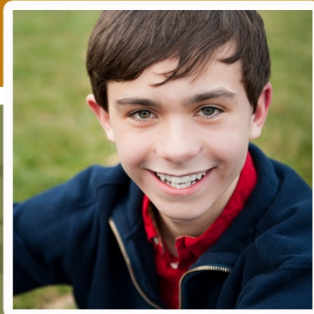




U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program

Report to Congress 2015

Substance Abuse and Mental Health Services Administration



U.S. Department of Health and Human Services

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Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to present the *Report to Congress, 2015*, for the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. This initiative, also known as the Children’s Mental Health Initiative (CMHI), was authorized by Public Law 102–321 to provide funds to public entities for the purpose of delivering comprehensive community mental health services to children and youth who have a serious emotional disturbance (SED) and their families. Since 1993, it has funded a total of 173 demonstration grants and cooperative agreements in states, territories, counties, and federally recognized tribal entities, to create systems of care that serve children and youth with serious mental health conditions, and their families. Data collected from grantees show that children and youth who received system of care services experienced positive behavioral and emotional health, and educational outcomes. Grantees also made overall gains in applying systems of care principles to transform service delivery systems. Building on the success of these systems of care outcomes, SAMHSA began awarding 1-year *Expansion Planning grants* in FY 2011 and 4-year *Expansion and Sustainability grants* in FY 2012, in order to stimulate the widescale adoption of the systems of care approach that is part of SAMHSA’s Theory of Change.¹ As of FY 2015, SAMHSA has awarded a total of 50 1-year *Expansion Planning grants* and 53 4-year *Expansion and Sustainability grants*.

This report presents outcomes from the national evaluation of the cohort of demonstration grantees, initially funded in FY 2009 and FY 2010, as well as information about the national evaluation of the cohort of *Expansion and Sustainability grants* funded since FY 2012. The report also highlights success stories of children and youth whose lives have been changed as a result of the system of care services that they received. Given SAMHSA’s strategic focus on integrated care, information is also presented about grantees’ efforts to integrate mental health and substance use prevention, treatment, and recovery support services with primary care, education, and child welfare.

Administrative and Legislative Initiatives

SAMHSA continues to ensure that behavioral health is consistently viewed and incorporated within the context of health care delivery and financing. The findings of this report highlight the need for changes in the administration of the CMHI program as SAMHSA seeks to promote the widescale adoption of the program. Such changes include the following:

- Provide technical assistance to communities that wish to establish systems of care even though the community may not have a grant.
- Focus on youth and young adults up to age 21 who are identified to be at clinically high risk for developing a first episode of psychosis.
- Build on lessons learned and create policy and infrastructure that promote cross-agency collaboration among systems of care across jurisdictions to bring the program fully to scale.
- Fund programs that build a workforce capable of effectively implementing age- and culturally appropriate evidence-based practices.

¹ SAMHSA’s theory of change framework is organized into five stages: innovation, translation, dissemination, implementation, and widescale adoption.

- Examine more systematic strategies to increase and coordinate funding for prevention efforts across federal and/or state agencies through meaningful partnerships.

Systems of Care: Connecting Families to Services

Charles² is a 5 year old boy who was diagnosed as having Attention-Deficit/Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) and who is being raised by his grandmother in Kentucky. According to his grandmother, Charles sometimes found it difficult to control his impulsive behaviors. He was inattentive in school and experienced sleeplessness at nights. Charles's grandmother sought services for Charles at the Kentucky SEED program where he was assessed and his medication use monitored. Charles also received the therapy he needed to control his impulsive and oppositional behaviors. As a result of these interventions, Charles is now able to apply the self-management skills that help him to function in the classroom as well as at home and in other social settings.

The services that Charles and his grandparents received are not routinely available to families. Charles's grandmother was fortunate to participate in **Kentucky SEED's** Grandparents as Parents (GAP) program, which supports grandparents who are raising their grandchildren.



Kentucky SEED is a CMHI-funded initiative of the Regional Interagency Council (RIAC) which aims to promote interagency collaboration among child-serving agencies and increase and improve the array of services available to children with serious emotional conditions and their families. The Council also seeks to ensure more efficient coordination of behavioral health services, reduced dependency on psychiatric hospitalization, and increased use of community-based services. The RIAC now serves as model for behavioral health service delivery among Head Start and preschools, and providers who specialize in treating young children.

What Is a System of Care?

A coordinated network of community-based services and supports organized to meet the challenges of children and youth and their families. System of care services should be

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

² All names, as well as certain details, used in this report have been changed to protect the privacy of individuals.

Characteristics of CMHI Grantees

Since 1993, the CMHI has funded states, county and local governmental entities, U.S. territories, Indian tribes and tribal organizations, and other American Indian/Alaska Native communities to promote the transformation and integration of the multiple systems—including mental health, primary care, education, child welfare, and juvenile justice—that serve children and youth 0–21 years of age who have been diagnosed as having a serious emotional disturbance,³ as well as their families. SAMHSA also used the opportunity to assess the fidelity of grantees’ programs to system of care principles and the best practices associated with serving children and youth with mental health conditions, and their families. The success of the program has enabled SAMHSA to embark on widescale adoption of the system of care framework through its funding of 50 one-year *Expansion Planning* and 53 four-year *Expansion and Sustainability grants*.



The currently active⁴ CMHI-funded demonstration and expansion grantees serve children, youth, and families, characterized by diversity in age, race, ethnicity, national origin, and language. Because of the emphasis on cultural and linguistic competency, systems of care are capable of serving populations such as African-Americans; American Indians/Alaska Natives; Hispanics/Latinos; individuals who identify as lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit; and recent immigration populations, that have

historically been poorly served.

Expansion and Sustainability grantees are focused on similar populations as the demonstration grants, and additional efforts are being made to promote widescale adoption of the system of care framework. Several city- and county-based initiatives are working to link previously funded systems of care with the statewide efforts. Among the 22 grantees funded in FY 2014, several statewide jurisdictions are focused on an integrated system of service delivery that connects previously funded systems of care to newly funded systems of care and better serve children and youth in their state.

Several CMHI grantees provide mental health services that are integrated with other child-serving systems. Integrated care, at its simplest, refers to the practice of incorporating mental and substance use disorder services into primary care settings and primary care into mental health and substance use service settings for the purpose of improving quality of care and outcomes.

³ The authorizing legislation for the CMHI uses the phrase *serious emotional disturbance*. Hereafter, this report uses the term *serious mental health conditions*, except when referring directly to the original authorizing legislation.

⁴ Of the 20 grantees receiving funding in FY 2009, one grantee’s funding ended in 2011, prior to the full 6-year period of the grant.

Providers, practitioners, and families are increasingly realizing that integrated care is the most effective approach to caring for individuals with multiple health care needs. Among other things, integration of services improves access to care, increases social inclusion; a decrease in use of high-cost emergency and inpatient services, and ultimately increases youth and families' satisfaction with services (Woltmann et al., 2012).



This focus on integration of care is consistent with SAMHSA's focus on the integration of mental health and substance use prevention, treatment, and recovery support services with primary care, education, and child welfare. System of care grantees that have had some success in integrating services across systems include the Madison County Unified School District system of care in Boise, Idaho, which provides mental health services in the county's schools. Project ABC in Los Angeles County, California, and MYCHILD in Boston, Massachusetts, co-locate counselors in pediatrician's offices to provide mental health services for children and families. This integrated approach to care enables grantees to provide more comprehensive services for children and youth and promote interagency collaboration.

The National Evaluation of the CMHI

National evaluation of the CMHI is mandated by the authorizing legislation, Section 565 of the Public Health Service Act for the purpose of describing, monitoring, and chronicling the progress of the program (Public Law 102–321, 42 U.S.C § 290ff-4(c)(1)). The goal is to assess the outcomes of children and youth and their families who are served by CMHI-funded grantees. Details on “longitudinal studies of outcomes of services provided by such systems, other studies regarding such outcomes, the effect of activities under this part on the utilization of hospital and other institutional settings, the barriers to and achievements resulting from interagency 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” are required by law (Public Law 102–321, 42 U.S.C. § 290ff-4(c)(1)).

Additionally, the law mandates that “[t]he Secretary shall, not later than 1 year after the date on which amounts are first appropriated under subsection (c) of this section, and annually thereafter, submit to the Congress a report summarizing evaluations carried out pursuant to paragraph (1) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this section as the Secretary determines to be appropriate” (Public Law 102–321, 42 U.S.C. § 290ff-4(c)(2)).

Who Are the Children and Youth Served by the CMHI?

Exhibit 1. Gender, Age, and Race/Ethnicity Frequencies: CMHI Population Compared to the U.S. Population

Longitudinal Data Collection Year	CMHI Grantees Initially Funded in 2009–2010	U.S. Population 2013*
Gender	<i>n</i> = 12,316	
Male	58.0%	49.2%
Female	41.8%	50.8%
Other (including transgender)	0.2%	**
Age	<i>n</i> = 12,307	
0–5 Years	22.3%	26.3%
6–11 Years	19.4%	26.9%
12–15 Years	29.0%	18.3%
16–21 Years	29.3%	28.5%
Race/Ethnicity	<i>n</i> = 12,190	
American Indian or Alaska Native	2.8%	0.8%
Asian	1.1%	5.2%
Black or African-American	27.8%	13.0%
Native Hawaiian or Pacific Islander	1.7%	0.2%
White	38.8%	62.4%
Hispanic/Latino	20.4%	17.1%
Two or More Races	7.3%	2.4%

* These estimates correspond with the midpoint of 2010–2015, the years in which grantees are receiving funding.

** Data not reported in U.S. Census Data.

The children and youth served by system of care grantees represent a diverse population that includes children and youth from traditionally underserved populations. Exhibit 1 describes the demographic characteristics of children and youth served by grantees initially funded in 2009–2010 and received system of care services as of June 11, 2015.



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

At entry into services, caregivers of children receiving services in systems of care initially funded in 2009 and 2010 provided information about the life experiences of children and youth.

Children and youth entering services were exposed to multiple social and economic risk factors. Almost one-third (30.7 percent) of children and youth lived with both biological or adoptive parents and two-thirds (65.1 percent) lived below the federal poverty threshold⁵ at intake (see Exhibit 2). In the 6 months prior to intake, 48.2 percent of caregivers were employed. Three-quarters of caregivers (74.9 percent) reported problems within their child’s primary support group, such as family health problems or children’s disciplinary problems, and slightly more than one half reported educational problems (51.6 percent) or problems related to the child’s social environment (51.7 percent). Caregivers also reported economic problems (21.3 percent), housing problems (16.3 percent), and problems related to their child’s interaction with the legal system or crime (20.5 percent).

More than one-half of children and youth (53.4 percent) had at least one biological family member who had experienced a drug or alcohol problem at some point in their lives, and nearly one third (29.1 percent) lived with a person who had experienced a drug or alcohol problem in the 6 months before intake. Caregivers reported that 39.7 percent of children and youth had been exposed to domestic violence at some point in their life, and 21.7 percent had been exposed to such violence within 6 months of entering into system of care services.

Among children and youth entering systems of care, 66.7 percent had a biological family member who had been diagnosed as having depression, and almost three quarters (73.5 percent) lived with someone who had shown signs of depression in the 6 months before entering services. Almost one-half of children and youth (48.4 percent) had a family member with a mental illness other than depression at some point in their life. Caregivers reported that 28.8 percent of children and youth had run away from home and 13.5 percent had attempted suicide at some point prior to their intake into system of care services.

Exhibit 2. Custody, Family Poverty, and Employment Status at Intake, Grantees Initially Funded in 2009–2010

Custody Status at Intake (<i>n</i> = 2,669)	
Two Biological or Adoptive Parents	30.7%
Biological Mother	45.7%
Biological Father	3.3%
Grandparents	6.2%
Aunt and/or Uncle	1.4%
Siblings	0.3%
Ward of the State	4.6%
Adult Friend	0.2%
Other	2.6%
Family Poverty Status Prior to Intake (<i>n</i> = 2,045)	
Below Poverty Threshold (\$24,250 for a family of 4)	65.1%
At or Near Poverty Threshold (\$24,251–\$36,375)	12.6%
Well Above Poverty Threshold (\$36,376 and above)	22.3%
Employment Status in the 6 Months Prior to Intake (<i>n</i> = 2,642)	
Caregiver Employed	48.2%

⁵ See <http://aspe.hhs.gov/2015-poverty-guidelines>. For a family of four in 2015, this represents income of \$24,250. The actual poverty threshold for a family is dependent on the size of the family, year, and their location.



Quick Facts about CMHI Families

- Data in this report represent children, youth, and families who received services from grantees initially funded in 2009 and 2010 and who participated in the national evaluation’s Longitudinal Outcome Study at intake and follow-up data collections at 6, 12, 18, and 24 months.
- The majority of children and youth receiving services were male (58.0 percent). More than one in five children receiving services (22.3 percent) was aged 5 years and younger, and more than one quarter were youth and young adults 16–21 years old (29.3 percent).
- Among the children and youth who received services, 38.8 percent identified as White/Caucasian, 27.8 percent as Black/African-American, and 20.4 percent as Hispanic/Latino(a).
- The most common sources of referral into systems of care were mental health providers (27.5 percent of referrals), caregiver or self-referrals (15.5 percent), and schools (12.9 percent).

Exhibit 3. Most Common DSM-IV-TR Diagnoses Assigned to Children and Youth at Intake, Grantees Initially Funded in 2009–2010

Diagnosis	Percentage
Mood Disorders	39.8%
Attention-Deficit/Hyperactivity Disorder	32.5%
Oppositional Defiant Disorder	19.0%
Adjustment Disorders	13.8%
Substance Use Disorders	10.6%
Anxiety Disorders	10.5%
Posttraumatic Stress Disorder/Acute Stress Disorder	9.3%
More than One Diagnosis	53.1%



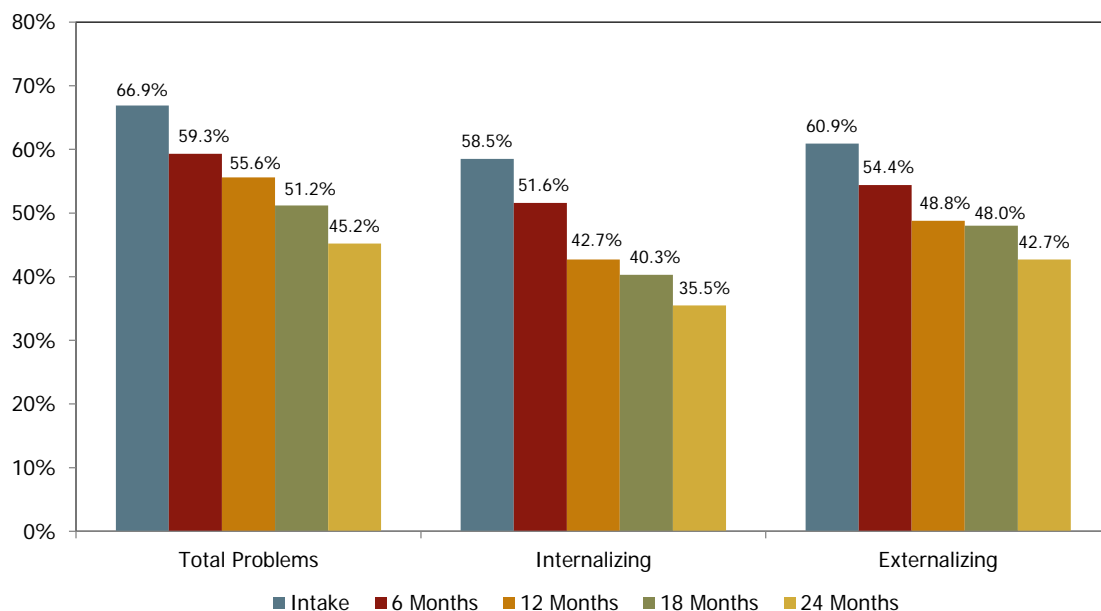
- Most children and youth (79.1 percent) who entered system of care services, in the 6 months prior to intake, attended school at least 80 percent of the time. More than one-third of children and youth (34.3 percent) who received traditional letter grades were reported to have received average grades of D or F on their most recent report card.
- More than one-third (39.8 percent) of children and youth were diagnosed as having mood disorders while 9.3 percent were diagnosed as having Posttraumatic Stress Disorders (Exhibit 3).

Outcomes of Children, Youth, and Families

Caregivers of children and youth, as well as youth aged 11 and older, entering services in systems of care initially funded in 2009 and 2010, provided information about the behavioral symptoms and functioning of the children and youth who received services, as well as caregiver outcomes.

Children and youth aged 1½ to 18 years old were assessed for behavioral and emotional symptoms using the Child Behavior Checklist (CBCL 1½–5; Achenbach & Rescorla, 2000; CBCL 6–18; Achenbach & Rescorla, 2001). Caregivers completed this measure about their children. The measure has two subscales: Internalizing Problems, such as depression and anxiety, and Externalizing Problems, such as rule breaking and aggression. The measure also includes a Total Problems Scale that assesses overall symptom levels. Exhibit 4 shows a decrease in the percentage of children and youth who scored in the “clinically elevated” range, indicating higher than normal levels of symptoms, for each scale beginning at intake and extending to the 24-month follow-up.

Exhibit 4. Percentage of Children and Youth Scoring in the Clinically Elevated Range on the CBCL, Grantees Initially Funded in 2009–2010



Improvement in Functioning

The functioning of children and youth was assessed by caregivers using the Columbia Impairment Scale (Bird et al., 1993). The scale assesses how well children and youth function in three domains (home, school, and community). According to caregivers, 70.7 percent of children and youth entering services were in the clinically elevated range, suggesting difficulties in functioning. At 6 months, this proportion fell to 65.6 percent, and after 12 months it fell further to 57.9 percent. The downward trend continued at 18 and 24 months, with a decrease to 53.7 percent and 47.5 percent, respectively.

Improvement in Symptoms of Anxiety and Depression

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

The percentage of youth who reported clinically elevated symptoms of anxiety varied over time. At intake into services, 27.6 percent of youth reported clinically elevated symptoms of anxiety. After 6 months, this proportion fell to 21.8 percent, but then increased somewhat to 26.4 percent after 12 months. After 18 months, the proportion was 29.9 percent and at 24 months after starting services, it had fallen to 20.7 percent.

More than a quarter (27.4 percent) of youth reported symptoms of depression in the clinically elevated range when they entered services. This proportion fell to 17.3 percent after 6 months, rose somewhat to 19.3 percent after 12 months and 22.8 percent after 18 months before falling to 16.8 percent 24 months after beginning system of care services.



Systems of Care Addresses Adolescent Depression

Natalie, an eighth grader, was experiencing problems with depression—she had spells of sadness and cried for no reason. At times, she had feelings of listlessness and lashed out at other children during her bouts of anger. Natalie's story is not unusual if one considers that her mother struggled with substance use issues throughout Natalie's childhood and that her grandmother was entrusted with her care. As Natalie's depression got worse her grandmother became distraught but had no idea where to look for help. Luckily, Natalie joined the school's teen group that provided afterschool activities for youth and young adults.

Upon entering the program, which is part of the **Madison County Idaho School District's** system of care for children with behavioral and emotional disorders, Natalie was screened and referred for mental health services and supports. Her grandmother, skeptical of seeking mental health services, placed her trust in the school program staff and allowed Natalie to participate in services. Natalie enrolled in one-on-one therapy with a certified counselor. Her mood and academic performance improved. Four years later, Natalie is on course to graduate high school and plans to attend college.

The services Natalie received were provided by the 2009-funded **Madison County Idaho School District**, which was awarded funding from SAMHSA to create a system of care. Consistent with system of care principles, the district brought together multiple partner agencies in rural Idaho to provide prevention and intervention services to the school population with behavioral and emotional needs using the Positive Behavior Intervention and Support (PBIS) practice. This integration of services has benefits for youth like Natalie but also for the families and wider communities.

Improvement in Educational Outcomes

Among children and youth who received system of care services and were enrolled in school, the proportion who attended school regularly, defined as missing no more than 1 day per week, on average, was 76.6 percent at intake. This proportion increased to 87.8 percent after 6 months. After 12 months, the proportion was 87.3 percent, although it fell somewhat to 86.3 percent after 18 months and to 83.8 percent after 24 months. Over time, the proportion of system of care participants who were suspended or expelled from school dropped significantly. Prior to intake, 39.9 percent of students who received system of care services had been suspended or expelled from school in the past 6 months. This number fell to 31.9 percent after 6 months and further to 24.5 percent after 12 months, 22.7 percent after 18 months, and 19.6 percent after 24 months.

Improvement in Living Situation

The proportion of children and youth who lived away from home in a placement such as a hospital, foster home, or juvenile justice facility within the past 6 months was 25.0 percent at entry into services. This proportion fell to 16.9 percent after 6 months, but rose somewhat to 19.5 percent after 12 months. By 18 months, the proportion fell to 16.3 percent, and after 24 months it had fallen further to 14.2 percent.

Reduction in Law Enforcement Contact

The proportion of youth aged 11 years and older who reported that they had been arrested in the past 6 months decreased from 18.4 percent of youth at intake to 14.3 percent after 6 months, and further to 8.2 percent after 12 months. The rate remained steady at 8.2 percent at after 18 months, and rose slightly to 9.2 percent after 24 months.

Improvement in Behavioral Health and Strengths

Caregivers completed the Behavioral and Emotional Rating Scale—Second Edition (Epstein, 2004), which measures a child's or youth's strengths in key areas related to school, family, relationships, and personal competence. Caregivers reported significant increases in the behavioral and emotional strengths of children and youth. After 6 months, 33.3 percent of caregivers reported that their child showed significant improvement in emotional strength and resiliency. After 12 months, the proportion increased to 35.7 percent, and it rose further to 37.5 percent at 18 months. By 24 months, 41.7 percent of caregivers reported a significant positive change in their child's symptoms.



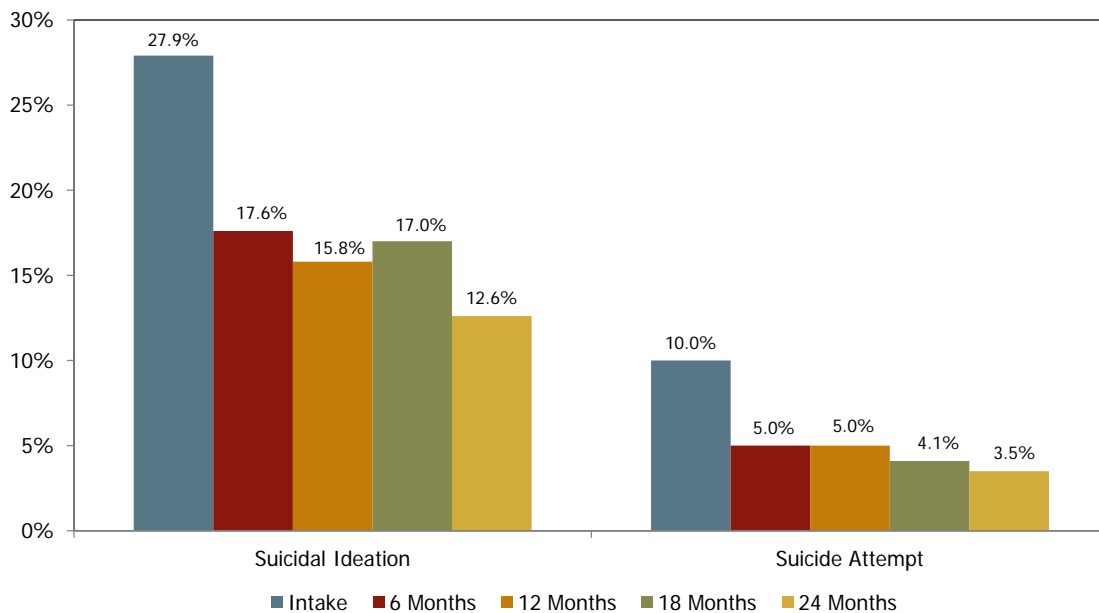
Caregiver Strain


The Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1998) is used at enrollment into the system of care to assess the stress felt by caregivers and again every 6 months up to 24 months to assess how caregivers are affected by the special demands associated with caring for a child with behavioral and emotional problems. More than one-fourth of caregivers (29.1 percent) reported significant reductions in global strain from intake to 6 months. After 12 months, 40.0 percent reported a reduction in strain, and this proportion increased further to 48.3 percent after 18 months and to 50.9 percent after 24 months.

Reduction in Suicidal Thoughts and Suicide Attempts

The percentage of children and youth who were reported by their caregivers to have expressed thoughts of suicide or who themselves reported that they had experienced these thoughts fell significantly over time. Exhibit 5 shows the percentage of children and youth who experienced these concerns in the 6 months prior to intake and then at 6-, 12-, 18-, and 24-month follow-up points.

Exhibit 5. Percentage of Children and Youth Experiencing Suicidal Ideation and Making a Suicide Attempt, Grantees Initially Funded in 2009–2010





Integrated Care: Behavioral Health, Primary Care, and Child-Serving Systems

CMHI-funded systems of care work closely with providers of primary care, education, child welfare, and juvenile justice to integrate care and ensure that children and youth receive the services that they need. Because the system of care approach promotes access to an array of services, many children and youth who enroll in systems of care to receive mental health services also receive the medical services that they need. Among children and youth who entered system of care services in grantees initially funded in FY 2009–2010 and who reported that they did not have a primary health care provider at intake, 46 percent were connected to one within the first 6 months. The percentage of these children and youth who had a routine physical examination in the previous 6 months rose from 37 percent before they entered services to 45 percent within 6 months.

Children in need of primary health care services were linked to these services and received care for recurring health problems. According to caregivers' reports at intake, 41.7 percent of children and youth had a recurring physical health problem such as asthma or diabetes, and 33.2 percent of these children and youth had seen their daily lives disrupted by these illnesses. At intake, the majority (70.9 percent) of children and youth were taking medication for at least one physical health problem, and 47.2 percent were taking medication for a behavioral health problem. These rates both increased somewhat, with 75.6 percent taking medication for a physical health problem and 47.4 percent for a behavioral health problem after 6 months.

Systems of care also contributed to a reduction in the use of costly emergency care by children, youth, and families. For example, in the 6 months prior to intake, families reported making an average of 0.45 visits to the emergency room for physical health problems. After entering systems of care, that number was reduced to 0.18. Inpatient hospitalization days were also reduced from 0.37 days per family to 0.19 days.

Efforts made by systems of care to link children and youth to services across systems provided integrated care that positively impacted their outcomes. For example, by coordinating services with the education system children and youth received the specialized educational support they needed for better academic performance. At intake, 44.0 percent of children and youth had an Individualized Education Plan (IEP) and more than one-half of the IEPs were provided primarily because of behavioral or emotional problems. Among children and youth who did not have an IEP at intake although their caregivers felt that they needed one, 75.2 percent were assessed for an IEP after 6 months.

Systems of care were also effective at coordinating services provided by the juvenile justice system. Among children and youth who had been referred to the system of care as a condition of a previous adjudicated offense, the rate of arrest in the previous 6 months dropped from 60.4 percent prior to entering services to 30.9 percent at 6 months after entering services.

Systems of Care Coordinate Services for Youth

Larry is a 15-year-old male who shows great promise despite his lifelong struggle with mental health and trauma related issues. During a short stay in detention, Larry was enrolled in the **Pennsylvania's System of Care Partnership's** High Fidelity Wraparound program, where he was assessed and referred to anger management classes as a condition of his release.

The need for anger management classes was written into Larry's treatment plan and, prior to his return home, the wraparound facilitator created a wraparound team that included his juvenile probation officer and two neighbors who volunteered to assist Larry's dad with his supervision in the community. Aside from providing ongoing therapy and support services for Larry, the wraparound facilitator and family support partner helped to enroll Larry in an online high school program to ensure that he graduates from high school. They also helped Larry's father access primary care services for his own medical concerns. The support provided by the High Fidelity Wraparound program has helped with Larry's smooth transition back to the community and will reduce the likelihood of his return to detention.

Larry and his dad were able to receive these services because **Pennsylvania's System of Care Partnership** has built a statewide network of care that provides high- quality services as part of the CMHI. Serving 13 counties statewide, the system of care has focused on building partnerships with the juvenile justice and child welfare systems so that young men like Larry can follow a positive trajectory despite their struggle with mental health problems. Moreover, the wraparound program uses family and community strengths to help young persons on the path to recovery.

Service Use by Children, Youth, and Families and Associated Costs

The most commonly received services within the first 6 months by children and youth receiving services from grantees initially funded in 2009 and 2010, were individual therapy (69.4 percent), case management (60.4 percent), assessment/evaluation (57.5 percent), and medication monitoring (49.4 percent). Of those caregivers and youth surveyed at 6 months after entering system of care services, 84.1 percent of caregivers and 86.3 percent of youth reported overall satisfaction with the services that they received.

Most caregivers (90.1 percent) reported that they were either likely or very likely to re-visit the program for services in the future, if needed. When asked if they would recommend the system of care program to others, 92.6 percent reported that they would.





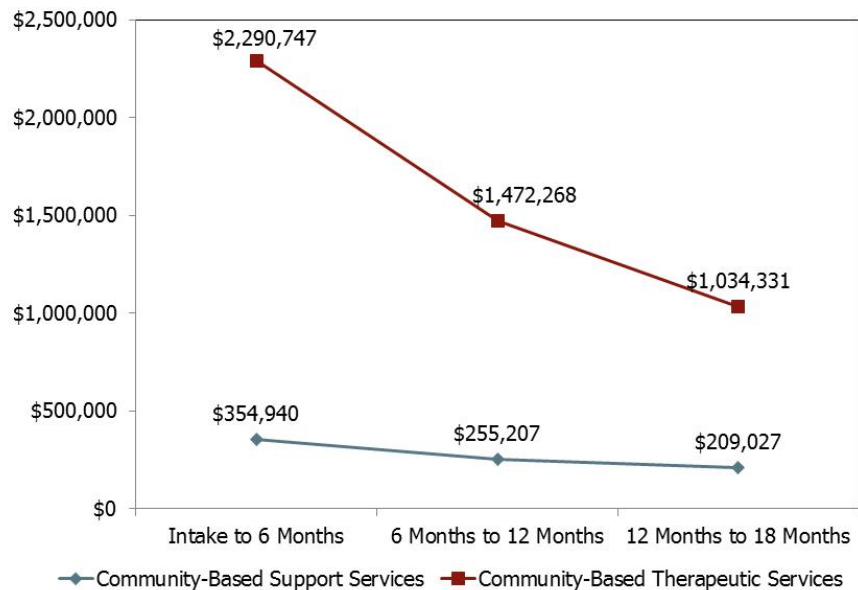
Based on data submitted by 14 CMHI-funded system of care grantees initially funded in 2009 and 2010, the total amount paid for therapeutic and support services was \$12,609,340, based on 129,191 service events with payment data, or 95.1 percent of all service events. The average total payment across all service sectors during this time period was \$4,115 per child or youth (median = \$1,368), or an average cost of \$159 per child or youth per month (median = \$52). Medicaid (68.9 percent) and the CMHI grant (15.3 percent) represented 84.2 percent of all payments, with the mental health, child welfare, and education agencies incurring 11.7 percent of payments.

The average number of days that children and youth receiving system of care services spent in inpatient hospital care decreased from 0.98 days in the 6 months prior to intake to 0.63 days in the 6 months prior to the 12-month follow-up, or by 0.35 days. When the average daily rate for these services is multiplied by the average number of days of inpatient psychiatric hospitalization of children and youth in a system of care between 6 months prior to intake and 12 months after intake, the average estimated total per-child inpatient hospitalization cost decreased from \$2,722.39 to \$1,750.11 over the year, representing a 35.7 percent reduction in average per-child inpatient hospitalization costs.

The average number of arrests was calculated using data collected from 835 youth 11 years of age and older who provided information at intake and at the 12-month follow-up. The average number of arrests

decreased from 0.38 in the 6 months prior to intake to 0.17 between 6 months and 12 months after intake. When the average 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 CMHI-funded system of care services was approximately \$2,204.76. This cost decreased to an average estimated cost per youth of \$986.34 between 6 months and 12 months after intake. This represents a 55.3 percent reduction in average per-youth costs, or \$1,218.42 less spent per youth.

Exhibit 6. Total Payments for Community-Based Support and Therapeutic Services from Intake to 18 Months between August 2010 and March 2015 in 14 Grantees Initially Funded in 2009–2010



(n = 857 children and youth; 54,718 service events)

Note: Analysis is limited to only those children and youth whose payment data were available across all three 6-month intervals.

Assessment of System-Level Change

The System of Care Assessment has three primary goals. First, it provides a description of each CMHS-funded system of care and assesses how well each grantee develops and implements services consistent with the system of care principles. Second, it documents how systems develop over time to meet the needs of the children, youth, and families at the service delivery level. Finally, it provides an assessment of how well services are being delivered and the degree to which the system has coordinated and collaborated with multiple child-serving agencies. To assess system of care development over time, three site visits are conducted over the funding period for the cooperative agreements. Visits occur every 18 to 24 months beginning in the second year of funding, to measure the amount of change over the life of the program.



From assessment point 1 to the third and final assessment point, independent evaluators, using information gathered from case reviews and interviews with youth, parents, and providers, rated system of care grantees initially funded in 2009 as improving in implementing their programs according to system of care principles across all nine areas assessed in the infrastructure domain (see Exhibit 7). Within the infrastructure domain, the principle of family-driven care consistently received the highest ratings from the first assessment point to the third and final assessment point. The greatest improvements over time were seen in the provision of community-based care, individualized services, and least restrictive care.

Grantees initially funded in 2009 also improved in implementing their programs according to system of care principles in seven of the nine areas assessed in the service delivery domain (see Exhibit 8). At the third assessment, grantees in this cohort received their highest ratings in the service delivery domain in implementing the principles of least restrictive and youth-guided care. The greatest improvements over time were in the principles of collaborative/coordinated, interagency, and youth-guided care.



Exhibit 7. Overall Infrastructure Ratings for System of Care Grantees Initially Funded in 2009, Assessment Points 1, 2, and 3

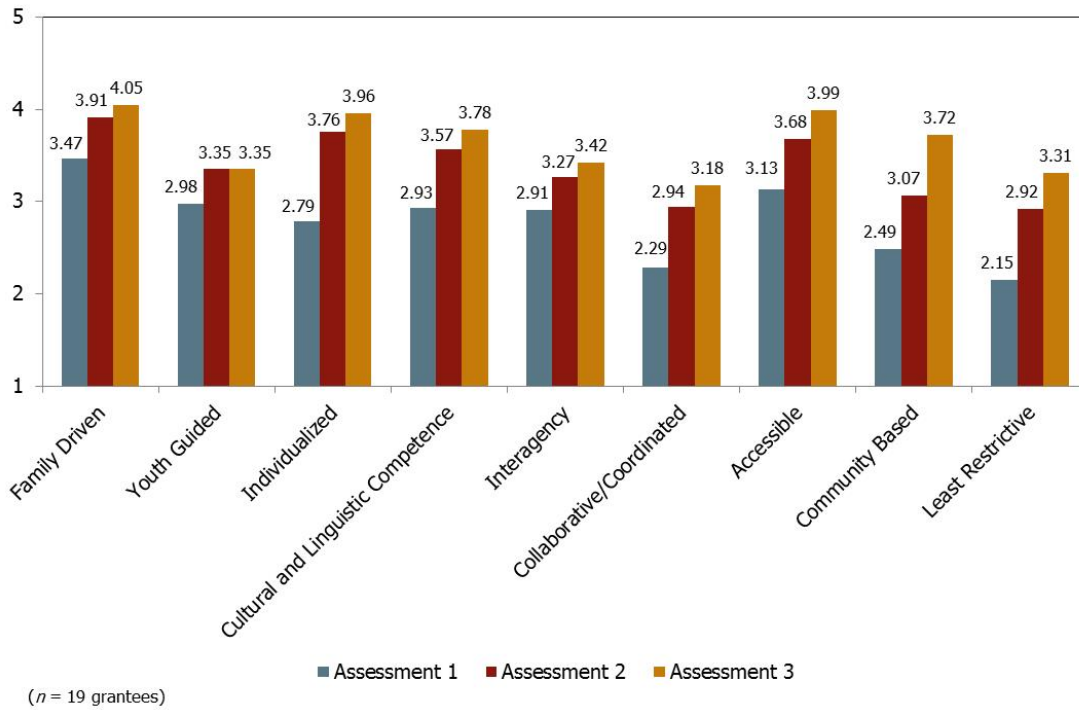
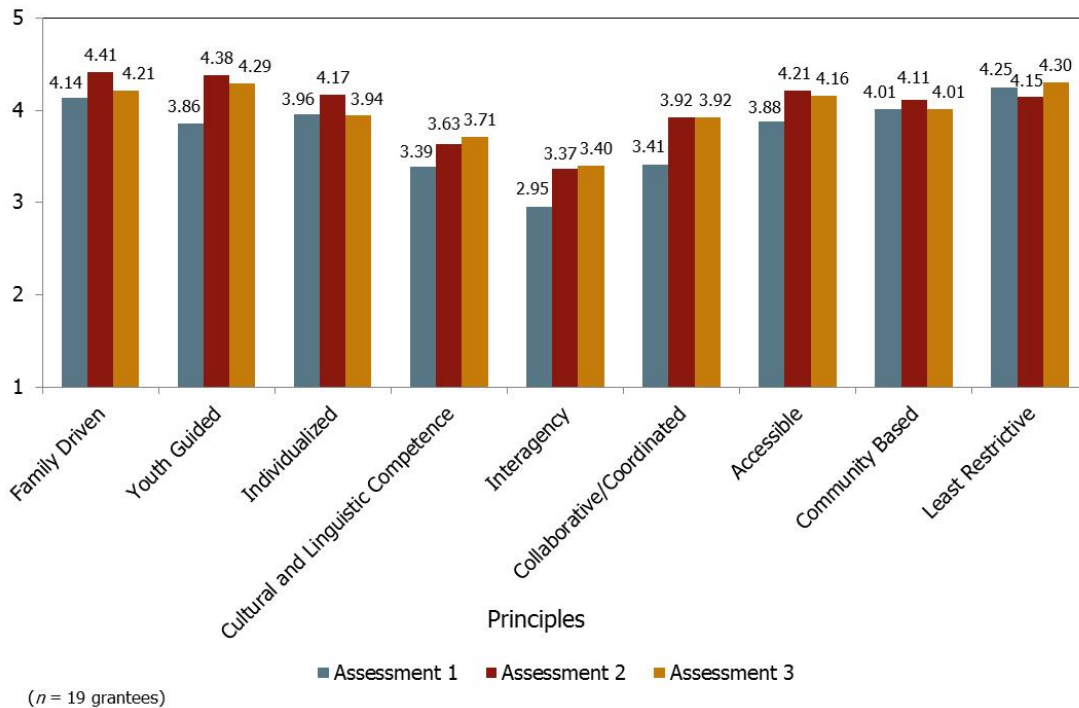


Exhibit 8. Overall Service Delivery Ratings for System of Care Grantees Initially Funded in 2009, Assessment Points 1, 2, and 3



National Evaluation of the Expansion and Sustainability of the Children’s Mental Health Initiative

Building on the success of the CMHI demonstration grants, SAMHSA took the initiative to transition the CMHI from an innovative community-based demonstration to a widescale expansion and integration of the system of care approach that aligns with SAMHSA’s Theory of Change. From FY 2011 to FY 2014, SAMHSA supported 50 one-year *Expansion Planning grants* that were specifically designed to help jurisdictions develop and complete a comprehensive short- and long-term strategic plan, with action steps, to improve, implement, expand and sustain systems of care across their jurisdiction. Following the *Expansion Planning grants*, from FY 2012 to FY 2015, SAMHSA awarded a total of 53 four-year *System of Care Expansion and Sustainability grants*. These agreements promote the expansion of system of care services and supports, including infrastructure development, strategic financial planning, and collaboration and partnership among child-serving systems (e.g., child welfare, education, juvenile justice, primary care, and substance abuse services and systems) so the system of care framework can be brought to scale and sustained after grant funding has ended.

Exhibit 9. Characteristics of Grantees

FY 2013 Grantees (n = 15)	
States/U.S. Territories	8
Tribes/Groups of Tribes	4
Counties/Groups of Counties	3
FY 2014 Grantees (n = 22)	
Statewide Jurisdictions	8
Tribes/Groups of Tribes	6
Counties/Groups of Counties	6
Cities	2

The national evaluation of the *Expansion and Sustainability grants* is designed to assess system of care expansion activities at the jurisdiction, local system, and child and family levels by 37 grantees funded in FY 2013 and FY 2014 (see Exhibit 9) and planning grants. The evaluation will comprise four core components or studies: Implementation, Network Analysis, Financial Mapping, and Child and Family Outcome Studies. Each study includes data collection activities at the jurisdiction, local system, and child and family levels.

The National Evaluation Team (NET) is conducting all jurisdiction and local system-level data collection activities directly with respondents. Child- and family-level data are collected by local service provider agencies. The NET will provide training and technical assistance regarding child and family outcome instruments added to a SAMHSA-based common data and performance tool and support local agencies in the collection of child and family outcome data. Through the seamlessly integrated common database tool and CMHI data collection mechanisms, the NET will receive de-identified client-level data from all implementation grantees. The NET obtained IRB and OMB approval to conduct and collect information from FY 2013–2014 grantees and data collection began in FY 2015, subsequent to OMB approval. Evaluation findings will be published in next year’s (2016) *Report to Congress*.

System of Care Integrates Care for Young Children in Massachusetts

The **Massachusetts Young Children’s Health Initiative for Learning and Development (MYCHILD)** was developed as a project of Massachusetts Partnership for Early Childhood Mental Health, which comprises the Massachusetts Executive Office of Health and Human Services, the Massachusetts Department of Public Health, and the Boston Public Health Commission. A critical challenge facing these partners in designing the program was the optimal locus of care given the aim of engaging families with very young children who might have difficulty recognizing or confronting mental health needs of infants, toddlers, and young children. The solution was to house services in the pediatric medical home—the primary care site where families are accustomed to bringing children for regular care, where they know the providers, and where the need for mental health care could be placed in a non-stigmatizing context. The **MYCHILD** initiative enhances the pediatric medical home by integrating a mental health clinician with special training in infant, toddler, and early childhood mental health care and a family partner into the primary care setting. They collaborate closely with the site’s pediatric primary care champion—an experienced pediatric provider who can “champion” integration, support the development of referral and consultation protocols, and facilitate knowledge sharing between primary care and mental health providers. Aside from the medical home setting, a unique feature of this model is the family partner role. The family partner is a paraprofessional or a parent or caregiver of a child with similar needs to those addressed by the program, who receives intensive training on and ongoing clinical supervision. The clinical-family partner team receives referrals from primary care clinicians at **MYCHILD** sites, and then works with each family to develop a personalized care plan that addresses both the child’s behavioral health needs and underlying needs of the family. The **MYCHILD** team works closely with primary care providers from the initial “warm hand-off” through discharge, assuring integration of pediatric physical and mental health care and increasing the capacity of the entire pediatric staff to address early childhood mental health.

While living at a shelter, Ella, a young woman in her 20s, spoke to her nurse practitioner about difficulty bonding with and caring for her premature and underweight infant. The nurse practitioner, who was also the primary care champion, referred Ella to **MYCHILD**. After initial trust building with Susan, her family partner, and Rebecca, the early-childhood mental health clinician, Ella disclosed that she had previously lost a child to Sudden Infant Death Syndrome (SIDS). The **MYCHILD** team met regularly with the nurse practitioner to discuss the physical and mental health needs of Ella and her baby. With a more complete picture of Ella’s circumstances, the **MYCHILD** team was able to collaborate and coordinate their approach with the shelter and the nurse practitioner. Susan used her own experience having lost a newborn to SIDS to connect with Ella and build a relationship based on their shared experience. Susan and Rebecca helped Ella to realize the importance of her own self-care. Through child-parent psychotherapy, Ella became more attuned to her newborn’s emotional and developmental needs. After about 6 weeks in **MYCHILD**, Ella was caring for herself enough to care for her baby, and began feeling a stronger mother-child bond. Ella’s baby gained weight, and Ella gained confidence in her parenting abilities. Nine months later, her baby was healthier and Ella enrolled in a professional training program. She is now a Certified Nursing Assistant with her own apartment. With help from the **MYCHILD** program, Ella gained the resources and abilities needed to confidently care for herself and her child, both now and in the future.

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