) (*n* = 4,772)	49.3 (10.8) (*n* = 3,199)	48.8 (10.6) (*n* = 2,480)	48.4 (10.7) (*n* = 2,015)	48.0 (10.9) (*n* = 1,555)	48.1 (11) (*n* = 1,035)	47.2 (10.6) (*n* = 674)
Anhedonia/Negative Affect	50.9 (7.8) (*n* = 4,760)	50.3 (7.7) (*n* = 3,194)	50.2 (7.7) (*n* = 2,466)	50.0 (7.6) (*n* = 2,003)	49.8 (7.5) (*n* = 1,533)	49.8 (7.5) (*n* = 1,019)	49.5 (7.4) (*n* = 663)
Negative Self-Evaluation	53.4 (10.7) (*n* = 4,764)	51.5 (10.4) (*n* = 3,194)	50.9 (10.1) (*n* = 2,475)	50.4 (10.2) (*n* = 2,017)	50.0 (10.1) (*n* = 1,553)	50.0 (10.2) (*n* = 1,035)	49.4 (9.9) (*n* = 674)
Somatic Complaints	51.8 (10.7) (*n* = 4,774)	50.3 (10.7) (*n* = 3,202)	49.7 (10.9) (*n* = 2,480)	49.3 (10.9) (*n* = 2,017)	48.8 (10.6) (*n* = 1,555)	48.8 (10.8) (*n* = 1,035)	47.5 (10.7) (*n* = 674)
Total Depression	**52.2 (10.3)** **(*n* = 4,773)**	**50.5 (10.2)** **(*n* = 3,202)**	**49.9 (10.1)** **(*n* = 2,480)**	**49.4 (10.2)** **(*n* = 2,018)**	**48.9 (10.1)** **(*n* = 1,555)**	**49 (10.3)** **(*n* = 1,035)**	**48 (10.1)** **(*n* = 674)**
At/Above Clinical Level (Total Depression)	**21.8%** **(*n* = 4,773)**	**17.1%** **(*n* = 3,202)**	**16.1%** **(*n* = 2,480)**	**15.3%** **(*n* = 2,018)**	**13.2%** **(*n* = 1,555)**	**14.5%** **(*n* = 1,035)**	**11.7%** **(*n* = 674)**

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	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	93.6 (20.9) (*n* = 714)	94.2 (20.1) (*n* = 498)	93.4 (20.4) (*n* = 322)	94.9 (21.7) (*n* = 212)	97.7 (24.2) (*n* = 126)	100.9 (21.8) (*n* = 67)	96.7 (25.5) (*n* = 18)
Daily Living Skills	89.9 (22.8) (*n* = 712)	92.0 (22.9) (*n* = 502)	92.8 (23.6) (*n* = 322)	96.5 (25.7) (*n* = 214)	97.9 (26.1) (*n* = 120)	101.7 (27.1) (*n* = 68)	103.9 (27.3) (*n* = 19)
Socialization	101.4 (23.8) (*n* = 711)	102.1 (24.1) (*n* = 508)	101.0 (24.1) (*n* = 328)	98.9 (23.3) (*n* = 215)	100.3 (21) (*n* = 128)	103.5 (20.9) (*n* = 74)	97.3 (29.4) (*n* = 20)
Motor Skills	99.2 (21.9) (*n* = 707)	98.8 (22.6) (*n* = 394)	96.4 (22.9) (*n* = 212)	97.1 (21.4) (*n* = 104)	98.8 (21.5) (*n* = 58)	99.9 (19.4) (*n* = 30)	112.4 (7.9) (*n* = 5)
Caregiver Strain Questionnaire (CGSQ)							
Subjective Externalizing Strain	2.3 (1.0) (*n* = 8,381)	2.2 (0.9) (*n* = 5,470)	2.2 (0.9) (*n* = 4,046)	2.1 (0.9) (*n* = 3,088)	2.1 (0.9) (*n* = 2,225)	2.1 (1.0) (*n* = 1,446)	2.1 (0.9) (*n* = 902)
Subjective Internalizing Strain	3.5 (1.0) (*n* = 8,375)	3.2 (1.1) (*n* = 5,469)	3.1 (1.1) (*n* = 4,044)	3.0 (1.1) (*n* = 3,088)	2.9 (1.1) (*n* = 2,224)	2.9 (1.1) (*n* = 1,446)	2.8 (1.1) (*n* = 901)
Objective Strain	2.6 (1.1) (*n* = 8,383)	2.3 (1.0) (*n* = 5,473)	2.2 (1.0) (*n* = 4,046)	2.2 (1.0) (*n* = 3,086)	2.1 (1.0) (*n* = 2,223)	2.1 (1.0) (*n* = 1,445)	2.1 (1.0) (*n* = 906)
Global Strain	8.5 (2.6) (*n* = 8,363)	7.7 (2.7) (*n* = 5,461)	7.5 (2.6) (*n* = 4,042)	7.2 (2.7) (*n* = 3,086)	7.1 (2.7) (*n* = 2,222)	7.1 (2.7) (*n* = 1,444)	7.0 (2.7) (*n* = 901)
Family Life Questionnaire (FLQ)							
Family Functioning Scale	3.4 (0.7) (*n* = 8,503)	3.4 (0.7) (*n* = 5,590)	3.4 (0.7) (*n* = 4,157)	3.5 (0.8) (*n* = 3,191)	3.4 (0.8) (*n* = 2,326)	3.4 (0.8) (*n* = 1,518)	3.4 (0.8) (*n* = 960)

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**	**30 Months %**	**36 Months %**
Living Situations Questionnaire (LSQ)							
Type of Living Arrangements[a]	(*n* = 8,453)	(*n* = 5,557)	(*n* = 4,138)	(*n* = 3,204)	(*n* = 2,335)	(*n* = 1,522)	(*n* = 957)
Homeless	1.2%	0.9%	0.8%	0.7%	0.9%	0.8%	0.7%
Home	95.7%	95.0%	95.7%	95.2%	95.0%	94.8%	93.8%
School Dormitory	0.2%	0.2%	0.2%	0.4%	0.4%	0.2%	0.4%
Recreational Camp	0.1%	0.2%	0.2%	0.2%	0.3%	0.3%	0.1%
Emergency Shelter	1.3%	1.1%	0.6%	0.5%	0.1%	0.3%	0.2%
Foster Home	3.4%	2.5%	1.8%	1.7%	1.9%	1.7%	1.6%
Therapeutic/Specialized Foster Home	0.9%	0.8%	0.7%	0.4%	0.6%	0.5%	0.5%
Group Home	2.3%	2.2%	1.9%	1.9%	2.1%	1.4%	1.4%
Medical Hospital	0.9%	0.6%	0.4%	0.4%	0.3%	0.3%	0.2%
Residential Treatment Center	5.1%	5.1%	5.1%	4.5%	3.8%	4.3%	5.4%
Psychiatric Hospital	5.7%	3.8%	3.3%	2.4%	2.4%	2.2%	2.2%
Youth Justice Related	4.5%	4.1%	2.9%	3.1%	3.2%	3.7%	3.1%
Adult Justice Related	0.3%	0.4%	0.5%	0.4%	0.8%	0.8%	1.5%
Other	1.6%	1.3%	1.4%	1.0%	1.1%	1.5%	2.2%
Stability in Living Arrangements	(*n* = 8,453)	(*n* = 5,557)	(*n* = 4,138)	(*n* = 3,204)	(*n* = 2,335)	(*n* = 1,552)	(*n* = 957)
One Living Arrangement	70.6%	78.1%	78.9%	81.3%	81.1%	80.0%	82.2%
Multiple Living Arrangements	29.4%	21.9%	21.1%	18.7%	18.9%	20.0%	17.8%
Education Questionnaire–Revised (EQ–R)							
Attending School	(*n* = 8,609) 92.9%	(n = 5,684) 93.4%	(n = 4,229) 93.2%	(n = 3,249) 91.9%	(n = 2,363) 89.0%	(n = 1,541) 86.7%	(n = 966) 82.1%
Excused and Unexcused Absences	(*n* = 7,225)	(*n* = 4,886)	(*n* = 3,617)	(*n* = 2,760)	(*n* = 1,934)	(*n* = 1,236)	(*n* = 718)
No Absences	30.7%	20.4%	23.8%	24.9%	26.5%	30.7%	30.6%
Less Than 1 Day Per Month	24.5%	27.9%	28.8%	28.6%	28.0%	24.5%	27.4%
About 1 Day a Month	16.7%	19.6%	18.9%	18.6%	16.5%	16.7%	13.2%
About 1 Day Every 2 Weeks	9.5%	12.3%	10.9%	11.2%	11.5%	9.5%	10.2%
About 1 Day a Week	6.3%	7.7%	6.6%	6.1%	7.0%	6.3%	6.5%
2 Days Per Week	4.4%	5.2%	5.2%	4.7%	4.2%	4.4%	5.3%
3 or More Days Per Week	7.8%	6.8%	5.8%	6.1%	6.2%	7.8%	6.7%

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Education Questionnaire–Revised (EQ–R)							
Educational Placement	(*n* = 7,280)	(*n* = 4,913)	(*n* = 3,642)	(*n* = 2,783)	(*n* = 1,938)	(*n* = 1,240)	(*n* = 719)
Public Day School	84.0%	80.5%	79.4%	77.7%	75.0%	73.6%	70.8%
Private Day/Boarding School	2.8%	3.0%	3.2%	2.6%	3.1%	2.7%	2.4%
Home School	2.2%	2.0%	2.4%	2.0%	2.2%	2.7%	2.5%
Alternative/Special Day School	17.0%	18.0%	17.3%	17.9%	19.2%	19.8%	20.9%
School in 24-Hour Restrictive Setting[c]	6.2%	5.2%	5.5%	4.8%	4.7%	5.9%	5.6%
Postsecondary School	0.1%	0.3%	0.8%	1.3%	1.7%	2.3%	2.5%
Other	3.5%	3.4%	3.1%	3.0%	3.1%	2.8%	4.6%
School Performance	(*n* = 7,050)	(*n* = 4,787)	(*n* = 3,559)	(*n* = 2,772)	(*n* = 1,907)	(*n* = 1,209)	(*n* = 712)
Grade Average A	20.0%	13.9%	13.4%	12.3%	11.2%	10.8%	9.7%
Grade Average B	9.1%	8.7%	7.5%	7.8%	7.9%	7.0%	8.3%
Grade Average C	23.0%	25.5%	25.5%	24.1%	26.2%	26.6%	27.1%
Grade Average D	20.2%	23.3%	25.8%	27.6%	28.2%	30.5%	29.6%
Failing All or Most Classes	7.5%	7.5%	9.1%	10.1%	10.5%	10.3%	12.4%
School Does Not Grade	17.5%	19.0%	16.5%	16.2%	14.3%	13.1%	11.1%
Other	2.7%	2.2%	2.2%	2.0%	1.7%	1.7%	1.8%
With an Individualized Education Plan (IEP)	(*n* = 7,217) 50.0%	(*n* = 4,867) 55.5%	(*n* = 3,594) 57.3%	(*n* = 2,773) 57.1%	(*n* = 1,904) 58.4%	(*n* = 1,213) 59.2%	(*n* = 704) 60.5%
Reasons for IEP[a]	(*n* = 3,592)	(*n* = 2,682)	(*n* = 2,041)	(*n* = 1,551)	(*n* = 1,091)	(*n* = 706)	(*n* = 417)
Behavior/Emotional Problems	73.7%	77.1%	75.9%	77.0%	78.9%	80.7%	83.0%
Learning Disability	52.6%	50.5%	53.3%	50.0%	54.3%	55.2%	55.9%
Physical Disability	3.5%	3.3%	3.5%	3.2%	3.2%	4.1%	2.9%
Developmental Disability or Mental Retardation	15.5%	14.8%	14.7%	14.1%	3.5%	2.5%	1.4%
Vision Impairment	3.6%	2.9%	2.6%	3.1%	12.7%	12.7%	12.7%
Speech Impairment	18.0%	16.4%	15.6%	13.9%	5.4%	3.8%	4.1%
Other	5.8%	5.3%	5.5%	5.3%	78.9%	80.7%	83.0%

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	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* = 3,049)	(*n* = 2,245)	(*n* = 1,754)	(*n* = 1,343)	(*n* = 976)	(*n* = 634)	(*n* = 381)
Special Class All or Most of the Day	49.2%	51.4%	53.1%	53.6%	57.0%	57.9%	65.6%
Special Class for a Portion of the Day	30.2%	29.6%	25.8%	24.9%	24.8%	22.6%	19.4%
Special Instruction As Part of a General Education Class	25.3%	23.9%	26.1%	27.1%	25.0%	25.1%	22.3%
Disciplinary Actions	(*n* = 7,055)	(*n* = 4,801)	(*n* = 3,558)	(*n* = 2,704)	(*n* = 1,887)	(*n* = 1,198)	(*n* = 699)
None	36.4%	29.4%	28.0%	26.3%	25.4%	23.3%	24.2%
Suspended	1.2%	0.7%	0.3%	0.4%	0.7%	0.7%	0.4%
Expelled	3.2%	2.3%	1.6%	1.4%	1.1%	1.8%	2.1%
Suspended and Expelled	59.2%	67.6%	70.1%	71.9%	72.8%	74.3%	73.2%
Delinquency Survey–Revised (DS–R)							
Juvenile Justice Contacts							
Questioned by Police	24.0% (*n* = 4,667)	18.2% (*n* = 2,995)	16.4% (*n* = 2,223)	16.8% (*n* = 1,745)	15.7% (*n* = 1,299)	17.2% (*n* = 831)	14.3% (*n* = 533)
Arrested	22.4% (*n* = 4,667)	15.2% (*n* = 2,995)	13.0% (*n* = 2,223)	11.2% (*n* = 1,745)	11.9% (*n* = 1,299)	12.6% (*n* = 831)	9.2% (*n* = 533)
Told to Appear in Court	21.7% (*n* = 4,667)	15.8% (*n* = 2,995)	13.9% (*n* = 2,223)	14.3% (*n* = 1,745)	12.5% (*n* = 1,299)	13.4% (*n* = 831)	10.3% (*n* = 533)
Convicted of a Crime	11.8% (*n* = 4,640)	7.6% (*n* = 2,989)	6.9% (*n* = 2,217)	6.8% (*n* = 1,738)	5.8% (*n* = 1,296)	5.2% (*n* = 826)	4.5% (*n* = 532)
On Probation	26.5% (*n* = 4,645)	22.4% (*n* = 2,985)	20.0% (*n* = 2,217)	16.9% (*n* = 1,737)	16.1% (*n* = 1,294)	13.8% (*n* = 828)	11.5% (*n* = 532)
Sentenced to Secure Facility	11.1% (*n* = 4,634)	7.8% (*n* = 2,986)	6.6% (*n* = 2,218)	6.6% (*n* = 1,738)	5.6% (*n* = 1,295)	6.0% (*n* = 828)	4.9% (*n* = 532)
Substance Problem Urgency (GAIN)							
Substance Use and Abuse Scale (SUS–9)	(*n* = 1,483)	(*n* = 810)	(*n* = 613)	(*n* = 479)	(*n* = 381)	(*n* = 247)	(*n* = 155)
Mean (*SD*)	3.2 (2.4)	2.9 (2.4)	2.6 (2.4)	2.6 (2.2)	2.3 (2.2)	2.1 (2.1)	2.1 (2.2)
Minimal/No Urgency	45.2%	51.7%	54.5%	55.1%	63.3%	65.2%	66.5%
Moderate Urgency	43.4%	39.8%	37.4%	37.8%	31.2%	30.0%	27.7%
High Urgency	11.4%	8.5%	8.2%	7.1%	5.5%	4.9%	5.8%

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Substance Problem Urgency (GAIN)							
Substance Dependence Scale (SUS–7)	(*n* = 1,474)	(*n* = 810)	(*n* = 613)	(*n* = 479)	(*n* = 380)	(*n* = 246)	(*n* = 156)
Mean (*SD*)	1.8 (2.0)	1.6 (1.8)	1.5 (1.9)	1.4 (1.8)	1.2 (1.7)	1.0 (1.5)	1.2 (1.7)
Minimal/No Urgency	57.6%	61.9%	64.1%	65.6%	70.8%	73.2%	71.8%
Moderate Urgency	34.2%	32.8%	29.7%	29.0%	25.0%	24.8%	24.4%
High Urgency	8.2%	5.3%	6.2%	5.4%	4.2%	2.0%	3.8%
Substance Problem Scale (SPS)	(*n* = 1,483)	(*n* = 810)	(*n* = 614)	(*n* = 479)	(*n* = 381)	(*n* = 247)	(*n* = 156)
Mean (*SD*)	5.0 (4.1)	4.4 (3.9)	4.1 (3.9)	4.0 (3.7)	3.5 (3.6)	3.1 (3.3)	3.3 (3.7)
Minimal/No Urgency	46.6%	50.4%	54.6%	56.2%	61.9%	64.8%	64.7%
Moderate Urgency	44.1%	42.7%	38.3%	38.2%	33.1%	32.8%	31.4%
High Urgency	9.3%	6.9%	7.2%	5.6%	5.0%	2.4%	3.8%
Multi-Sector Service Contacts–Revised (MSSC–R)							
Number of Different Services Utilized	n/a	(*n* = 4,702)	(*n* = 2,672)	(*n* = 1,785)	(*n* = 1,130)	(*n* = 665)	(*n* = 362)
Mean (*SD*)		5.2 (2.9)	5.0 (2.9)	4.8 (2.9)	4.7 (2.8)	4.4 (2.8)	4.5 (2.9)
1–3		30.5%	34.8%	37.0%	39.4%	1.4%	1.9%
4–6		40.1%	38.9%	37.5%	40.0%	46.6%	43.6%
7–9		21.2%	18.3%	18.5%	14.7%	33.4%	35.6%
10 or more		8.2%	7.9%	7.0%	5.9%	14.2%	14.1%

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**	**30 Months %**	**36 Months %**
Multi-Sector Service Contacts–Revised (MSSC–R)							
Type of Services Utilized: Traditional							
Individual Therapy	n/a	69.4% (*n* = 4,685)	66.7% (*n* = 2,700)	65.7% (*n* = 1,801)	67.6% (*n* = 1,140)	64.7% (*n* = 663)	68.7% (*n* = 367)
Case Management	n/a	68.0% (*n* = 4,670)	63.8% (*n* = 2,696)	60.6% (*n* = 1,796)	54.6% (*n* = 1,140)	48.8% (*n* = 660)	47.8% (*n* = 366)
Assessment or Evaluation	n/a	57.6% (*n* = 4,632)	45.7% (*n* = 2,676)	42.7% (*n* = 1,788)	42.7% (*n* = 1,137)	36.8% (*n* = 658)	41.8% (*n* = 366)
Medication Treatment/Monitoring	n/a	43.6% (*n* = 4,668)	47.3% (*n* = 2,698)	49.7% (*n* = 1,800)	53.8% (*n* = 1,141)	57.0% (*n* = 661)	55.4% (*n* = 368)
Family Therapy	n/a	31.6% (*n* = 4,674)	29.4% (*n* = 2,695)	28.3% (*n* = 1,794)	24.5% (*n* = 1,141)	23.0% (*n* = 662)	26.2% (*n* = 367)
Group Therapy	n/a	22.3% (*n* = 4,669)	21.6% (*n* = 2,690)	22.7% (*n* = 1,794)	20.1% (*n* = 1,133)	18.1% (*n* = 659)	19.6% (*n* = 368)
Crisis Stabilization	n/a	13.5% (*n* = 4,668)	10.3% (*n* = 2,696)	9.5% (*n* = 1,798)	8.9% (*n* = 1,138)	9.5% (*n* = 660)	8.9% (*n* = 369)

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Multi-Sector Service Contacts–Revised (MSSC–R)							
Type of Services Utilized: Innovative							
Recreational Activities	n/a	28.3% (*n* = 4,675)	26.6% (*n* = 2,696)	26.6% (*n* = 1,799)	26.3% (*n* = 1,134)	21.8% (*n* = 661)	17.4% (*n* = 368)
Family Support	n/a	28.4% (*n* = 4,671)	24.4% (*n* = 2,685)	22.1% (*n* = 1,797)	16.8% (*n* = 1,134)	17.0% (*n* = 660)	15.7% (*n* = 369)
Transportation	n/a	22.8% (*n* = 4,682)	20.8% (*n* = 2,697)	20.4% (*n* = 1,798)	18.7% (*n* = 1,140)	18.7% (*n* = 659)	17.7% (*n* = 368)
Flexible Funds	n/a	20.4% (*n* = 4,667)	18.7% (*n* = 2,686)	16.4% (*n* = 1,796)	12.3% (*n* = 1,137)	9.9% (*n* = 658)	7.9% (*n* = 368)
Behavioral/Therapeutic Aide	n/a	14.5% (*n* = 4,669)	11.7% (*n* = 2,690)	11.0% (*n* = 1,800)	12.1% (*n* = 1,136)	9.9% (*n* = 659)	12.6% (*n* = 366)
Family Preservation	n/a	9.5% (*n* = 4,648)	8.1% (*n* = 2,687)	8.2% (*n* = 1,798)	7.6% (*n* = 1,139)	7.6% (*n* = 661)	6.5% (*n* = 367)
Respite	n/a	10.2% (*n* = 4,673)	11.9% (*n* = 2,695)	12.1% (*n* = 1,796)	11.7% (*n* = 1,140)	9.7% (*n* = 660)	9.2% (*n* = 368)
Transition	n/a	2.7% (*n* = 4,661)	2.5% (*n* = 2,685)	2.6% (*n* = 1,791)	3.7% (*n* = 1,137)	2.1% (*n* = 658)	3.3% (*n* = 365)
Independent Living	n/a	2.1% (*n* = 4,654)	2.0% (*n* = 2,684)	1.6% (*n* = 1,794)	2.6% (*n* = 1,137)	3.0% (*n* = 660)	4.1% (*n* = 367)
Afterschool Programs	n/a	15.1% (*n* = 4,668)	14.8% (*n* = 2,696)	13.5% (*n* = 1,796)	12.7% (*n* = 1,137)	11.5% (*n* = 655)	13.6% (*n* = 367)

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

Communities Funded in 2002–2006							
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %	30 Months %	36 Months %
Multi-Sector Service Contacts–Revised (MSSC–R)							
Type of Services Utilized: Restrictive							
Day Treatment	n/a	5.6% (*n* = 4,674)	6.2% (*n* = 2,695)	6.7% (*n* = 1,802)	7.6% (*n* = 1,140)	8.3% (*n* = 661)	9.5% (*n* = 368)
Inpatient Hospitalization	n/a	8.1% (*n* = 4,678)	6.4% (*n* = 2,702)	6.9% (*n* = 1,801)	5.9% (*n* = 1,136)	5.4% (*n* = 661)	6.0% (*n* = 365)
Residential Treatment Center	n/a	6.4% (*n* = 4,677)	6.2% (*n* = 2,696)	6.4% (*n* = 1,796)	5.7% (*n* = 1,137)	7.1% (*n* = 660)	9.0% (*n* = 365)
Therapeutic Group Home	n/a	2.2% (*n* = 4,674)	2.1% (*n* = 2,696)	1.7% (*n* = 1,796)	1.8% (*n* = 1,137)	1.8% (*n* = 660)	2.2% (*n* = 367)
Therapeutic Foster Care	n/a	1.9% (*n* = 4,674)	1.6% (*n* = 2,695)	1.7% (*n* = 1,793)	1.9% (*n* = 1,134)	1.5% (*n* = 660)	2.2% (*n* = 366)
Residential Camp	n/a	2.3% (*n* = 4,676)	1.8% (*n* = 2,698)	1.2% (*n* = 1,802)	1.5% (*n* = 1,137)	1.5% (*n* = 661)	1.6% (*n* = 368)
	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)							
Caregiver Perception of Services	n/a	4.0 (0.7) (*n* = 4,398)	4.1 (0.7) (*n* = 2,557)	4.0 (0.7) (*n* = 1,721)	4.0 (0.7) (*n* = 1,073)	4.0 (0.7) (*n* = 629)	4.1 (0.7) (*n* = 352)
Access to Services	n/a	4.3 (0.8) (*n* = 4,393)	4.3 (0.8) (*n* = 2,557)	4.2 (0.8) (*n* = 1,720)	4.2 (0.9) (*n* = 1,074)	4.2 (0.9) (*n* = 630)	4.2 (0.9) (*n* = 352)
Participation in Treatment	n/a	4.2 (0.7) (*n* = 4,399)	4.2 (0.7) (*n* = 2,558)	4.2 (0.8) (*n* = 1,721)	4.2 (0.8) (*n* = 1,073)	4.2 (0.8) (*n* = 630)	4.2 (0.8) (*n* = 351)
Cultural Sensitivity	n/a	4.5 (0.6) (*n* = 4,298)	4.5 (0.6) (*n* = 2,507)	4.4 (0.7) (*n* = 1,676)	4.4 (0.7) (*n* = 1,048)	4.4 (0.7) (*n* = 608)	4.5 (0.6) (*n* = 346)
Satisfaction With Services	n/a	4.0 (0.9) (*n* = 4,398)	4.1 (0.9) (*n* = 2,560)	4.0 (0.9) (*n* = 1,724)	4.0 (0.9) (*n* = 1,073)	4.0 (0.9) (*n* = 630)	4.1 (0.8) (*n* = 352)
Outcomes	n/a	3.5 (0.9) (*n* = 4,385)	3.6 (0.9) (*n* = 2,554)	3.6 (0.9) (*n* = 1,720)	3.7 (0.9) (*n* = 1,075)	3.6 (1.0) (*n* = 629)	3.7 (1.0) (*n* = 352)

Table H–4: Child, Youth, and Family Outcomes at Intake, 6 Months, 12 Months, 18 Months, 24 Months, 30 Months, and 36 Months for Communities Funded in 2002–2006 (continued)

	Communities Funded in 2002–2006						
	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)							
Youth Perception of Services	n/a	3.9 (0.7) (*n* = 2,364)	4.0 (0.6) (*n* = 1,476)	4.0 (0.7) (*n* = 1,062)	4.0 (0.6) (*n* = 694)	4.0 (0.7) (*n* = 392)	4.1 (0.7) (*n* = 234)
Access to Services	n/a	4.0 (0.9) (*n* = 2,352)	4.0 (0.8) (*n* = 1,471)	4.0 (0.9) (*n* = 1,058)	4.1 (0.8) (*n* = 693)	4.0 (0.9) (*n* = 391)	4.0 (0.9) (*n* = 234)
Participation in Treatment	n/a	3.6 (0.9) (*n* = 2,364)	3.7 (0.9) (*n* = 1,477)	3.7 (0.9) (*n* = 1,063)	3.8 (0.8) (*n* = 694)	3.8 (0.9) (*n* = 391)	3.9 (0.9) (*n* = 234)
Cultural Sensitivity	n/a	4.3 (0.7) (*n* = 2,323)	4.3 (0.7) (*n* = 1,462)	4.3 (0.7) (*n* = 1,055)	4.3 (0.6) (*n* = 687)	4.3 (0.7) (*n* = 387)	4.3 (0.7) (*n* = 233)
Satisfaction With Services	n/a	3.9 (0.8) (*n* = 2,365)	4.0 (0.8) (*n* = 1,478)	4.0 (0.8) (*n* = 1,064)	4.0 (0.8) (*n* = 695)	4.0 (0.8) (*n* = 392)	4.1 (0.8) (*n* = 234)
Outcomes	n/a	3.9 (0.8) (*n* = 2,364)	3.9 (0.8) (*n* = 1,477)	3.9 (0.8) (*n* = 1,062)	3.9 (0.7) (*n* = 694)	3.9 (0.8) (*n* = 392)	4.1 (0.7) (*n* = 234)
Cultural Competence and Service Provision (CCSP)							
Importance of Provider's Understanding of Family's Culture	n/a	2.7 (1.2) (*n* = 4,550)	2.8 (1.2) (*n* = 3,078)	2.7 (1.2) (*n* = 2,379)	2.7 (1.2) (*n* = 1,758)	2.7 (1.1) (*n* = 1,203)	2.6 (1.2) (*n* = 795)
Frequency of Provider's Culturally Competent Practices	n/a	4.6 (0.6) (*n* = 4,073)	4.6 (0.6) (*n* = 2,384)	4.6 (0.6) (*n* = 1,584)	4.6 (0.6) (*n* = 1,006)	4.6 (0.6) (*n* = 590)	4.6 (0.6) (*n* = 334)
Overall	**n/a**	**4.2 (0.5) (*n* = 4,211)**	**4.2 (0.5) (*n* = 2,453)**	**4.2 (0.5) (*n* = 1,619)**	**4.2 (0.5) (*n* = 1,032)**	**4.2 (0.6) (*n* = 606)**	**4.2 (0.5) (*n* = 344)**

[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

Table H–5: Baseline Characteristics: Child and Youth Demographic Information for Communities Funded in FY 2008

Communities Funded in 2008	
	Overall Sample (*n* = 753)
Gender	(*n* = 753)
Male	67.1%
Female	32.9%
Age in Years	(*n* = 750)
0–5 Years	27.5%
6–11 Years	21.3%
12–15 Years	27.1%
16 Years or Older	24.1%
Race and Ethnicity	(*n* = 727)
American Indian or Alaska Native Alone	3.4%
Asian Alone	1.1%
Black or African American Alone	13.3%
White Alone	60.4%
Of Hispanic Origin	15.8%
Multiracial	5.9%

Appendix I

Tables

Table I–1: Clinical Diagnoses at Intake*

DC:0–3R Axis I Diagnosis	(*n* = 510)
Adjustment Disorders	20.4%
Sensory Stimulation-Seeking/Impulsive	16.7%
Anxiety Disorders	13.9%
Hypersensitivity (Fearful/Cautious, Negative/Defiant)	10.8%
Posttraumatic Stress Disorder	7.8%
Regulation Disorders of Sensory Processing	5.9%
Deprivation/Maltreatment Disorder	5.5%
Mixed Disorders of Emotional Expressiveness	3.7%
Multi-System Developmental Disorder (MSDD)	3.5%
Disorders of Affect	3.3%
Disorders of Relating and Communicating	2.9%
Sleep Onset Disorder	2.9%
Depression	2.2%
Hyposensitivity/Underresponsive	2.2%
Prolonged Bereavement/Grief Reaction	1.4%
Feeding Disorders	0.8%
Other	11.4%
***DSM–IV* Axis I and II Diagnosis**	**(*n* = 22,951)**
Mood Disorders	35.7%
Attention-Deficit/Hyperactivity Disorder (ADHD)	32.3%
Oppositional Defiant Disorder	23.3%
Adjustment Disorders	13.8%
Posttraumatic Stress Disorder and Acute Stress Disorder	8.5%
Anxiety Disorder	8.3%
V Code	7.4%
Disruptive Behavior Disorder	7.0%
Substance Use Disorders	6.5%
Conduct Disorder	5.7%
Learning, Motor Skills, and Communication Disorders	3.8%
Autism and Other Pervasive Developmental Disorders	3.3%
Impulse Control Disorders	2.5%
Schizophrenia and Other Psychotic Disorders	2.3%
Mental Retardation	2.2%
Personality Disorders	1.1%
Substance-Induced Disorders	0.3%
Other	10.2%

* Percentages do not sum to 100% because each child or youth might have more than one diagnosis.

Table I–2: Locations in Which Services Were Received

Location	Received Service Between: Intake and 12-Month Interviews %	Received Service Between: 12-Month and 24-Month Interviews %
Mental health clinic or private practice (*n* = 1,643)	94.0%	92.9%
School (*n* = 1,600)	92.0%	91.3%
Home (*n* = 1,353)**	85.4%	78.3%
Social Services or Child Welfare offices (*n* = 1,047)**	56.4%	51.4%
Community location or service center (*n* = 1,035)	49.8%	49.3%
Medical hospital (*n* = 945)	38.2%	36.7%
Juvenile court / Probation (*n* = 927)	34.4%	36.4%
Psychiatric hospital / unit (*n* = 864)**	26.4%	21.1%
Non-hospital residential setting (*n* = 848)	19.2%	20.0%
Jail / Youth detention (*n* = 819)*	11.4%	14.5%
Other setting (*n* = 686)	24.8%	24.2%

* Change is significant at $p < .01$ level.

** Change is significant at $p < .001$ level.

Table I–3: Successes and Challenges in Implementing Interagency Collaboration

Successful Interagency Collaboration

- Co-location of staff from different agencies
- Cross-training of agency staff
- Establishing governing bodies that include cross-agency representation from most of the publicly funded child-serving agencies
- Changes in attitudes of non-mental health agencies (e.g., schools) about the importance of mental health treatment
- Placing mental health staff onsite in different agencies
- Staff from non-mental health agencies with which the child and family are involved attending mental health service planning meetings, and vice versa (e.g., mental health providers attend individualized education program (IEP) meetings at schools)
- Including representatives from all involved publicly funded child-serving agencies on wraparound teams, as appropriate
- Unified service planning, i.e., a single service plan for each child and family

Challenges to Interagency Collaboration

- Pooling, blending, or braiding funding allocated to the separate agencies
- Incorporating all child-serving agencies into the quality monitoring and evaluation processes
- Developing a governing body that includes all stakeholders and has authority over grant services
- Changing administrative processes enough to share them across agencies, such as a shared MIS
- Finding sufficient resources to make the changes necessary for greater interagency collaboration
- Engaging the public health and primary care sectors, both on governing bodies and in service planning and provision
- Different federal and state requirements for different agencies
- Changing attitudes and business processes that are entrenched in separate agencies

Table I–4: Caregiver Satisfaction Related to Whether Received Information about Services Being Provided

Information Provided	Satisfaction with Service Quality:		Satisfaction with Service Outcomes:	
	Provided Information	Not Provided Information	Provided Information	Not Provided Information
Details about treatment	4.05	3.20*	3.56	2.91*
Expected improvements	4.14	3.39*	3.64	3.03*
Research evidence	4.22	3.63*	3.72	3.20*
Provider's experience	4.21	3.50*	3.69	3.13*

* Difference is significant at *p* < .001 level.

Appendix J

Figures

Figure J–1: Percentages of Children and Youth with Clinical Levels of Behavioral and Emotional Problems at Intake, 12 Months, and 24 Months
Communities Funded in 2002–2006

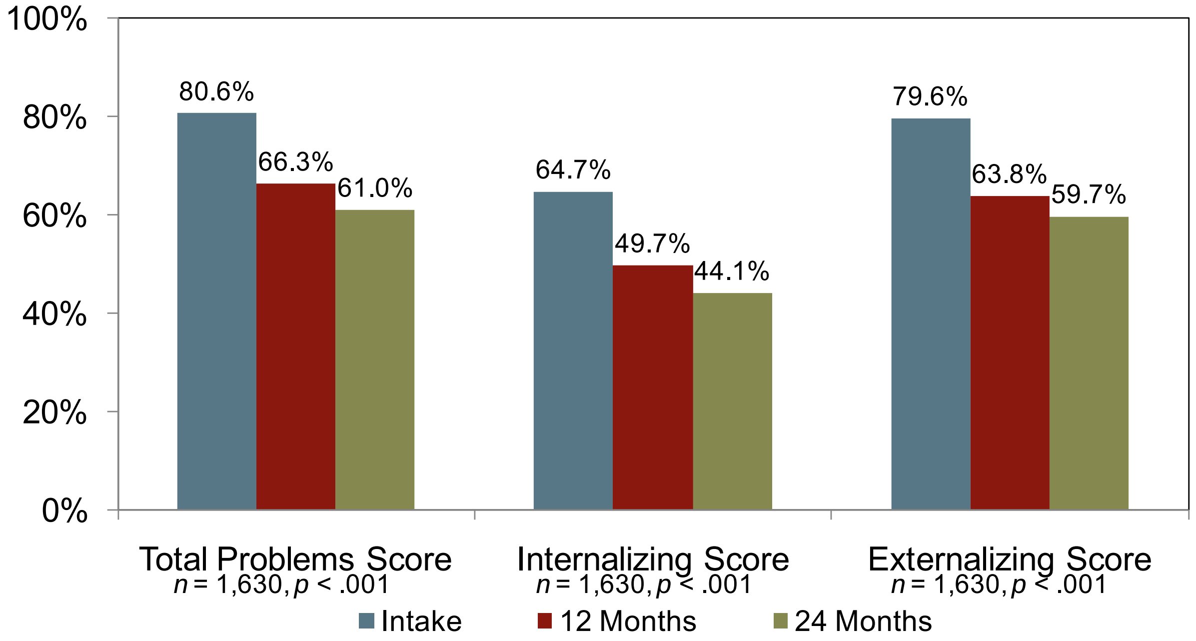


Figure J–2: Percentages of Children Aged 3–21 with Clinical Levels of Functional Impairment at Intake, 12 Months, and 24 Months
Communities Funded in 2002–2006

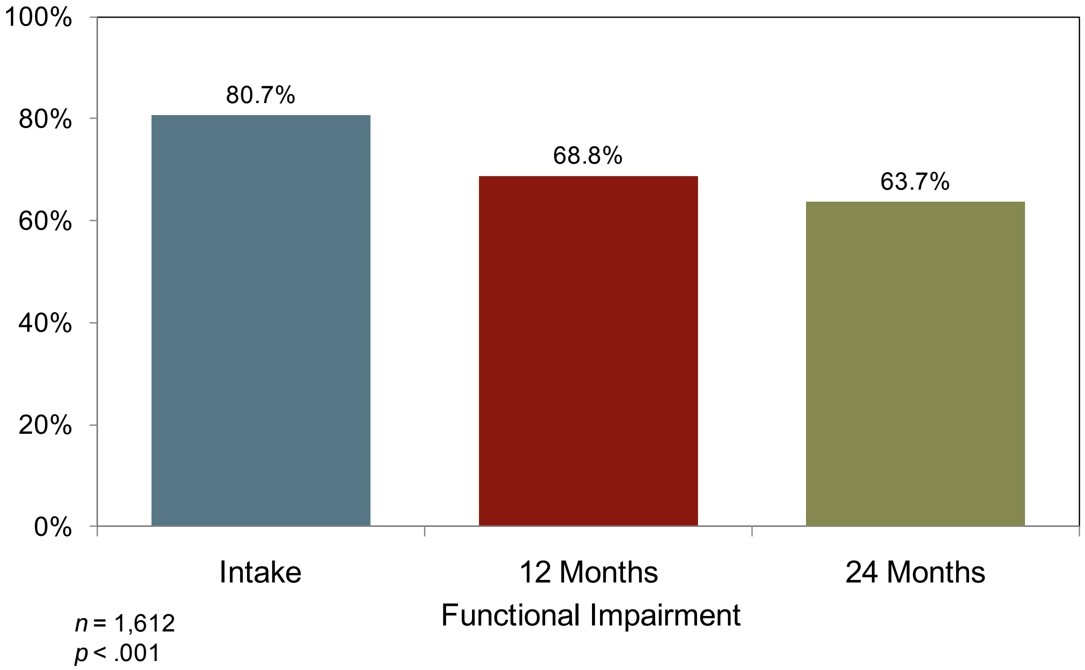


Figure J–3: Percentages of Youths with Clinical Levels of Anxiety and Depression at Intake, 12 Months, and 24 Months
Communities Funded in 2002–2006

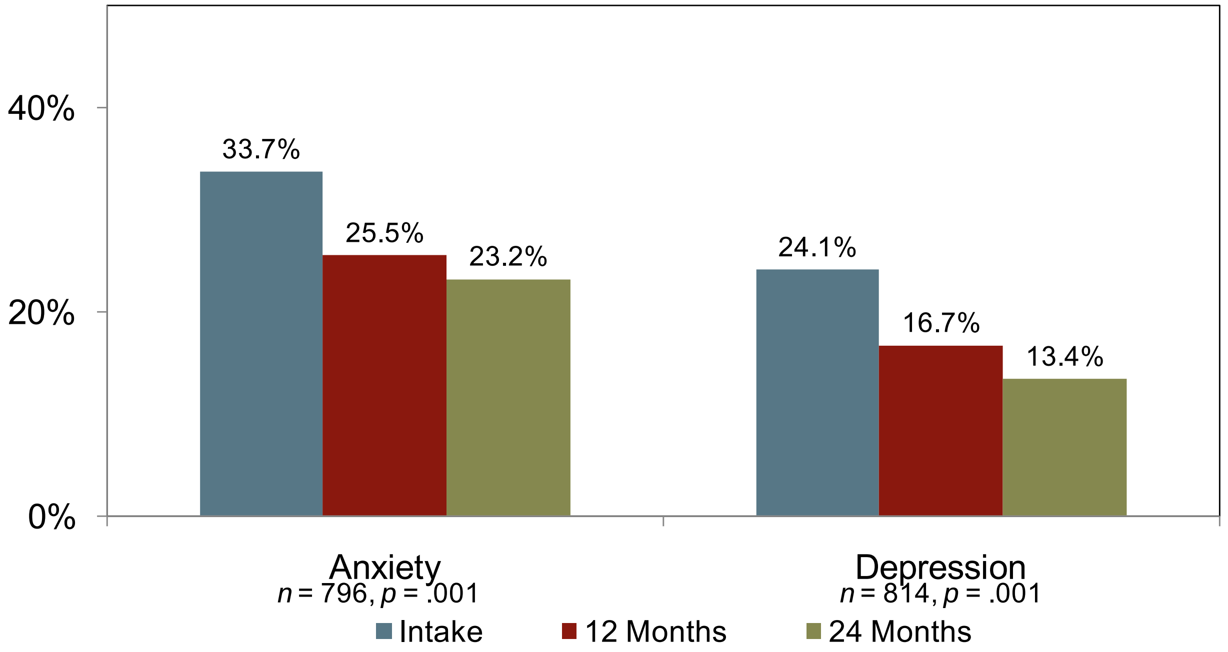


Figure J–4: Change in School Attendance, Performance, and Disciplinary Actions at Intake, 12 Months, and 24 Months
Communities Funded in 2002–2006

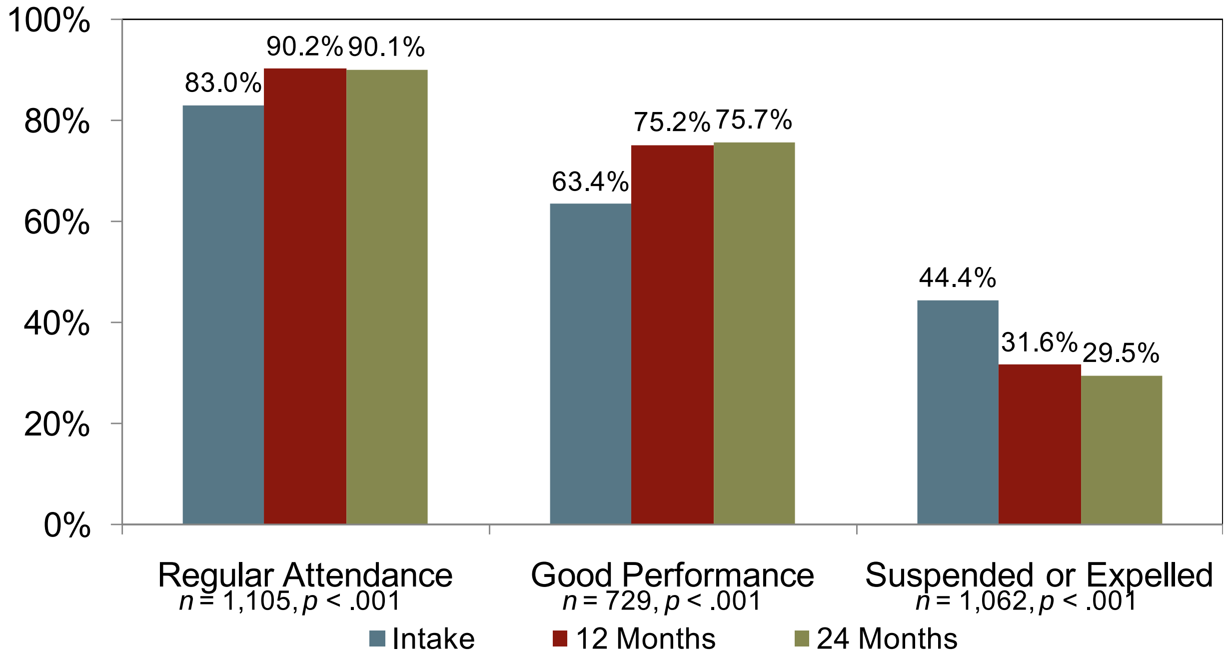
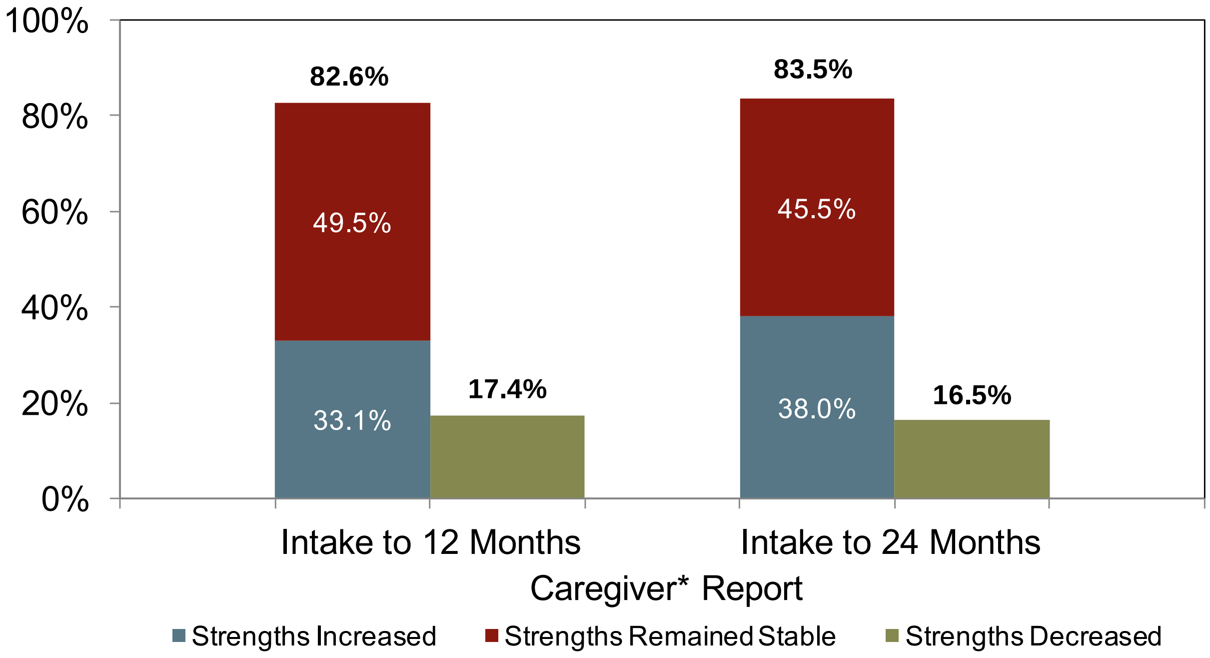
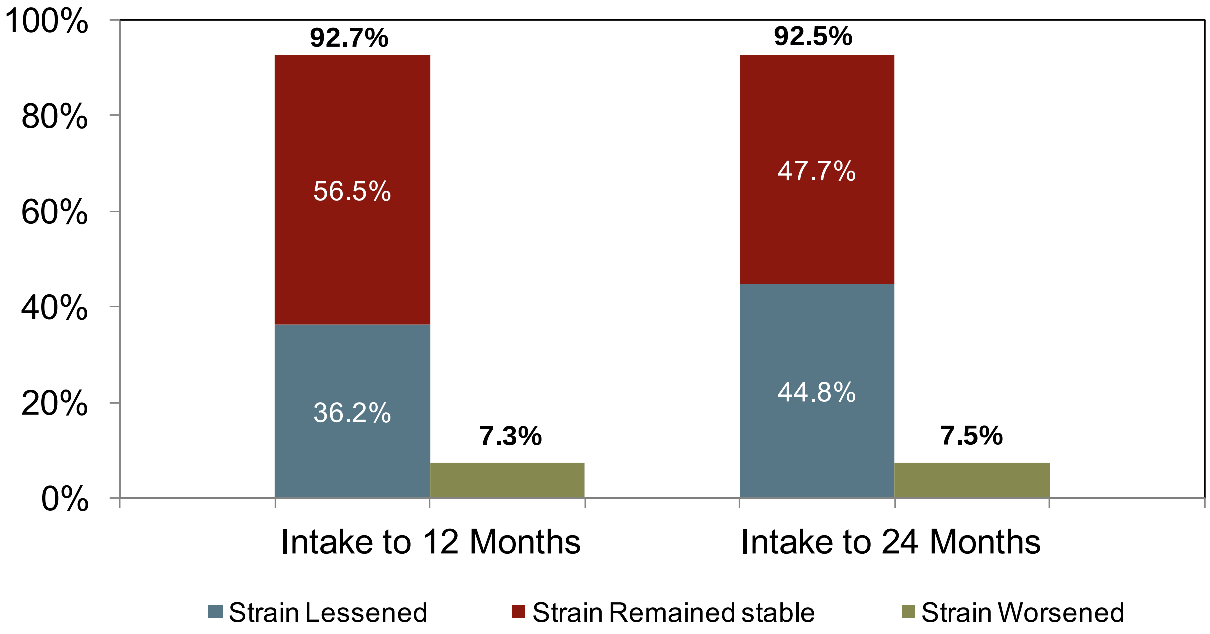


Figure J–5: Change in Children's and Youths' Behavioral and Emotional Strengths from Intake to 12 Months and Intake to 24 Months
Communities Funded in 2002–2006



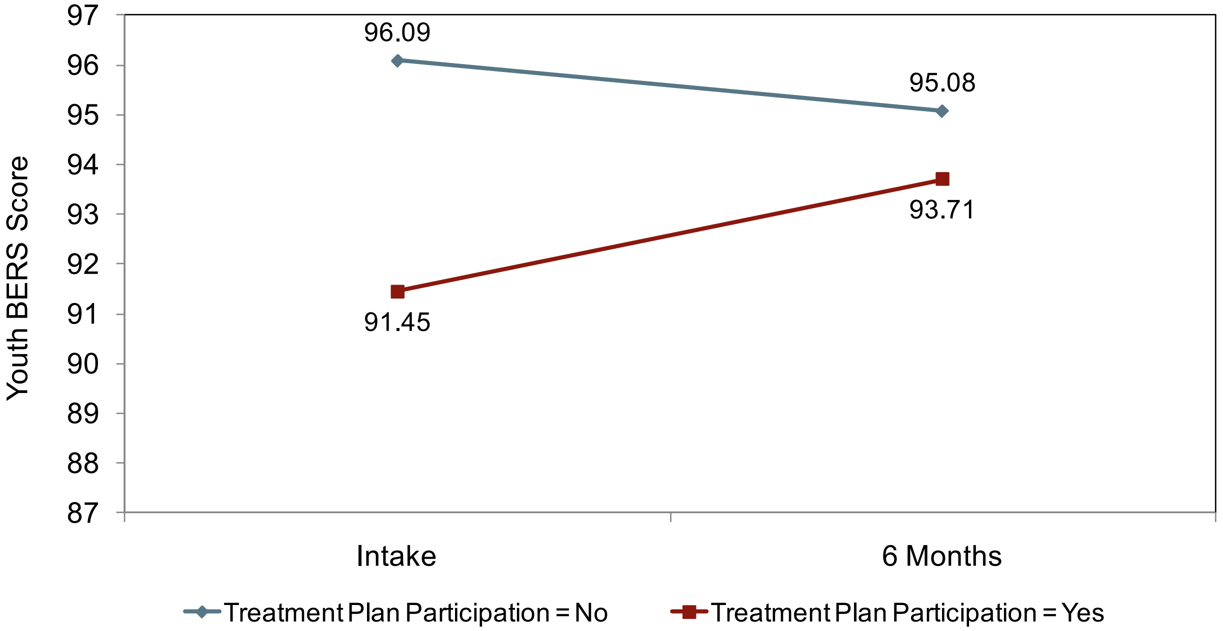
n = 782
p < .001
* Only caregivers of youth 11 and older.

Figure J–6: Change in Caregiver Global Strain from Intake to 12 Months and Intake to 24 Months
Communities Funded in 2002–2006



n = 1,594
p < .001

Figure J–7: Youth Treatment Planning Participation and Youths' Strengths at Intake and 6 Months Communities Funded in 2002–2006



n = 1,694
Within Subjects X Time: *F* = 9.614, *p* = .002
Between Subjects X Time: *F* = 7.880, *p* = .005

CARING FOR EVERY CHILD'S MENTAL HEALTH

Systems of Care

PEP12-CMHI2010