The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances

Evaluation Findings: Report to Congress 2012–2013

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Sylvia M. Burwell
Secretary

Substance Abuse and Mental Health Services Administration

Pamela S. Hyde, J.D.
Administrator

Center for Mental Health Services

Paolo del Vecchio, M.S.W.
Director

Division of Service and Systems Improvement

Gary M. Blau, Ph.D.
Acting Director

Child, Adolescent and Family Branch

Diane Sondheimer, MSN, MPH, CPNP
Acting Branch Chief

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Executive Summary

The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, also known as the Children's Mental Health Initiative (CMHI), is a cooperative agreement program administered by the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. CMHI was authorized by Public Law 102–321 and provides funds to public entities to promote recovery and resilience for children and youth who have a serious mental health disorder and their families. There are compelling reasons to focus on this age group. It is estimated that between 13 and 20 percent of children and youth have a diagnosable mental, emotional, or behavioral disorder, costing the public $247 billion annually (National Research Council and Institutes of Medicine, 2009; Perou et al., 2013). Because approximately one-half of all diagnosed mental health concerns found in adults started by age 14 and three fourths by age 24 (Kessler et al., 2005), there are major advantages to early identification, referral, and treatment of problems. Yet, among children and youth in need of mental health services, more than half do not receive adequate help (Merikengas et al., 2011).

CMHI funds are provided to states, local governments, U.S. territories, Indian tribes and tribal organizations, and other American Indian/Alaska Native communities. The funds are used to promote the transformation of the multiple systems—including mental health, primary care, education, child welfare, and juvenile justice—that serve children and youth aged 0–21 who have been diagnosed as having a serious emotional disturbance,[1] as well as their families. Grantees receive funding from SAMHSA to establish a comprehensive spectrum of mental health and other necessary services and supports organized into a coordinated network to meet the multiple and changing needs of these children and their families (Stroul & Friedman, 1994).

Children and youth[2] with serious mental health conditions face many challenges in their daily lives. They are at a greater risk for substance-related disorders (Hawkins, 2009; Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008; Wu et al., 2008) and encounters with the juvenile justice system (Cocozza, Skowyra, Burrell, Dollard, & Scales, 2008; Pullmann et al., 2006). Students with serious mental health conditions are more likely to fail classes, earn low grades, miss days of school, and have high dropout rates than students with other disabilities (Clark et al., 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research demonstrates poor long-term outcomes for these children and youth (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Due to the myriad challenges faced by families in acquiring needed services, children and youth are left at risk for difficulties in school, in the home, and/or in the community.

The system of care philosophy, on which the CMHI is based, incorporates the following eight principles, which state that services and supports 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.

The CMHI has seen a significant increase in funding since its inception in fiscal year (FY) 1993 from the initial funding of $4.9 million to $111 million in FY 2013, representing the award of 173 grants and cooperative agreements.

The legislation authorizing the CMHI mandates a national evaluation to describe, monitor, and chronicle its progress. The national evaluation consists of multiple studies designed to examine several aspects of the CMHI at different levels (see Appendix D, Description of Study Components, for descriptions of all national evaluation studies). These include descriptive, longitudinal, system-level, and services and costs studies, and studies of special populations. Descriptive data are collected at entry into services (i.e., intake) on all children and youth. Child, youth, and family service experience and outcomes data are collected at intake and every 6 months for up to 24 months. System-level data are collected in years 2 and 4 of program funding, and services and costs data are extracted from management information systems maintained by grantees.

The 2012–2013 Report to Congress describes the

- system of care approach used by the CMHI;
- implementation of the system of care philosophy;
- elements of the system of care approach that promote quality health care;
- characteristics, outcomes, and service experiences of the children, youth, and families receiving services through the CMHI, with a special focus on child welfare; early childhood; youth and young adults; dual diagnosis (mental health and substance use disorders); lesbian, gay, bisexual, transgendered, questioning, intersex, and two-spirit (LGBTQI2-S) individuals; and juvenile justice subgroups;
- outcomes for children and youth with and without health insurance coverage
- caregivers' and youths' assessment of system of care services and the level of system change.

The 2012–2013 Report to Congress presents analyses of outcomes for grantees initially funded from FY 2008 to FY 2010 to implement systems of care, which includes data for children, youth, and caregivers who received services through June 2013.

- Data for behavioral and functional outcomes are presented for children, youth, and caregivers from grantees initially funded in FY 2008 and FY 2009. Children and youth from sites initially funded in FY 2010 were not included because these sites had not completed any 18-month follow-up interviews.
- Descriptive and service experience data are presented for children, youth, and caregivers from all grantees.

A glossary of terms is included in Appendix C.

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

CMHI-funded system of care grantees initially funded in 2008–2010 serve a diverse group of children and youth,

including many who are typically underserved by the mental health system, with the following notable characteristics:

- CMHI children and youth were more likely to be male (59.2 percent compared to 49.2 percent nationally).
- Nearly all children and youth served in CMHI-funded grantees (91.3 percent) were in the custody of a parent or other relative; however, only 30.6 percent of all children and youth were in the legal custody of both biological (or adoptive) parents, as compared to 69.4 percent in the general U.S. population (U.S. Census Bureau, n.d.).
- More than one-half of the children and youth (61.4 percent) were living below the poverty level;[3] this percentage is nearly three times the national average of 21.9 percent for all children and youth aged 0–18 years in the general population (U.S. Census Bureau, 2011).
- 43.1 percent of children and youth were reported to have some sort of chronic health condition, such as allergies, asthma, or migraine headaches.

Caregivers reported that, in the 6 months prior to intake,

- 70.8 percent of children and youth had lived with someone who had a mental health problem,
- 58.3 percent had a biological family member who had a substance use problem,
- 42.1 percent had been exposed to domestic violence,
- 35.5 percent lived in a household where someone had been convicted of a crime.

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

- Mood disorders (37.8 percent).
- Attention-deficit/hyperactivity disorder (32.6 percent).
- Oppositional defiant disorder (17.6 percent).
- Adjustment disorders (15.3 percent).
- Posttraumatic stress disorder/acute stress disorder (9.7 percent).
- Disruptive behavior disorder (8.8 percent).

Outcomes of Children, Youth, and Families

Children, youth, and their families were assessed at intake into CMHI-funded system of care services and at 6-month intervals for a period of up to 24 months. Among the improvements found in the lives of children, youth, and families:

- After 6 months in services, 28.4 percent of children and youth showed a significant reduction in their overall symptoms. This proportion rose to 33.2 percent at 12 months, and to 40.1 percent by 18 months after intake.[4]
- The percentage of children and youth who had thoughts of suicide fell from 18.6 percent prior to intake to 11.4 percent after 18 months, a reduction of 38.7 percent over their baseline assessment at intake.[5]
- School suspension or expulsion fell from 33.1 percent at intake to 18.9 percent at 18 months, a reduction of 42.9 percent over baseline.[6]
- The percentage of children and youth who lived in multiple places over the previous 6 months decreased from 21.4 percent prior to intake to 13.9 percent by 18 months.[7]
- The percentage of youth who engaged in unlawful behavior fell from 66.5 percent in the 6 months prior to intake to 41.5 percent at 18 months after intake.

Similarly, arrest rates fell from 15.0 percent at intake to 9.5 percent at 18 months after intake.

- From intake to 6 months, 30.0 percent of caregivers reported a significant reduction in global strain. By 12 months, this proportion had increased to 35.8 percent, and by 18 months, the percentage had increased further to 41.6 percent.[8]
- Caregivers who were employed at intake (48.7 percent) reported missing an average of 4 days of work in the previous 6 months due to their child's behavioral or emotional problems. At 18 months, the number of days of work lost in the previous 6 months due to the child's behavioral or emotional problems decreased to 1.8 days.[9]

Outcomes of Children and Youth with and without Insurance Coverage at Intake

The majority of children and youth (89.5 percent) in the Longitudinal Child and Family Outcome Study were enrolled in a publicly funded health insurance program such as Medicaid or were covered by private insurance. Additionally, some services were paid for by Supplemental Security Income (SSI) or by Temporary Aid to Needy Families (TANF). Of these children and youth, 81.5 percent were covered by Medicaid, 13.4 percent were covered by private insurance, 11.1 percent by SSI, 5.5 percent by TANF, and 5.0 percent by the Children's Health Insurance Program (CHIP).[10]

Children and youth who had no health insurance coverage at intake showed a similar rate of improvement to those who had coverage. It is likely that systems of care assisted families in accessing health insurance and other resources and in particular children and youth who did not have access to health insurance and mental health services and supports. Among children and youth who entered systems of care without health care coverage, 27.1 percent showed significant improvement in their overall behavioral and emotional symptoms within the first 6 months after intake. After 12 months, 30.5 percent of this group showed significant improvement. For children and youth who had health care coverage, 30.3 percent showed significant improvement after 6 months, while 36.1 percent showed significant improvement after 12 months.

Outcomes for Special Populations

Because of poor outcomes often associated with children and youth in particularly vulnerable populations, special analyses were conducted to determine outcomes related to children and youth served by child welfare, juvenile justice, and early childhood programs; youth and young adults aged 14–21 years; those who experienced symptoms of both mental health and substance use problems; and who identified as LGBTQI2-S.

Children and youth in these vulnerable populations served by the grantees funded in 2008–2010 showed improvement in symptoms after receiving CMHI-funded services for 6 months. The percentage of children and youth who showed significant improvement in behavior and emotional symptoms was as follows: children served by early childhood programs (37.4 percent), children and youth involved in the child welfare (28.5 percent) and juvenile justice (26.5 percent) systems, youth and young adults (23.4 percent), youth who identified as LGBTQI2-S (29.3 percent), and youth experiencing dual conditions (mental health and substance use problems) (16.2 percent).

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

Systems of care expanded the availability of effective supports and services to children, youth, and families. Ninety-two percent of caregivers reported that their child received at least one type of service during the first 6 months in system of care services. On average, children and families received about five different types of services in the 6 months before intake (mean = 5.3, *SD* = 2.76). At 6 months after intake, children and families received nearly six different types of services (mean = 5.7, *SD* = 3.08) and more than five different types of services during the 12 months following intake (mean = 5.3, *SD* = 3.00). By 18 months after intake, families received fewer than five different types of services (mean = 4.8, *SD* = 2.82). The number of different types of services received tended to decrease over time after enrollment into systems of care.[11]

The most frequently used services and supports in the first 6 months of services were individual therapy (72.2 percent), case management (55.9 percent), assessment or evaluation (52.0 percent), medication monitoring services (51.4 percent), and school-based services (47.7 percent).

Special analyses of costs of services provided (not including the costs of prescription medications) between April 2009 and June 2013 were conducted by 10 grantees. During this period, 58,007 community-based support and community-based therapeutic services were delivered to 883 children and youth. The estimated average monthly cost per child or youth was $718, with a median monthly cost of $198. Medicaid, the major payer for services, paid for 36.9 percent of total payments to providers.

Systems of care contributed to a reduction in the amount spent on inpatient hospitalization and juvenile justice services. Total payments across all grantees decreased by 34.9 percent between the first 6 months and the second 6 months after intake, from $2,121,321 to $1,379,956. The average estimated inpatient hospitalization costs per child decreased from $4,631 in the 6 months prior to intake to $2,735 between 6 and 12 months after intake. This represents a 40.9 percent reduction in average inpatient hospitalization costs per child, and an overall savings of $1,579,368. Similarly, an estimated reduction of $1,057, on average, per youth aged 11 and older was achieved in relation to arrests during their first 12 months in services.

Caregiver and Youth Assessments of the Effectiveness of Systems of Care

The legislation authorizing CMHI mandates an assessment of the views of caregiver and youth with regard to the effectiveness of systems of care. Caregivers as well as youth and young adults (aged 11 years and older) served by grantees initially funded in 2008–2010 were asked to respond to questions about their service experience and satisfaction with services. Overall satisfaction with services was high among caregivers and youth after 6 months of services. Results showed that 80.3 percent of caregivers and 85.4 percent of youth reported overall satisfaction with services.

System Change

CMHI-funded grantees are expected to implement and sustain improvement in their infrastructure and service delivery domains in accordance with system of care principles (see page i above and Appendix E for a list of principles). Site visits are conducted every 18 to 24 months over the funding

period for the cooperative agreements, beginning in the second year of funding. Grantees initially funded in 2008 showed the most improvement from the first to the second assessment in implementing the principle of individualized care within the infrastructure domain. Activities in the infrastructure domain that are used to implement the provision of individualized care include having and using flexible funds to support the provision of services to meet the unique needs of children, youth, and families; training program staff, partner agency staff, and private providers on the concept of individualized care; developing a complete array of services in the community such that key service options are not missing; and collecting information on the extent to which services are provided in an individualized manner across the service array, and on child and youth outcomes.

Grantees also improved in implementing their programs according to system of care principles in eight of nine areas assessed in the service delivery domain, and received overall higher ratings in the service delivery domain than in the infrastructure domain. The principle of providing youth-guided care received the highest rating at the second assessment. This cohort of grantees showed the most improvement within the service delivery domain from the first to the second assessment in the principle of cultural and linguistic competence.

Summary

Results from the national evaluation of the CMHI indicate that children, youth, and families made substantial gains in several areas. Data from the national evaluation demonstrate that funded systems of care

- reach many children and youth typically underserved by the mental health system;
- improve behavioral and emotional health outcomes for children and youth;
- enhance family outcomes such as reduced caregiver strain and increased employment;
- expand the availability of effective supports and services;
- save money by reducing expenditures on residential treatment, inpatient hospitalization, and juvenile justice services;
- continue to implement and maintain fidelity to the system of care principles;
- promote satisfaction through the use of evidence-based treatments.

As in any system improvement effort, and particularly during times of fiscal austerity, CMHI-funded grantees face many challenges in sustaining their efforts to effectively serve children and youth with serious mental health conditions and their families, and effecting broad system-level changes after federal funding ends. Such challenges include building a culturally and linguistically competent workforce; promoting cross-agency collaboration to serve the needs of children, youth, and families; developing and sustaining an efficient structure for collaboration among multiple agencies; and implementing multiple strategies for sustaining systems of care and their services over time. Despite these challenges, CMHI-funded grantees continue to demonstrate significant improvements that promote quality care and positive outcomes for children, youth, and their families.

Introduction

The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, also known as the Children's Mental Health Initiative (CMHI), is a cooperative agreement program administered by the Child, Adolescent and Family Branch (CAFB) in the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services. CMHI was authorized by Public Law 102–321 and provides funds to public entities to promote recovery and resilience for children and youth who have a serious mental health disorder and their families. There are compelling reasons to focus on this age group. It is estimated that between 13 and 20 percent of children and youth have a diagnosable mental, emotional, or behavioral disorder, costing the public $247 billion annually (National Research Council and Institutes of Medicine, 2009; Perou et al., 2013). Because approximately one-half of all diagnosed mental health concerns found in adults started by age 14 and three fourths by age 24 (Kessler et al., 2005), there are major advantages to early identification, referral, and treatment of problems. Yet, among children and youth in need of mental health services, more than half do not receive adequate help (Merikengas et al., 2011).

CMHI funds are provided to states, local governments, U.S. territories, Indian tribes and tribal organizations, and other American Indian/Alaska Native communities. The funds are used to promote the transformation of the multiple systems—including mental health, primary care, education, child welfare, and juvenile justice—that serve children and youth aged 0–21 who have been diagnosed as having a serious emotional disturbance,[12] as well as their families. Grantees receive funding from SAMHSA to establish a comprehensive spectrum of mental health and other necessary services and supports organized into a coordinated network to meet the multiple and changing needs of these children and their families (Stroul & Friedman, 1994).

Children and youth with serious mental health conditions face many challenges in their daily lives. They are at a greater risk for substance-related disorders (Hawkins, 2009; Manteuffel, Stephens, Brashears, Krivelyova, & Fisher, 2008; Wu et al., 2008) and encounters with the juvenile justice system (Cocozza, Skowyra, Burrell, Dollard, & Scales, 2008; Pullmann et al., 2006). Students with serious mental health conditions are more likely to fail classes, earn low grades, miss days of school, and have higher dropout rates than are students with other disabilities (Clark et al., 2008; Epstein, Nelson, Trout, & Mooney, 2005; Wagner & Cameto, 2004). Research demonstrates poor long-term outcomes for these children and youth (Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). Due to the myriad challenges faced by families in acquiring needed services, children and youth are left at risk for difficulties in school, in the home, and/or in the community.

The Patient Protection and Affordable Care Act passed in 2010 now allows uninsured children and youth to access a comprehensive array of behavioral health services and supports that were not previously available to them and their families. The Affordable Care Act makes provisions for an additional 41 million Americans, including roughly 20 million

children living in situations that make it difficult to obtain insurance coverage (McMorrow, Kenney & Coyer, 2011). The data collected through the CMHI national evaluation provide an opportunity to examine the extent to which children with serious mental health conditions have access to health services—a topic that is particularly relevant to the implementation of the Affordable Care Act. Data from this report show that from 2009 to 2013, 10.5 percent of children and youth who received system of care services did not have health insurance coverage when they entered services.

Beginning in 2014, the Affordable Care Act requires that new health insurance policies sold through state health exchanges include coverage for mental health and substance use disorders and that these benefits are at parity with medical benefits. Also in 2014, insurers will no longer be able to deny coverage because of a pre-existing behavioral health condition. Access to behavioral health services for children and youth with serious mental health conditions—including those receiving system of care services—will likely be enhanced in states which choose to expand Medicaid coverage. The Affordable Care Act (section 2703) also provides states with the option to enhance their Medicaid program through the development of *Health Homes* that are designed to provide primary health care services and comprehensive care management for individuals with mental health and substance use disorders, as part of a coordinated network of services. The CMHI-funded system of care approach includes similar provisions for coordinating services for children, youth, and families across fragmented systems. Because the system of care philosophy aligns well with the "patient-centered medical option" under the Affordable Care Act, there is the potential for the system of care approach to be used as a model for designing medical homes and making services more readily accessible for children, youth, and families.

System of Care Philosophy and Goals

The CMHI was shaped by several federal and state initiatives, beginning in 1984 with the Child and Adolescent Service System Program (CASSP). CASSP was a national effort designed to help states and communities build comprehensive, community-based systems of care that were youth guided and family focused. This approach has since become a cornerstone of many mental health service delivery programs within communities across the country. More recently, the National Conference on Mental Health was launched with the aim of increasing access to behavioral health services and reducing the discrimination that can occur for people who have mental health disorders. The National Conference, sponsored by the White House, was held on June 3, 2013, and builds upon the Affordable Care Act with its aim of expanding mental health coverage for millions of Americans, including the allocation of $130 million of the President's fiscal year (FY) 2014 budget toward improving mental health outcomes for young people.

The system of care philosophy is grounded in the belief that services should be both comprehensive and coordinated across all child-serving entities. The eight principles that guide the implementation of systems of care state that all services provided 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.

In order to put these guiding principles into action, the goals of the CMHI include the following objectives:

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

The CMHI is particularly aligned with two of SAMHSA's strategic initiatives as outlined in *Leading Change: A Plan for SAMHSA's Roles and Actions 2011–2014* (SAMHSA, 2011; see Appendix A), the Trauma and Justice Initiative and the Recovery Support Initiative.

SAMHSA Strategic Initiative on Trauma and Justice

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

SAMHSA Strategic Initiative on Recovery Support

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

This *2012–2013 Report to Congress* provides an overview of the CMHI program and its national evaluation, and reports on the outcomes of children, youth, and families served. The report also describes the children, youth, and families served by the funded grantees, and highlights outcomes for children with and without health insurance coverage as well as outcomes for children and youth in particularly vulnerable groups. The report discusses service use and costs as well as information regarding system effectiveness and change from the perspective of children, youth, and families. The report concludes with a summary and recommendations for the future.

Characteristics of Grantees Receiving CMHI Funding

The extensive network of system of care grantees provides a foundation from which to develop and refine emerging strategies to improve the lives of children and youth with serious mental health conditions and their families. CMHI-funded grantees also offer opportunities to learn about the costs associated with receiving behavioral health services. Finally, the evaluation of these grantees has provided a resource to identify service practices that are best suited to meet the unique needs of children, youth, and families. A complete list of all grantees funded by the CMHI is provided in Appendix B.

CMHI funding recipients are characterized by different populations of focus, representing diversity in age, race, ethnicity, and language, and groups that are underserved and especially vulnerable. Some grantees, such as Kent County, Michigan, and Orange County, Florida, serve the general population of children aged 0–21 years, while other grantees have used their funds to expand services to a more narrow age range. For example, Durham, North Carolina, serves youth and young adults aged 16–21 years, while Guam and Massachusetts serve children aged 0–5 years. Other grantees focus specifically on the mental health needs of children and youth with a specific service need (e.g., at risk for homelessness or out-of-home placement, involvement with child welfare, or with co-occurring mental health and substance use disorders). The system of care in Honolulu, Hawaii, for example, serves girls aged 11–18 years who are involved in the juvenile justice system.

CMHI-funded grantees focus on providing culturally and linguistically appropriate services to historically underserved populations such as African-Americans; American Indians/Alaska Natives; Hispanics/Latinos; individuals who identify as lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2-S); and recent immigrant populations that have been displaced by war or natural disaster. Some of the languages spoken within the CMHI-funded grantees include Cambodian, Creole, Cantonese, French, Hmong, Portuguese, Russian, Spanish, Tagalog, Thai, Vietnamese, and a variety of languages spoken within American Indian and Alaska Native communities.

The CMHI-funded system of care grantees are located across the country and vary in size and population density. The largest service areas include territories such as Guam and Puerto Rico, and states such as Oklahoma and Delaware. Some CMHI recipients are state-level agencies that have made efforts to develop systems of care in multiple service areas across their state or the state as a whole. States such as Mississippi and Kentucky have focused on developing statewide implementation of systems of care. Other CMHI recipients are county or city agencies that serve large urban areas such as Boston, Massachusetts; Miami-Dade County, Florida; Baltimore, Maryland; and Hamilton County (Cincinnati), Ohio. Rural communities in southeastern Illinois and southeastern Indiana have also benefitted from CMHI funding. Multnomah County (Portland), Oregon; Muscogee (Creek) Nation; and San Francisco, California, serve American Indian/Alaska Native children, youth, and families who live in those urban areas.

The National Evaluation of the CMHI

Authorizing Legislation

The national evaluation of the Children's Mental Health Initiative (CMHI) is mandated by Public Law 102–321, Section 565 of the Public Health Service Act to describe, monitor, and chronicle the progress of the program (see text box). The purpose of the national evaluation is to assess outcomes for children and youth and their families from the grantees that receive funding under the initiative. In addition, the evaluation also provides an opportunity to share recommendations for administrative and legislative initiatives as the Secretary of the U.S. Department of Health and Human Services determines to be appropriate. Information is also provided on the implementation of existing systems of care and evaluation results have often been instrumental in identifying critical and emerging issues in children's mental health. In the past, findings from the national evaluation have informed treatment planning, service delivery and program funding decisions, and have resulted in modifications to U.S. mental health policies related to children and youth.[13]

Authorizing Legislation of the National Evaluation of the CMHI

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

Since the initial authorization of the CMHI in 1992, the initiative has remained one of the most comprehensive efforts at promoting broad-level, transformational changes to the mental health care system, specifically for children and youth diagnosed as having serious mental health conditions, as well as for the families of these children and youth. From the beginning of the initiative to FY 2000, CMHI funds were provided through a grant mechanism, and since then funds have been awarded to grantees through cooperative agreements. CMHI has seen a significant increase in funding since its inception in fiscal year FY 1993 from the initial funding of $4.9 million to $111 million in FY 2013, representing the award of 173 grants and cooperative agreements. To date, funding has been provided to support grantees in 50 states, the District of Columbia, Puerto Rico, Guam, and 21 federally recognized tribal communities. As required in the authorizing legislation, funding of CMHI grantees is allocated according to a local–federal match over the life of the funding period, which is 6 years. During the first 3 years, the proportion of match is $3 of federal funding for every $1 of local funding. In the fourth year, the match proportion is dollar for dollar. During the fifth and sixth years, the federal contribution is $1 for every $2 in local funds. To date, more than 103,000 children and their families have been served by CMHI-funded systems of care.

Table 1 describes the data collection schedule for the national evaluation.

Table 1. National Evaluation Data Collection Schedule[a]

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

[a] X's represent the years in which grantees participate in the national evaluation. Shaded cells indicate the years represented in this report.
[b] The evaluation was funded to be conducted during years 2–5 of program funding.

Design and Methods of the National Evaluation

The *2012–2013 Report to Congress* presents noteworthy findings regarding 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 change. Findings from the national evaluation of the 58 grantees providing system of care services to children, youth, and families between 2008 and 2013 are reported. Each grantee is funded for a 6-year period, with continuous enrollment of children, youth, and families into services and into the evaluation after the first year, which is dedicated to planning. For the national evaluation, enrollment into the Longitudinal Child and Family Outcome Study continues only through the fifth year to ensure that follow-up interviews can be conducted before funding ends.

A glossary of terms is included in Appendix C. The national evaluation studies that were used for data analyses are described in Appendix D. Most findings are from interviews with caregivers of children and youth.[14] Caregivers reported information about their children's and their families' experiences in systems of care. Where feasible, youth aged 11 and older responded for themselves. Many findings are based on interviews conducted at 6-month intervals (i.e., at intake and at 6, 12, 18, and 24 months after intake).[15] Data are also derived from intake records and from interviews with grantee staff. In cases where a child or youth was receiving extended services from an institutional setting, such as a correctional setting or inpatient medical center, a staff member who had frequent contact with the child or youth provided information. Denominators for the analyses may vary, because not all respondents completed all interview items. Findings based only on intake data are noted in the text, tables, and figures.

Grantees generally begin collecting data 1 year after their initial funding. Data included in this report were collected from March 1, 2009, when the first grantees funded in FY 2008 began collecting data, to June 11, 2013, when data for this report were downloaded for analysis. Data are included for grantees initially funded in 2008 through 2010.

Descriptive and longitudinal data are provided in this report on all children and youth who received services during the period of 2008 through June 2013. Descriptive data were collected from intake records of 12,951 children and youth enrolled in grantees initially funded from FY 2008 through FY 2010. Longitudinal outcomes data were collected from a subset of 4,397 caregivers and 2,589 youth aged 11 and older who received services from grantees funded in FY 2008 and FY 2009.

The instruments used to collect data are described in Appendix E. This report includes data from the following sources:

- Descriptive data (e.g., demographic information, diagnosis, exposure to risk factors, child and family history, and functional characteristics) for each child and youth when they entered system of care services.
- Longitudinal child, youth, and family outcomes data based on a subset of children and youth who were assessed at intake and at 6-month intervals up to 18 months. Data collected at these intervals focus on several aspects of the child's or youth's clinical and social functioning, behavioral and emotional strengths, educational performance, engagement with law enforcement, juvenile justice outcomes, use of substances, and the stability of their living arrangements. Data were also collected on the strain felt by caregivers when caring for children and youth who experience serious mental health conditions.
- Data related to the provision of services; the experience children, youth, and families have with their service providers and the services they receive; the cultural and linguistic competence of service delivery; and satisfaction with services.
- Data related to the experiences of vulnerable populations of children and youth: those involved in the child welfare or juvenile justice systems; youth and young adults aged 14–21 years; very young children (early childhood); lesbian, gay, bisexual, transgender, questioning, intersex, and two-spirit (LGBTQI2-S) youth; and youth who experienced co-occurring mental health and substance use conditions.
- Data related to the cost of services that were collected by service providers and made available to the national evaluation.
- Data related to system change activities collected through two assessments of 16 grantees funded in 2008 and one assessment of 20 grantees funded in 2009. Assessments were conducted every 18–24 months beginning in the second year of funding.

Appendix F provides a description of the methods used to conduct the analyses in this report. Summary data collected from children and youth who received services in grantees initially funded in 2008–2010 can be found in Appendix G. Findings that are statistically significant within the text of this report are indicated by a footnote.

In addition to these activities, the national evaluation also produces The *Continuous Quality Improvement (CQI) Progress Report* (see Appendix H), a report unique to each individual grantee designed to share current performance data in five domains: (1) system-level outcomes, (2) child and family outcomes, (3) satisfaction with services, (4) family and youth involvement, and (5) cultural and linguistic competence. This report supports each grantee in conducting its own assessments so that it can make data-driven decisions to assist in improving the quality of their program.

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

Demographics

The demographic characteristics of children and youth at intake into services in CMHI-funded systems of care differed from those of the general population in the U.S. (see Table 2).[16] In comparison to the national population, children and youth were more likely to be male (59.2 percent in CMHI grantees compared to 49.2 percent of the general population in the U.S.). The CMHI also has been successful in providing high-quality services and supports to some populations where health disparities exist. For example, the CMHI population has greater proportions of children and youth who are American Indian or Alaska Native, Black or African-American, Native Hawaiian or Pacific Islander, and multi-racial than are reported in the general U.S. population. Appendix G provides percentages and sample sizes for additional items.

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

	CMHI Grantees Funded 2008–2010	U.S. Population 2010
Gender	***n* = 12,741**	
Male	59.2%	49.2%
Female	40.0%	50.8%
Other	0.6%	***
Age	***n* = 12,543**	
0–5 Years	25.9%	25.2%
6–11 Years	19.7%	25.5%
12–15 Years	26.5%	17.3%
16–21 Years	27.9%	32.1%

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

	CMHI Grantees Funded 2008–2010	U.S. Population 2010
Race/ Ethnicity	***n* = 12,309**	
American Indian or Alaska Native	7.8%	0.9%
Asian	0.9%	4.5%
Black or African-American	22.3%	14.2%
Native Hawaiian or Pacific Islander	0.9%	0.2%
White	47.0%	54.5%
Hispanic/ Latino	15.0%	22.4%
Two or More Races	6.1%	3.3%

Nearly all children and youth served in CMHI-funded grantees (91.3 percent) were in the custody of a parent (biological or adaptive) or other relative. However, only 30.6 percent were in the legal custody of both biological parents, as compared to 69.4 percent in the U.S. population,[17] 42.3 percent were in the care of their biological mothers only, and 4.0 percent were in the custody of their biological fathers only. Of the 23.1 percent of children and youth not in the custody of their biological parents, most were in the custody of other family members (e.g., grandparents, siblings), adoptive parents, or friends, or were wards of the state. More than three-fifths of the children and youth (61.4 percent) were living below the federal poverty level,[18] compared to 21.8 percent of children and youth nationally (U.S. Census Bureau, 2013c). Nearly half of the caregivers (49.3 percent) reported that

they had been employed during the 6 months prior to their child's intake into services[19] (see Table 3).

Table 3. Custody, Family Poverty, and Employment Status at Intake, Grantees Initially Funded in 2008-2010

Custody Status at Intake (*n* = 3,621)	(*n* = 3,621)
Two Biological/Adoptive Parents or One Biological Parent and One Step or Adoptive Parent	30.6%
Biological Mother	42.3%
Biological Father	4.0%
Grandparent(s)	7.5%
Aunt and/or Uncle	1.9%
Sibling(s)	0.2%
Ward of the State	5.9%
Adult Friend	0.1%
Other[a]	2.7%
Family Poverty Status Prior to Intake	**(*n* = 3,359)**
Below Poverty Threshold	61.4%
At or Near Poverty Threshold (101–150% of Poverty Threshold)	13.0%
Above Poverty Threshold (150% of Poverty Threshold and Above)	25.6%
Employment Status in the 6 Months Prior to Intake	**(*n* = 3,584)**
Caregiver Employed	49.3%

[a] "Other" includes children and youth who were in the custody of other relatives, including cousins and great-grandparents, those in legal custody of foster parents or other court-assigned guardians, and those who were in joint custody of two or more of these options.

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

According to caregivers, in the 6 months prior to intake, 42.1 percent of children and youth had been exposed to domestic violence, and 35.5 percent lived in a household where someone had been convicted of a crime. Caregivers also reported that 70.8 percent had lived with someone who had a mental health problem, and 58.3 percent had a family member who had a substance use problem.

Referrals to CMHI-Funded System of Care Services

Approximately one-third (30.8 percent) of the referrals to CMHI-funded systems of care were made by mental health agencies. Other sources of referrals included caregivers or youth as self-referrals (14.5 percent), schools (11.3 percent), the child welfare system and family courts (12.7 percent), and the juvenile justice system (6.8 percent). A growing number of referrals (4.5 percent) came from general medical providers such as primary care physicians.

School Attendance

Most children and youth (80.5 percent) who entered system of care services were in school or preschool in the 6 months before intake. Of these children and youth, most (80.0 percent) attended school regularly, defined as attendance at least 80 percent of scheduled school days.

Mental Health Status of Children and Youth at Intake

Presenting Problems

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

At intake into services the most common diagnoses given from the DSM-IV-TR were mood disorders (37.8 percent) and attention-

deficit/hyperactivity disorder (32.6 percent). About a sixth of the children and youth were diagnosed with oppositional defiant (17.6 percent) and adjustment (15.3 percent) disorders. Other diagnoses included posttraumatic stress disorder and acute stress disorder (9.7 percent), disruptive behavior disorder (8.8 percent), and other anxiety disorders (8.4 percent).

Substance Use

Caregivers reported that nearly 1 in 8 children and youth (12.1 percent) had experienced a problem with drugs or alcohol in the 6 months prior to intake.

Health Status of Children and Youth at Intake

In addition to behavioral and emotional symptoms, many children and youth had chronic medical problems affecting their daily lives. Caregivers were asked to describe their child's recurring health problems (such as allergies, asthma, migraine headaches, and epilepsy) if any were present. Among all children and youth with intake data on health issues in the Longitudinal Outcome Study, 43.1 percent were reported to have some sort of chronic health condition. This rate remained fairly consistent across all time points. The most frequently reported health problems were allergies (20.8 percent), asthma (17.8 percent), and migraine headaches (6.2 percent) (see Table 4).

Table 4. Percentage of Children and Youth with a Recurring Health Problem at Intake, Grantees Initially Funded in 2008-2010[a]

Health Problem	%
Allergies	20.8%
Asthma	17.8%
Migraine Headaches	6.2%
Overweight	2.5%
Neurological Disorders/Epilepsy	1.7%
One or More Recurring Health Problems	43.1%

(*n* = 5,935)

[a] Percentages do not sum to 100 percent, due to some children and youth experiencing more than one health problem.

Summary

- CMHI children and youth were more likely to be male (59.2 percent compared to 49.2 percent nationally).
- Nearly all children and youth served by CMHI grantees (91.3 percent) were in the custody of a parent or other relative.
- Only 30.6 percent of all children and youth were in the legal custody of both biological (or adoptive) parents, as compared to 69.4 percent in the general U.S. population.
- More than one-half of the children and youth (61.4 percent) were living below the federal poverty level, compared to 21.8 percent of children in the U.S. population.
- Six months prior to entering services, 70.8 percent of children and youth had lived with someone who had a mental health problem, 42.1 percent had been exposed to domestic violence, and 35.5 percent lived in a household where someone had been convicted of a crime.
- More than one-third (37.8 percent) of children and youth were diagnosed with mood disorders, 32.6 percent with attention-deficit/hyperactivity disorder, 17.6 percent with oppositional defiant disorder, 9.7 percent with posttraumatic stress disorder/acute stress disorder, and 8.8 percent with disruptive behavior disorder. Additionally, 12.1 percent of children and youth were reported to have experienced a problem with drugs and alcohol in the 6 months prior to intake.
- In addition to mental health concerns, 43.1 percent of children and youth had one or more chronic health problem, such as allergies, asthma, or migraine headaches.

Outcomes of Children, Youth, and Families

Systems of care transform child-serving systems, which serve children and youth, and allow families to more easily access services. These services are directed at helping children and youth recover from serious mental health concerns and function better in school, at home, and in the community. This section details several improvements made by children, youth, and families who participated in system of care services. Outcomes are reported for children, youth, and caregivers who received services from grantees initially funded in 2008–2009 who had completed intake and follow-up assessments at 6, 12, and 18 months after intake. Attrition analyses showed that the group of children, youth, and caregivers who provided data for the evaluation at all four time periods did not differ significantly at intake from those who did not. Children, youth and caregivers who had complete data were more likely to have an Individualized Education Plan (IEP) in place at intake[20] and to receive special education services.[21] They were also less likely to have been arrested in the 6 months prior to intake.[22]

Mental Health Outcomes of Children and Youth

Improvement in Behavioral and Emotional Symptoms

There were steady improvements over time in the behavioral and emotional symptoms of children and youth served in systems of care.

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

Reduction in the Proportion of Children and Youth with Elevated Behavioral and Emotional Symptoms

The proportion of children and youth whose levels of externalizing symptoms, such as aggression or rule-breaking, fell within the clinically significant range (the range indicating that significant problems are present, i.e., a T-score of 64 or above) showed improvements. According to caregiver reports at entry into services (i.e., intake), 68.8 percent of children and youth exceeded this clinically significant range. Within 6 months of receiving services, this proportion fell to 57.9 percent, and by the 18-month follow-up it fell further to 53.5 percent[23] (see Figure 1).

Improvements were also seen with respect to internalizing symptoms, such as depression or anxiety. At intake, 60.1 percent of children and youth receiving services were rated by their caregivers as having significant problems with internalizing symptoms. Within 6 months of receiving services this percentage fell to 53.6 percent. After 12 months, the proportion fell to 47.8 percent and by 18 months, the proportion was 41.6 percent[24] (see Figure 1).

The percentage of children and youth whose scores on the CBCL Total Problems Scale were in the clinically significant range, indicating significantly high levels of problems, decreased over time. At intake, 72.8 percent of children and youth had scores that were significantly high. This

proportion fell to 63.0 percent after 6 months and fell further to 59.6 percent after 12 months, and to 55.8 percent after 18 months[25] (see Figure 1).

Reduction in Levels of Behavioral and Emotional Symptoms

The percentage of children and youth who displayed a statistically significant difference between their intake and follow-up interview scores was also calculated. Significant differences are defined through the Reliable Change Index (RCI), which compares a child's scores on standardized clinical instruments at two points in time, adjusts for the reliability of the instrument, and creates a standardized score (i.e., a Z-score) indicating how much change has occurred. Children and youth who had a standardized score of greater than 1.96 were considered to have significantly improved.

Six months after intake, 28.4 percent of children and youth showed significant reduction in their overall symptoms. This proportion rose to 33.2 percent showing improvement from intake to 12-month follow-up and to 40.1 percent by 18 months after intake.[26]

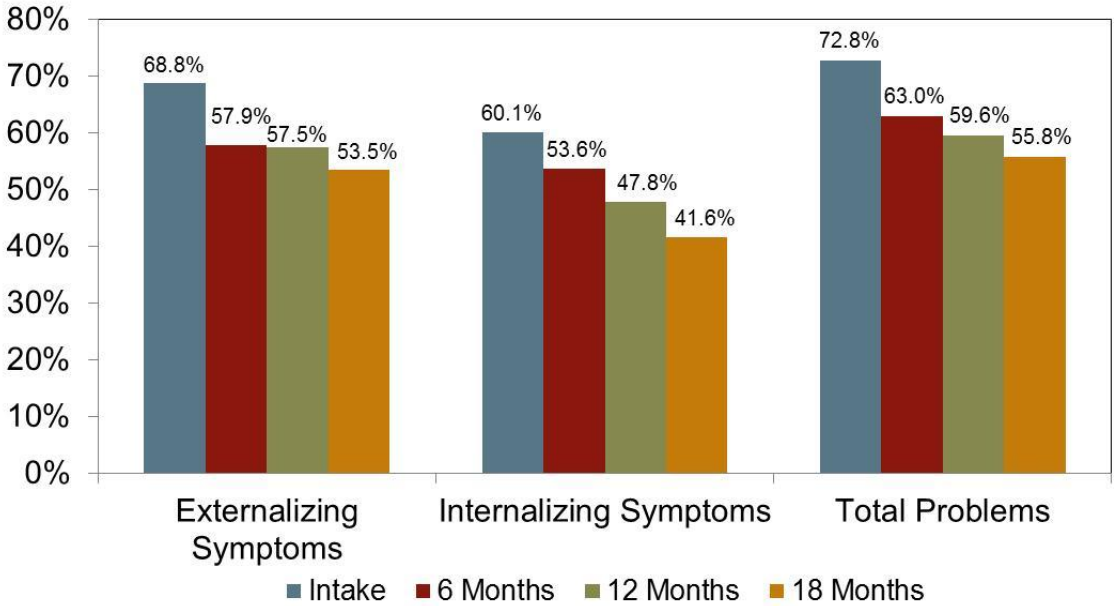
Improvement in Functioning

The Columbia Impairment Scale (CIS; Bird et al., 1993) was used to determine the overall level of functioning in the children and youth receiving system of care services. The CIS is a measure of basic areas of functioning for children and youth, and includes scales measuring interpersonal relationships, behavioral problems, and emotional problems.

Reduction in Levels of Impairment

Within 6 months of intake into CMHI-funded systems of care, 15.9 percent of children and youth showed clinically significant improvement in functioning. By the 12-month follow-up, 20.0 percent had shown significant improvement, and 22.6 percent showed significant improvement by the 18-month follow-up.[27]

Figure 1. Percentage of Children and Youth with Clinical Levels of Behavioral and Emotional Symptoms at Intake, 6 Months, 12 Months, and 18 Months, Grantees Initially Funded in 2008–2009



n = 379; *p* < .001

Improvement in Symptoms of Anxiety and Depression

Youth aged 11 years and older provided information about their symptoms of anxiety and depression using 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.

Anxiety

Reduction in the Proportion of Children and Youth with Elevated Levels of Symptoms of Anxiety. The proportion of children and youth who reported particularly high levels of anxiety symptoms decreased. At intake, 27.5 percent of youth reported significantly high levels of symptoms of anxiety. By the 6-month follow-up, this proportion had fallen to 20.6 percent. At the 12-month follow-up, the proportion reporting clinically significant levels of anxiety was 22.5 percent, and at the 18-month follow-up, it was 17.6 percent.[28]

Reduction in Levels of Symptoms of Anxiety. Six months after intake, 20.6 percent of youth showed a significant decrease in their levels of anxiety. This percentage decreased to 13.7 percent after 12 months, although it increased at the 18-month follow-up to 23.5 percent.

Depression

Reduction in the Proportion of Children and Youth with Elevated Levels of Symptoms of Depression. The proportion of children and youth who reported notably high levels of symptoms of depression also decreased somewhat over time. At intake, 24.4 percent of youth reported symptoms of depression in the significantly elevated range. Within 6 months, 16.2 percent reported symptoms of depression in the significantly elevated range. This proportion decreased somewhat to 15.7 after 12 months, and although it increased to 19.3 percent at 18 months following intake, the increase was not statistically significant.

Reduction in Levels of Symptoms of Depression. Six months after intake, 13.2 percent of youth improved significantly in their symptoms of depression. At 12 months after intake, the proportion had risen somewhat to 16.2 percent, and then to 17.8 percent after 18 months.

Reduction in Suicidal Thoughts and Suicide Attempts

At intake, caregivers were asked whether their child or youth had expressed thoughts of suicide or if they had made a suicide attempt within the past 6 months. Youth aged 11 years and older were also asked the same questions. The percentage of children and youth who were reported by caregivers to have had thoughts of suicide in the previous 6 months fell from 18.6 percent at intake to 11.6 percent at 6 months after receiving services. At the 18-month follow-up, the proportion of children and youth reported to have experienced thoughts of suicide fell to 11.4 percent.[29]

The percentage of children and youth who made a suicide attempt in the previous 6 months fell from 4.9 percent at intake to 2.7 percent within 6 months. At 12 months, the proportion was 3.3 percent, and this held steady at the 18-month follow-up with 3.3 percent of children and youth reporting a suicide attempt in the previous 6 months.

Additional Outcomes of Children and Youth

Improvement in Educational Outcomes

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

Among children and youth receiving system of care services and who were enrolled in school, the percentage who attended school regularly, defined as attending 80 percent of school days or more, rose somewhat over time from 84.0 percent in the 6 months prior to intake to 86.5 percent in the 6 months after intake. Within 12 months of enrolling in system of care services, the proportion attending school regularly increased to 89.6 percent. At the 18-month follow-up, 87.5 percent of children and youth were regularly attending school.

In addition to school attendance, the academic performance of children and youth improved somewhat. At intake, 66.7 percent of children received passing grades, defined as a grade average of C or better, during the 6 months prior to intake. After 6 months, 68.3 percent received passing grades, and the percentage continued to increase to 73.2 percent after 12 months and to 75.6 percent after 18 months.

Children and youth were less likely to be suspended or expelled from school after participating in system of care services. At intake, 33.1 percent of children and youth had been suspended or expelled from school in the previous 6 months. Six months after intake, this percentage fell to 21.3 percent. This proportion increased slightly to 23.2 percent at the 12-month follow-up, but fell again to 18.9 percent at the 18-month follow-up.[30]

Improvement in Living Situations

Caregivers of children and youth provided information on the place(s) where and with whom children and youth had lived during the 6 months prior to each interview, including any placements away from home. Children and youth were reported to have achieved greater stability in their living situations after receiving system of care services. In the 6 months prior to intake, 21.4 percent of children and youth lived in a setting that was not their home, such as a foster home, jail or prison, or hospital. After 6 months, this percentage fell to 14.7 percent; it rose slightly to 17.5 percent at 12 months and fell to 13.9 percent after 18 months.[31]

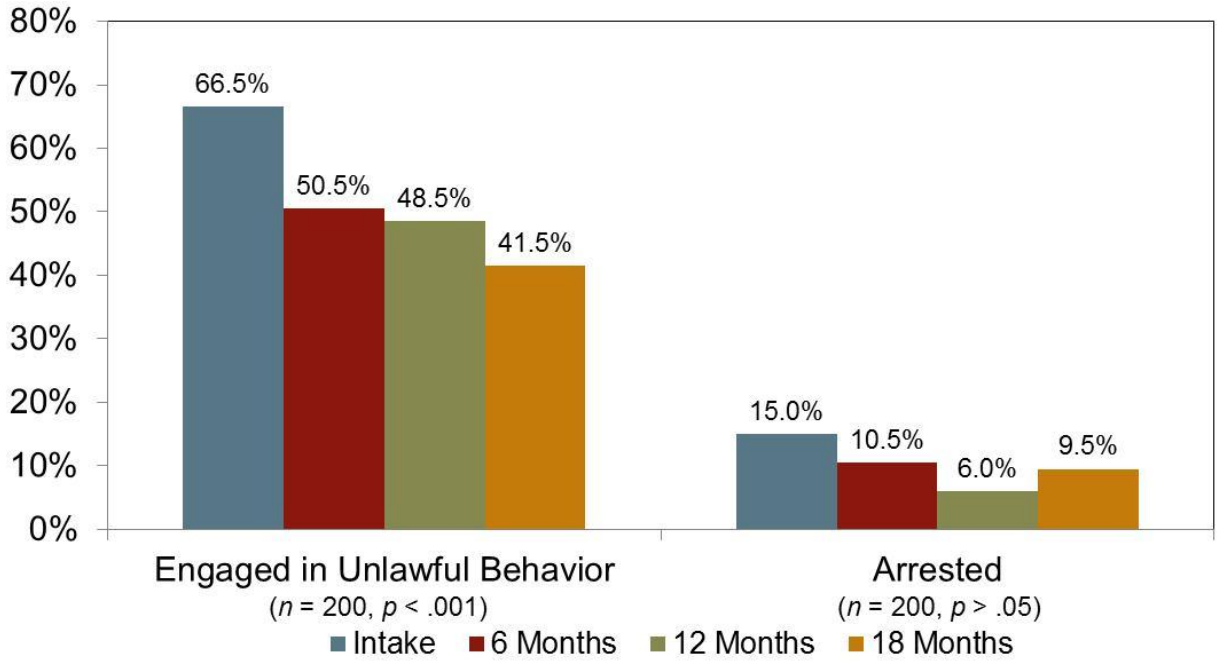
Reduction in Law Enforcement Contacts

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

At intake, 66.5 percent of youth reported that they had engaged in at least 1 of the 22 unlawful behaviors assessed. After 6 months, the percentage of youth who reported engaging in at least one unlawful behavior in the previous 6 months fell to 50.5 percent. This proportion fell further to 48.5 percent after 12 months of receiving services, and to 41.5 percent after 18 months (see Figure 2).

At intake, 15.0 percent reported that they had been arrested within the previous 6 months. At 6 months, this proportion fell to 10.5 percent and at the 12-month follow-up, 6.0 percent reporting being arrested within the previous 6 months. At 18 months, the proportion fell to 9.5 percent (see Figure 2).

Figure 2. Change in Youth Juvenile Justice System Involvement at Intake, 6 Months, 12 Months, and 18 Months, Grantees Initially Funded in 2008–2009



Caregiver Outcomes

Caring for children and youth with serious behavioral and emotional difficulties can be stressful for caregivers and families. Systems of care seek to improve caregiver functioning by reducing the strain associated with caring for a child with serious mental health conditions, supporting improved employment situations, and increasing access to resources for the family.

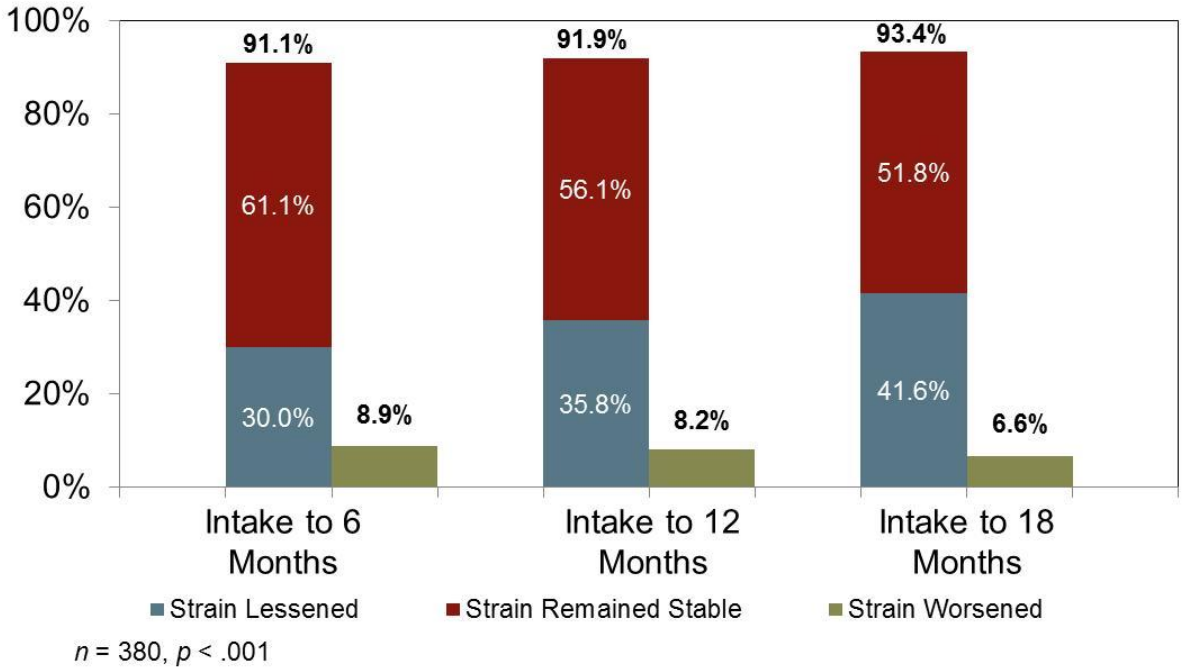
Improvement in Caregiver Strain

Caregivers reported on their level of strain associated with caring for a child with serious mental health conditions by responding to the Caregiver Strain Questionnaire (CGSQ; Brannan, Heflinger, & Bickman, 1998). The questionnaire assesses three related dimensions of caregiver strain: subjective externalizing strain (e.g., expressing 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) as part of a total global strain score.

Reduction in Levels of Caregiver Strain

Caregivers reported significant reductions in global strain from intake to 18 months. After receiving services for 6 months, 30.0 percent of caregivers reported significant reduction in global strain, and after 12 months in services this percentage increased to 35.8 percent. Approximately 41.6 percent reported decreased global strain from intake to 18 months (see Figure 3).[32]

Figure 3. Change in Caregiver Global Strain from Intake to 6 Months, Intake to 12 Months, and Intake to 18 Months, Grantees Initially Funded in 2008–2009



Caregiver parenting stress was assessed using the Parenting Stress Index–Short Form (PSI/SF; Abidin, 1995). The PSI was designed to measure the overall level of parenting stress experienced by caregivers of children between the ages of 1 month and 12 years. At intake, 74.7 percent of caregivers reported levels of parenting stress in the *severe* range. This proportion significantly decreased to 71.6 percent at 6 months, to 67.0 percent at 12 months, and to 62.4 percent by the 18-month follow-up.[33]

Improvement in Caregiver Work Life

Among caregivers who reported being employed at intake and at follow-up interviews, caregivers who completed the 18-month follow-up reported a significant decrease in the number of days of work lost due to their child's behavioral or emotional problems. Caregivers who were employed at intake (48.7 percent) reported missing an average of 4 days of work in the previous 6 months due to their child's behavioral or emotional problems. At 18 months, the number of days of work lost in the previous 6 months due to the child's behavioral or emotional problems decreased to 1.8 days.[34]

At intake, 12.6 percent of caregivers reported that they were unemployed but thought they would be employed if their child did not have behavioral or emotional problems. This percentage increased slightly to 15.6 percent at 6 months after intake, but declined to 11.5 percent at 18-month follow-up.

Outcomes of Children and Youth with and without Insurance Coverage at Intake

At intake, the vast majority of children and youth in the Longitudinal Outcome Study (89.5%) were enrolled in a publicly funded health care program such as Medicaid or were covered by private insurance. Additionally, some services were paid for by Supplemental Security Income (SSI) or Temporary Aid to Needy Families (TANF).

Of these children and youth, 81.5 percent of children and youth were covered by Medicaid, 13.4 percent were covered by private insurance, 11.1 percent by SSI, 5.5 percent under TANF, and 5.0 percent under the Children's Health Insurance Program (CHIP).[35]

Among children and youth who entered systems of care without health care coverage, 27.1 percent showed significant improvement in their overall behavioral and emotional symptoms (CBCL 1½–5; Achenbach & Rescorla, 2000; CBCL 6–18; Achenbach & Rescorla, 2001) within the first 6 months after intake. After 12 months, 30.5 percent of this group showed significant improvement. For children and youth who had health care coverage, 30.3 percent showed significant improvement after 6 months, while 36.1 percent of children and youth showed significant improvement after 12 months. These results suggest that children and youth who had no health insurance coverage at intake showed a similar rate of improvement to those who did have coverage. It is likely that systems of care assisted families in accessing health insurance and other resources and in particular children and youth who did not have access to health insurance and mental health services and supports. Additional outcomes are presented in Table I-1 in Appendix I.

Analysis of Outcomes for Vulnerable Populations

Because poorer outcomes are often associated with children and youth in particularly vulnerable subgroups, special analyses were conducted to determine outcomes related to children and youth served by child welfare, juvenile justice, and early childhood programs (aged 0–5 years); youth and young adults aged 14–21 years; those who experienced symptoms of both mental health and substance use problems; and those who identified as lesbian, gay, bisexual, transgender, questioning, intersex, or two-spirit (LGBTQI2-S).

Children and youth in these vulnerable populations served by the grantees funded in 2008–2010 showed improvement in clinical problems as measured by the Child Behavior Checklist (CBCL 1½–5; Achenbach & Rescorla, 2000; CBCL 6–18; Achenbach & Rescorla, 2001) At the 6-month follow-up, the percentage of children and youth who showed significant improvement in behavioral and emotional symptoms was as follows: children served by early childhood programs (37.4 percent), children and youth involved in the child welfare (28.5 percent) and juvenile justice (26.5 percent) systems, youth and young adults (23.4 percent), youth who identified as LGBTQI2-S (29.3 percent), and youth experiencing dual conditions (mental health and substance use problems) (16.2 percent). Additional outcomes are presented in Table I-2 in Appendix I.

Summary

- Children and youth showed sustained improvements on measures of mental health concerns.
- Children and youth were significantly less likely to experience thoughts of suicide, and were less likely to make suicide attempts after becoming involved in systems of care.
- There were notable improvements in educational outcomes. Rates of children and youth attending school regularly, avoiding major disciplinary actions, and receiving passing grades all showed upward trends from intake to 18 months.
- Youth aged 11 and older reported significantly fewer arrests as well as reduced involvement in unlawful activities.
- A significant proportion of caregivers experienced reduced strain from intake to 18 months.
- Caregivers reported a significant decrease in the number of missed days of work due to their child's emotional or behavioral problems from 4 days at intake to 1.8 days at 18 months.
- The proportion of caregivers of young children who were classified with severe parenting stress declined significantly from intake to 18 months.
- Children and youth who were covered by health insurance were as likely to show improvements as those who were not covered. Behavioral and emotional symptoms improved for 30.3 percent of children and youth with health insurance coverage from intake to 6 months and for 36.1 percent at 12 months. For children and youth without health insurance coverage, symptoms improved from intake to 6 months for 27.1 percent and at 12 months for 30.5 percent.
- Children and youth from particularly vulnerable populations, such as those involved with child welfare or juvenile justice, showed improvement in their behavioral and emotional symptoms.
- Table 5 summarizes the outcomes reported above.

Table 5. Summary of Outcomes of Children and Youth at Intake and 18 Months, Grantees Initially Funded in 2008–2009

Outcome	Proportion at Intake	Proportion at 18 Months
Significantly Elevated Levels of Externalizing Symptoms (CBCL)	68.8%	53.5%
Significantly Elevated Levels of Internalizing Symptoms (CBCL)	60.1%	41.6%
Significantly Elevated Levels of Total Symptoms (CBCL)	72.8%	55.8%
Significantly Elevated Levels of Anxiety (RCMAS)	27.5%	17.6%
Significantly Elevated Levels of Depression (RADS)	24.4%	19.3%
Thoughts of Suicide	18.6%	11.4%
Suicide Attempt	4.9%	3.3%
Regular Attendance at School	84.0%	87.5%
"C" Average or Better at School	66.7%	75.6%
Suspended or Expelled from School	33.1%	18.9%
Out-of-Home Living Placement	21.4%	13.9%
Engaged in Unlawful Behavior	66.5%	41.5%
Arrested	15.0%	9.5%
Severe Levels of Parenting Stress (PSI)	74.7%	62.4%

Table 5. Summary of Outcomes of Children and Youth at Intake and 18 Months, Grantees Initially Funded in 2008-2009 (continued)

Outcome	Proportion Who Improved, Intake to 6 Months (RCI)	Proportion Who Improved, Intake to 18 Months (RCI)
Improvement in Externalizing Symptoms (CBCL)	21.9%	31.7%
Improvement in Internalizing Symptoms (CBCL)	18.5%	26.4%
Improvement in Total Symptoms (CBCL)	28.4%	40.1%
Improvement in Symptoms of Anxiety (RCMAS)	20.6%	23.5%
Improvement in Symptoms of Depression (RADS)	13.2%	17.8%
Improvement in Caregiver Strain (CGSQ)	30.0%	41.6%

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

Involvement in Service Planning

Coordinating services in systems of care includes holding service planning meetings at intake with families, youth, and others important to determining the full array of services and supports needed by each child or youth and family. For the overwhelming majority of children and youth in the Longitudinal Outcome Study, caregivers were involved in planning services (81.8 percent). In addition, the majority of youth aged 11–21 (76.0 percent) reported participating in their own service planning; 68.1 percent of service planning meetings included a care manager, and 52.8 percent included a mental health staff member (therapist, behavioral aide, respite worker, or others). Family advocates participated in nearly one-third (34.9 percent) of the meetings. Other child- and youth-serving agency representatives from education (13.0 percent), child welfare (8.0 percent), and juvenile justice (5.2 percent) participated in smaller numbers.

Types of Services Received

Ninety-two percent of caregivers reported that their child received at least one type of service during the first 6 months in system of care services. Among the children and families with complete service use data at intake, 6 months, 12 months, and 18 months, on average, children and families received about five different types of services in the 6 months before intake (mean = 5.3, *SD* = 2.76). At 6 months after intake, children and families received nearly six different types of services (mean = 5.7, *SD* = 3.08) and more than five different types during the 12 months following intake (mean = 5.3, *SD* = 3.00). The number of different types of services received tended to decrease over time after enrollment into systems of care.[36] This is to be expected as children and youth improve in their functioning over time.

The most frequently used services and supports in the first 6 months of services were individual therapy (72.2 percent), case management (55.9 percent), assessment or evaluation (52.0 percent), medication treatment monitoring services (51.4 percent), and school-based services (47.7 percent) (see Table 6).

Individual therapy, medication treatment monitoring services, and school-based services remained the most frequently used types of services between the 6-month and 18-month time periods after intake. However, medication monitoring services was the second most frequently received service. This significant decrease in assessment or evaluation might be expected, as these activities tend to occur at intake.[37] Additionally, Table 6 shows that there were significant decreases observed in the rates of usage for inpatient hospitalization and crisis stabilization, which are generally the most restrictive and expensive. Reduction in the use of these services is consistent with the system of care philosophy, which promotes a shift from cost-intensive and restrictive services to least restrictive community-based services.

Table 6. Types of Services and Supports Received by Children, Youth, and Their Families at Intake, 6 Months, 12 Months, and 18 Months, Grantees Initially Funded in 2008–2009

Type of Service	6 Months Before Intake	After Intake		
		6 Months	12 Months	18 Months
Mental Health Services				
Assessment or Evaluation Services** (*n* = 288)	76.3%	52.0%	46.2%	43.7%
Individual Therapy (*n* = 293)	69.0%	72.2%	74.6%	61.3%
Medication Treatment Monitoring Services (*n* = 294)	48.6%	51.4%	50.7%	53.2%
Group Therapy (*n* = 292)	22.6%	19.1%	22.6%	18.4%
Family Therapy (*n* = 292)	21.9%	24.7%	22.3%	17.3%
Inpatient Hospitalization Services** (*n* = 293)	14.4%	13.0%	10.6%	7.0%
Crisis Stabilization Services** (*n* = 293)	12.6%	8.8%	7.4%	6.3%
Residential Treatment Center (*n* = 292)	6.0%	4.6%	6.0%	6.4%
Support Services				
School-Based Services (*n* = 291)	49.8%	47.7%	49.5%	48.0%
Family Advocacy and Peer Support Services*** (*n* = 285)	41.4%	43.2%	34.4%	23.9%
Case Management Services** (*n* = 290)	40.5%	55.9%	43.7%	34.4%
Informal Support (*n* = 292)	40.4%	40.4%	41.1%	37.6%
Caregiver or Family Support Services (*n* = 293)	32.0%	43.0%	34.9%	30.6%
Transportation Services (*n* = 292)	15.9%	19.8%	21.9%	15.5%
Recreational Activities (*n* = 292)	13.8%	20.8%	19.4%	17.0%
Services from a Therapeutic Aide (*n* = 292)	11.6%	15.8%	14.7%	11.9%
Afterschool/Child Care (*n* = 292)	11.3%	13.4%	10.2%	10.2%
Flexible Funds (*n* = 292)	10.2%	29.2%	23.2%	18.0%

** Linear trend is significant at $p < .01$ level.

*** Linear trend is significant at $p < .001$ level.

Location of Services

During the first 6 months after intake, caregivers reported that the most common places where services were received were mental health settings (74.8 percent) and homes (61.5 percent). Approximately 57 percent of caregivers reported that services were provided in schools (see Table 7). In addition, services also were reported as being received in social services or child welfare offices and in community settings (28.3 percent and 20.9 percent, respectively). Caregivers also commonly

reported receiving services in juvenile court settings (17.6 percent) and jail or detention centers (7.3 percent).

Table 7. Locations in Which Children, Youth, and Their Families Received Services: Grantees Initially Funded in 2008-2010

Location	%
Mental Health Clinic or Private Practice (*n* = 1,599)	74.8%
Home (*n* = 1,578)	61.5%
School (*n* = 1,571)	56.5%
Social Services or Child Welfare Offices (*n* = 1,571)	28.3%
Medical Hospital (*n* = 1,576)	21.4%
Community Location or Service Center (*n* = 1,573)	20.9%
Juvenile Court/Probation (*n* = 1,548)	17.6%
Psychiatric Hospital/Unit (*n* = 1,572)	11.8%
Non-Hospital Residential Setting (*n* = 1,561)	8.8%
Jail/Youth Detention (*n* = 1,561)	7.3%
Other Setting (*n* = 1,487)	5.0%

Services and Costs

Expenditures by Service and Funder

This analysis of the cost of services is based on 58,007 community-based support[38] and community-based therapeutic[39] services received by 883 children and youth following intake into CMHI-funded system of care grantees. The analysis is based on services provided between April 2009 and June 2013 by 10 grantees initially funded in 2008. Table I-3 in Appendix I details the number and percentage of children, as well as the mean number of service events per child per month, by service group and service type.

The average length of time during which children and youth received services was 18.2 months (median = 16.6 months). The average total cost associated with the services provided during this time was $5,996 per child or youth (median = $1,653), or an average cost of $718 per child or youth per month (median = $198). Children and youth received an average of 65.69 service events of any type (median = 23.0) over this time.

Of the children and youth served by these system of care grantees, 47.5 percent received community-based support services. The average number of community-based support service events received by children and youth was 4.06. The most commonly received types of community-based support services were caregiver support/family support (15.1 percent), advocacy (14.4 percent), and training/tutoring/education/ mentoring (11.4 percent).

Among children and youth served by these 10 system of care grantees, 93.1 percent received community-based therapeutic services. The average number of community-based therapeutic service events received by children in this group was 6.47. The most commonly received types of community-based therapeutic services were case management/clinical coordination (56.3 percent), individual therapy/counseling (45.0 percent), intake/screening/ diagnosis (39.4 percent), and medication treatment/monitoring/administration (21.2 percent).

Table 8 displays the percentage paid for these services by source of payment. The total amount paid for these services was $8,334,941 (based on 53,210 services with payment data). Medicaid, the major payer, paid 36.9 percent of the total payments, while education agencies paid 28.0 percent, CMHI grant funding 13.5 percent, mental health agencies 11.8 percent, and child welfare agencies 7.1 percent. Other sources

of payment accounted for 2.7 percent of the total payments.

Table 8. Percentage Paid by Source of Payment Between April 2009 and June 2013 in 10 Grantees Initially Funded in 2008

Payment Source	
Medicaid	36.9%
Education Agency	28.0%
CMHI Grant	13.5%
Mental Health Agency	11.8%
Child Welfare Agency	7.1%
Other	2.7%

Figure 4 displays the percentage of children and youth receiving community-based support and community-based therapeutic services. This analysis is limited to children and youth whose service use data were available from intake to 6 and 12 months. In the first 6 months after intake, 83.6 percent of children and youth received at least one community-based therapeutic service, and 62.3 percent received at least one community-based support service. For both categories of services, the percentage of children and youth who received these services decreased over time. The proportion of children and youth receiving community-based therapeutic services and the proportion of children and youth receiving community-based support services decreased at a similar rate (10.9 percent and 8.3 percent, respectively).

Figure 4. Percentage of Children and Youth Who Received Community-Based Support and Therapeutic Services by Service Category from Intake to 6 Months and 6 Months to 12 Months in 10 Grantees Initially Funded in 2008

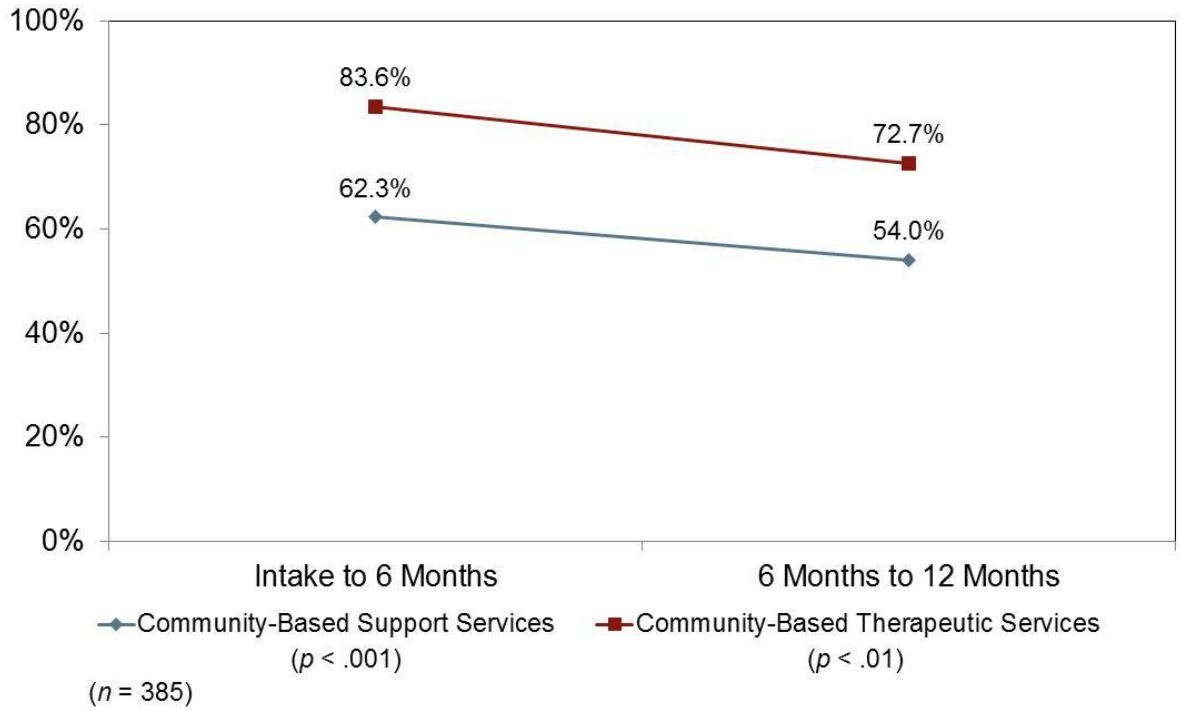
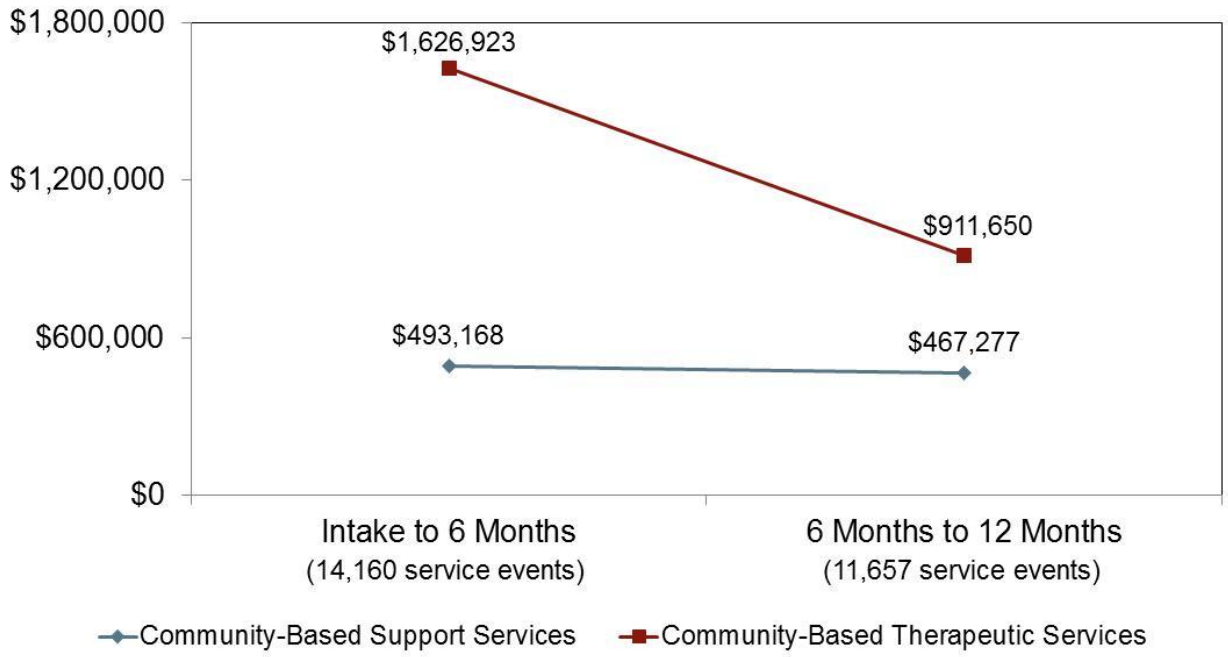


Figure 5 displays total payments by service category over time for all records that had available payment data. Total payments for community-based support services ($493,168 from intake to 6 months and $467,277 from 6 to 12 months) and total payments for community-based therapeutic services ($1,626,923 from intake to 6 months and $911,650 from 6 to 12 months) in these 10 system of care grantees follow a pronounced downward trend that resulted in a 35.0 percent total cost reduction between the first 6 months and second 6 months of services (from a combined total of $2,120,091 to $1,379,956, respectively). Payments incurred for community-based therapeutic services were the main driver of this decreasing trend. Indeed, payments incurred for community-based support services decreased at a lower rate and represent a relatively smaller proportion of total payments.

Figure 5. Total Payments for Community-Based Support and Therapeutic Services from Intake to 6 Months and 6 Months to 12 Months in 10 Grantees Initially Funded in 2008



Case Study: Service Use and Costs, Early Childhood Grantee

This case study profiles a grantee whose focus is on serving young children aged 0–5 years and their families. The grantee established a cross-agency infrastructure that coordinates support and therapeutic services across multiple child-serving sectors. Within this infrastructure, this grantee collected detailed data for the Services and Costs Study on 14,950 services received by 171 young children between January 5, 2010, and May 8, 2013. These data were collected from collaborating partner agencies and include service use and costs data related to mental health services, child welfare services, special education services, and medical services. Because this grantee serves only young children (aged 0–5 years) and their families, other potential system of care partner agencies such as juvenile justice and youth organizations are not applicable.

Children served by this grantee received services for an average of 22.7 months after enrollment. Children received proportionately more child welfare services than services from other service sectors. Children received an average 2.83 mental health services per child per month and 8.35 child welfare services per child per month, with fewer special education (1.13 service events per child per month) and medical (0.57 service events per child per month) services. Overall, children accessing services from this grantee received 6.13 services per month on average (see Table 9).

Specific types of services received by children from this grantee were grouped as community-based support services, community-based therapeutic services, foster care services, or other. Table 9 depicts these service groups followed by specific types of services received within each service group. Examining service use within these service groups, Table 9 indicates that 87.1 percent of children received community-based support services and 79.5 percent received community-based therapeutic services. Services included in the foster care services group only represent services received by a small group of children who received foster care services. The vast majority of child welfare services (including foster care) are included in the community-based support or community-based therapeutic services groups. Consistent with this grantee's focus on young children and families, the most commonly received type of service across all service groups was caregiver and family support, received by 73.1 percent of children and their families. On average, these children received 1.73 caregiver and family support services per month.

Table 9 also shows costs associated with 14,703 services for which payment data were available. The total amount paid across these services was $1,005,124, or an average of $5,878 per child, over the 3 years represented in the data. Community-based support services accounted for 40.8 percent of services provided, but reflected only 11.3 percent of the total payments. In contrast, community-based therapeutic services accounted for 57.9 percent of services provided, and 88.5 percent of total payments. The large percentage of total payments attributed to community-based therapeutic services was due to the fact that the two service types with the highest expenditures, Case Management and Preschool Special Education Programs (Part B), accounted for 57.7 percent of all payments (39.5 percent and 18.2 percent, respectively).

Table 9. Service Group/Type by Mean Number of Service Events per Child per Month, Early Childhood Grantee

Service Group/ Service Type	Children with Reported Service Events[a]		Mean Number of Service Events per Child per Month	Service Events with Reported Payment Data		Total Payments over 3 Years	
	n	%		*n*	%	$	%
Total	171		6.13	14.703		$1,005,124	
Community-Based Support Services	149	87.1%	2.95	5,993	40.8%	$114,393	11.3%
Caregiver Support/Family Support	125	73.1%	1.73	3,513	23.9%	$56,889	5.7%
Social Work Service	19	11.1%	2.48	576	3.9%	$14,911	1.5%
Vocational/Life Skills Training/ Independent Living Skills/Youth Transition	6	3.5%	—	7	0.0%	—	—
Transportation	6	3.5%	—	7	0.0%	—	—
Child Protective Service	42	24.6%	1.24	608	4.1%	$18,635	1.9%
Case Evaluation and Monitoring	24	14.0%	4.52	1,034	7.0%	$19,964	2.0%
Adoption Service	6	3.5%	—	248	1.7%	—	—
Community-Based Therapeutic Services	136	79.5%	4.37	8,519	57.9%	$889,604	88.5%
Intake/Screening/Diagnosis/ Assessment	80	46.8%	0.27	260	1.8%	$24,422	2.4%
Evaluation	63	36.8%	0.44	374	2.5%	$24,272	2.4%
Consultation/Meeting	33	19.3%	0.24	99	0.7%	$5,119	0.5%
Case Management/Clinical Coordination	70	40.9%	4.61	4,533	30.8%	$396,624	39.5%
Service Planning	39	22.8%	1.11	766	5.2%	$55,982	5.6%
Crisis Intervention/Crisis Stabilization/Crisis Hotline	1	0.6%	—	1	0.0%	—	—
Emergency Room Psychiatric Service	2	1.2%	—	3	0.0%	—	—
Medication Treatment/ Monitoring/Administration[b]	24	14.0%	0.19	65	0.4%	$6,568	0.7%
Medical Care/Physical Health Care/Lab Related to Mental Health	57	33.3%	0.54	403	2.7%	$17,766	1.8%
Individual Therapy/ Counseling/Psycho-Social Therapy/Play Therapy	62	36.3%	0.81	804	5.5%	$65,658	6.5%
Family Therapy/Family Counseling	28	16.4%	0.42	177	1.2%	$12,496	1.2%

Table 9. Service Group/Type by Mean Number of Service Events per Child per Month, Early Childhood Grantee (continued)

Service Group/ Service Type	Children with Reported Service Events[a]		Mean Number of Service Events per Child per Month	Service Events with Reported Payment Data		Total Payments over 3 Years	
	n	%		*n*	%	$	%
Preschool Special Education Program (Part B)	19	11.1%	0.09	23	0.2%	$183,300	18.2%
Physical Therapy/ Occupational/Speech/ Hearing/Language Service	40	23.4%	1.80	1,010	6.9%	$90,997	9.1%
Teacher Aide Service/Other Paraprofessional Service	1	0.6%	—	1	0.0%	—	—
Foster Care Services	3	1.8%	—	28	0.2%	—	—
Other Services	48	28.1%	0.26	163	1.1%	$631	0.1%

Note: Service events are based on various units of time, ranging from minutes to months. Some services reported as only one event may represent a combination of services or multiple days of services.

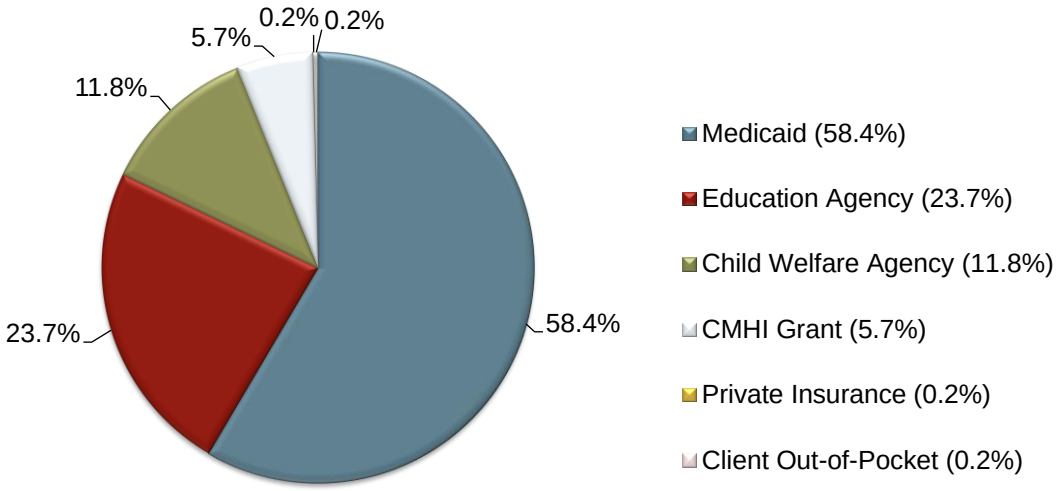
[a] Because children may receive services from more than on service group, percentages may sum to more than 100%.

[b] Medication monitoring includes only services provided, such as a consultation with a psychiatrist, and does not include the costs of prescription medications.

—Represents data for fewer than 10 children; data are not shown to protect confidentiality.

Figure 6 summarizes data on the sources of payment for system of care services. The primary source of payment for system of care services was Medicaid. This is consistent with the fact that 70 percent of families served by the grantee live below the poverty line and almost 15 percent live at or near the poverty line. The total amount paid by Medicaid for service events with payment data was $586,556, or 58.4 percent of the total reported payments. Additional sources of payment included education agencies (23.7 percent) and child welfare agencies (11.8 percent), with the CMHI grant paying for only 5.7 percent of system of care services.

Figure 6. Amounts Paid by Source, Early Childhood Grantee



Total amount of payments = $1,005,124
n = 14,703 service events

This grantee's focus on providing system of care services to young children and their families, and the emphasis on caregiver and family support services, illustrates the cost-efficient use of resources to deliver these support services. Additionally, most services were paid for by sources other than the CMHI grant, with less than 6 percent of the total payments paid by the grant.

Case Study: Service Use and Costs, Grantee Serving Children and Youth Aged Birth–21 Years

The following case study profiles a system of care grantee that serves children and youth from birth to 21 years of age. This grantee had enrolled 153 children and youth into the Longitudinal Child and Family Outcome Study by March 2013. In addition to the data collected for the Longitudinal Outcome Study, the grantee collected more detailed data for the Services and Costs Study. These included data on services received by 150 children (98.0 percent) between January 29, 2010, and March 31, 2013, and the costs of these services.

Data presented in this case study were accessed through the management information systems of multiple service providers. To collect these data, the system of care established data sharing agreements and procedures across all of their collaborating partner agencies. Data were collected from the full spectrum of service sectors participating in the system of care, including data on services received through the mental health, child welfare, juvenile justice, special education, physical health, and family organization service sectors. As shown in Table 10, children and youth served by this grantee received proportionately more mental health services than services from other service sectors. The mean number of mental health services received per child per month was 1.03 (see Table 10). Further analysis of these data revealed that children and youth received 1.7 services per month on average across all service sectors, and received services for 38.6 months, on average (data not shown).

Table 10. Service Events by Service Sector, Grantee Serving Children and Youth Aged 0–21 Years

	Mental Health	Child Welfare	Juvenile Justice	Special Education	Physical Health	Family Organization	Youth Organization	Other Agency
Reported Service Events	2,772	279	53	148	205	1,172	102	85
Percentage of Reported Service Events	56.9%	5.7%	1.1%	3.0%	4.2%	24.1%	2.1%	1.7%
Number of Children with Reported Service Events	129	56	25	49	15	123	8	17
Percentage of Children with Reported Service Events[a]	86.0%	37.3%	16.7%	32.7%	10.0%	82.0%	5.3%	11.3%
Mean Number of Service Events per Child per Month	1.03	0.27	0.11	0.25	0.46	0.52	—	0.14

150 children; *n* = 4,873 service events

Note: Service events are based on various units of time, ranging from minutes to months. Some services reported as only one event (e.g., a 5-day inpatient hospitalization or a 1-month residential treatment stay) may represent a combination of services or multiple days of services. Physical health service events include only services related to mental health care.

[a] Because children may receive services from more than one agency, percentages may sum to more than 100%.

— Represents data for fewer than 10 children; data are not shown to protect confidentiality.

Table 11 displays the percentage of children and youth receiving services by service group over the time children were enrolled in services. Proportionately more children and youth received community-based support services and community-based therapeutic services during their first 6 months of enrollment than between 6 and 18 months after enrollment. The most common type of community-based support services received was advocacy services (received by 82.0 percent) and the most common types of community-based therapeutic services were case management (received by 54.7 percent) and individual therapy (51.3 percent) (data not shown).

Figure 7 displays amounts paid to providers by source of payment. The total amount paid for services was $7,219,438 (based on 97.4 percent of services with payment data). The cost of services provided by this grantee was paid by a wide variety of programs, with only 7.7 percent paid by CMHI grant funding. Medicaid, the major payer for these services, paid for 29.3 percent of total payments. The education sector, the second largest source of payment, paid for 28.0 percent of total payments. These results reflect the ability of CMHI to leverage and consolidate services across many different payers.

Table 11: Percent of Children Receiving Services by Service Group over Time, Grantee Serving Children and Youth Aged Birth-21 Years

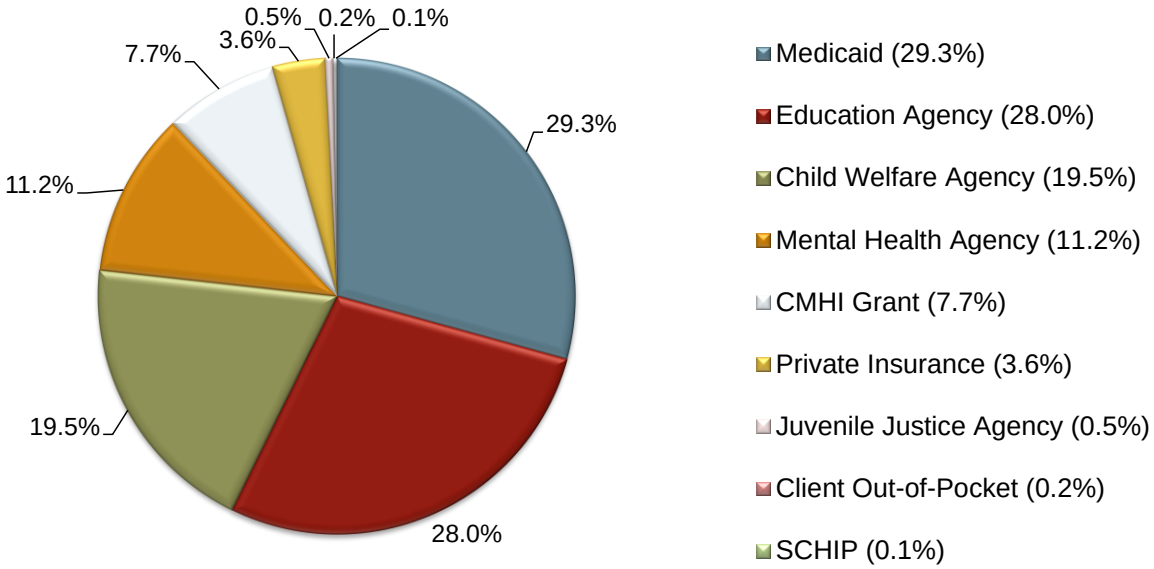
Service Group	Percent of Children and Youth Receiving Services		
	Intake to 6 Months	6 Months to 12 Months	12 Months to 18 Months
Community-Based Support	93.1%	66.7%	46.1%
Community-Based Therapeutic	76.5%	65.7%	55.9%
Psychiatric Inpatient	9.8%	9.8%	6.9%
Residential Treatment	6.9%	8.8%	4.9%
Foster Care	1.0%	1.0%	2.0%
Detention/Jail/Prison	2.0%	1.0%	*
Other	9.8%	7.8%	3.9%

n = 102 children and youth; *n* = 3,215 service events

* Data not reported.

Note: Analysis is limited to only those children and youth whose service use data were available across all 6-month intervals. Because children and youth may receive service in more than one service group, percentages may sum to more than 100%.

Figure 7. Amounts Paid by Source of Payment, Grantee Serving Children and Youth Aged Birth -21 Years



Total amount of payments = $7,219,438
n = 4,745 service events

Reduction in Inpatient Hospitalization 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. The average number of days of inpatient care is based on data for all 1,172 children and youth in the grantees initially funded in

2008–2009 whose caregivers provided information during both their intake and 12-month interviews about whether their children received any inpatient hospitalization care and, if so, for how many days.

The average number of days spent in inpatient hospital care decreased from 1.71 days in the 6 months prior to intake to 1.01 days in the 6 months prior to the 12-month interview.

The average charge per day for inpatient hospital care for children and youth between 1 and 18 years old with a primary diagnosis of a mental disorder is estimated to be $2,708 in 2013 dollars.[40] When this daily rate is multiplied by the average number of days of inpatient hospitalization of children and youth in a system of care, the average estimated total cost per child for the use of inpatient hospitalization in the 6 months prior to intake was approximately $4,631. This cost decreased to an average estimated cost per child of $2,735 between 6 and 12 months after intake, representing a 40.9 percent reduction in average per-child inpatient hospitalization costs.

Reduction in Cost of Arrests in Five Grantees

The average number of arrests decreased slightly from 0.37 in the 6 months prior to intake to 0.18 in the 6 months prior to the 12-month interview in the grantees initially funded in 2008–2009. This decrease is consistent with the decrease in the percentage of youth reporting an arrest in the previous 6 months at the 12-month follow-up interview. The average number of arrests was calculated on data collected from 591 youth aged 11 and older who provided information at intake and at 12 months.

The estimated average cost per juvenile arrest is $5,655.90 in 2013 dollars.[41] When this cost per juvenile arrest is multiplied by the average number of arrests, the average estimated cost per youth in the 6 months prior to intake was approximately $2,059. This cost decreased to an average estimated cost per youth of $1,002 between 6 and 12 months after intake. This represents a 51.4 percent reduction in average per youth costs.

Summary

- Children and youth in 10 grantees received community-based therapeutic services and supports for an average of 18.2 months (median = 16.6 months). The average total cost associated with the services over this time was $5,996 per child or youth (median = $1,653), or an average cost of $718 per child or youth per month.
- The most commonly received types of community-based therapeutic services were case management/clinical coordination (56.3 percent), individual therapy/counseling (45.0 percent), intake/screening/diagnosis (39.4 percent), and medication treatment/monitoring/administration (21.2 percent).
- Medicaid, the major payer of services, accounted for 36.9 percent of the total payments. Education agencies paid 28.0 percent of the total payments. CMHI grant funding paid 13.5 percent of the total payments, followed by mental health agencies (11.8 percent) and child welfare agencies (7.1 percent). Other sources of payment accounted for 2.7 percent of the total payments.
- Total payments for community-based support services ($493,168 from intake to 6 months and $467,277 from 6 to 12 months) and total payments for community-based therapeutic services ($1,626,923 from intake to 6 months and $911,650 from 6 to 12 months) decreased by 35.0 percent between the first 6 months and the second 6 months of services.
- Costs for inpatient hospitalizations decreased to an average estimated cost per child of $2,735 between 6 and 12 months after intake, representing a 40.9 percent reduction in average per-child inpatient hospitalization costs.
- Costs related to arrests decreased to an average estimated cost per youth of $1,002 between 6 and 12 months after intake, representing a 51.4 percent reduction in average costs of arrest per youth.
- Case studies from two grantees show how grantees were able to leverage several different types of services to ultimately leverage and consolidate services across many payers.

Caregiver and Youth Assessment of System of Care Services

Caregiver and Youth Satisfaction with Services

The legislation authorizing CMHI mandates an assessment of the views of caregiver and youth with regard to the effectiveness of systems of care. Caregivers and youth (aged 11 years and older) from grantees initially funded in 2008–2010 were asked to respond to questions about their service experience and satisfaction with services. Overall satisfaction with services was high among caregivers and youth after 6 months of services. Table 12 shows that 80.3 percent of caregivers and 85.4 percent of youth reported overall satisfaction with services.

Youth generally had more positive opinions than their caregivers about the outcomes that system of care services produced in their own lives. Youth were most satisfied with the cultural sensitivity shown by providers, as well as their ability to relate better to others. Caregivers were most satisfied with the cultural sensitivity of the services and their ability to access services easily. Youth were also more positive about their functioning in school and at home than their caregivers.

Caregivers of youth, and youth aged 11 years and older were asked several questions about their feelings of engagement in treatment. Engagement in treatment was defined as involvement in selecting the services they received and having an input into treatment goals. Caregivers and youth who felt engaged in treatment were more likely to be satisfied with services than those who were not. Table 13 shows that 95.2 percent of youth who reported feeling engaged in treatment were satisfied with services, compared to 59.5 percent who did not feel engaged in treatment. Caregivers who felt engaged in treatment were also more likely to report that they were satisfied with services (84.7 percent) than those who did not feel engaged in treatment (54.3 percent).

Table 12. Caregiver and Youth Satisfaction with Services 6 Months After intake into Services, Grantees Initially Funded in 2008-2010

Areas of Satisfaction	Percent Satisfied	
	Caregivers (*n* = 1,553)	Youth (*n* = 890)
Cultural Sensitivity	96.7%	95.6%
Access to Services	90.3%	86.7%
Participation in Services	85.8%	75.8%
Social Connectedness to Others	83.1%	87.8%
Functioning at Home and School	63.3%	77.9%
Outcomes of Services and Treatments	62.1%	76.0%
Overall Satisfaction	80.3%	85.4%

Table 13.Caregiver and Youth Satisfaction with Services and Treatment Engagement, Grantees Initially Funded in 2008-2010

	Youth Engaged in Treatment	Youth Not Engaged in Treatment
Percent of Youth Satisfied with Services (*n* = 605; *p* < .001)	95.2%	59.5%
	Caregiver Engaged in Treatment	**Caregiver Not Engaged in Treatment**
Percent of Caregivers Satisfied with Services (*n* = 616; *p* < .001)	84.7%	54.3%

Caregivers also responded to questions about the importance of service providers' sensitivity to the unique culture of their families' life. More than half of caregivers (53 percent) reported that it was very important or extremely important for their providers to understand their child's culture. In general, caregivers reported that providers in systems of care addressed these issues of culture in a consistently appropriate manner. For example, 84 percent of caregivers reported that their provider either "most of the time" or "always" understood the family's beliefs about mental health. Fifty-three percent of caregivers reported that their providers explicitly asked about traditions, beliefs, and values that the family held when planning services or providing care. Overall, 72 percent of caregivers reported that providers in the system of care were attentive to the cultural needs of the family.

Caregiver Awareness of Evidence-Based Services

Caregivers were asked whether their providers had discussed the evidence for the types of services that were being offered to their child. The majority (64.8 percent) reported that they had been informed of the evidence base. Table 14 shows that when caregivers were informed about the evidence that supported the services they received, they were more likely to be satisfied with services. For example, 84.7 percent of the caregivers who said that they were informed about the evidence that supported the services reported satisfaction with services; however, only 67.4 percent of caregivers who said they were not informed about the evidence reported satisfaction with the services.

Table 14. Caregiver Information about Evidence Base for Services and Satisfaction, Grantees Initially Funded in 2008-2010

	Caregiver Informed About Evidence	Caregiver Not Informed About Evidence
Percent of Caregivers Satisfied with Services (*n* = 1,481, *p* < .001)	84.7%	67.4%

Summary

- The overwhelming majority of children, youth, and their caregivers who received system of care services reported overall satisfaction with the services provided.
- A significantly high percentage of children, youth, and their caregivers who felt that they were engaged in treatment were also satisfied with the services they received.
- Caregivers were more satisfied with services when they felt fully engaged in treatment, as well as when they were informed about the evidence that supported the services that their children or youth received.

Implementation of the System of Care Approach

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

Site visits are conducted every 18 to 24 months over the funding period for the cooperative agreements, beginning in the second year of funding. Information is collected through a combination of document and randomly selected case record reviews, semi-structured interviews, observations made onsite, and telephone interviews. Respondents include project directors, core agency representatives, direct service providers, care coordinators, youth coordinators, family organization representatives, individual youth and family members who receive services, program evaluators, cultural competence coordinators, and social marketers. This section focuses on two cohorts of system of care grantees: those funded in 2008 and those funded in 2009. Grantees funded in 2008 completed two assessments (baseline in FY 2010 and follow-up in FY 2012). Grantees funded in 2009 completed the baseline assessment in FY 2011; a second assessment is underway in FY 2013. Note that ratings are based on a 5-point ordinal scale with a score of 5 indicating the highest level of development in system of care implementation.

Grantees Funded in 2008

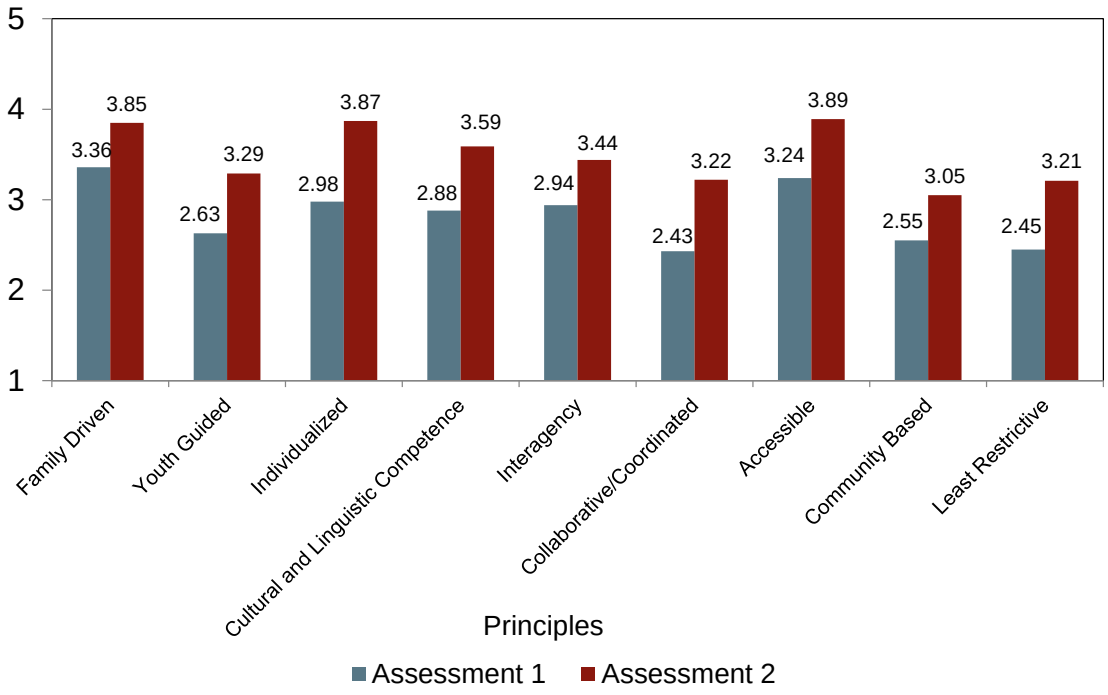
Infrastructure Domain

As Figure 8 shows, from assessment point 1 to assessment point 2, system of care grantees initially funded in 2008 improved in implementing their programs according to system of care principles across all nine areas assessed in the infrastructure domain. Grantees in this cohort received their highest rating in implementing the principle of accessible services at the second assessment. Service accessibility includes engaging in active outreach to the intended service population; developing and implementing an easy intake processes; ensuring minimal time between referral and service initiation; allowing flexibility in time and location for service planning and provision; providing sufficient capacity across the service array; arranging for transportation assistance to services; and making efforts to reduce financial barriers to care.

This cohort of grantees showed the most improvement from the first assessment to the second in implementing the principle of individualized care. These activities include having and using flexible funds to support the provision of services to meet the unique needs of children, youth, and families; training program staff, partner agency staff and private provides on the concept of

individualized care; developing a complete array of services in the community such that key service options are not missing; and collecting information on the extent to which services are provided in an individualized manner across the service array; and on child and youth outcomes.

Figure 8. **Overall Infrastructure Ratings for System of Care Grantees Initially Funded in 2008, Assessment Points 1 and 2**



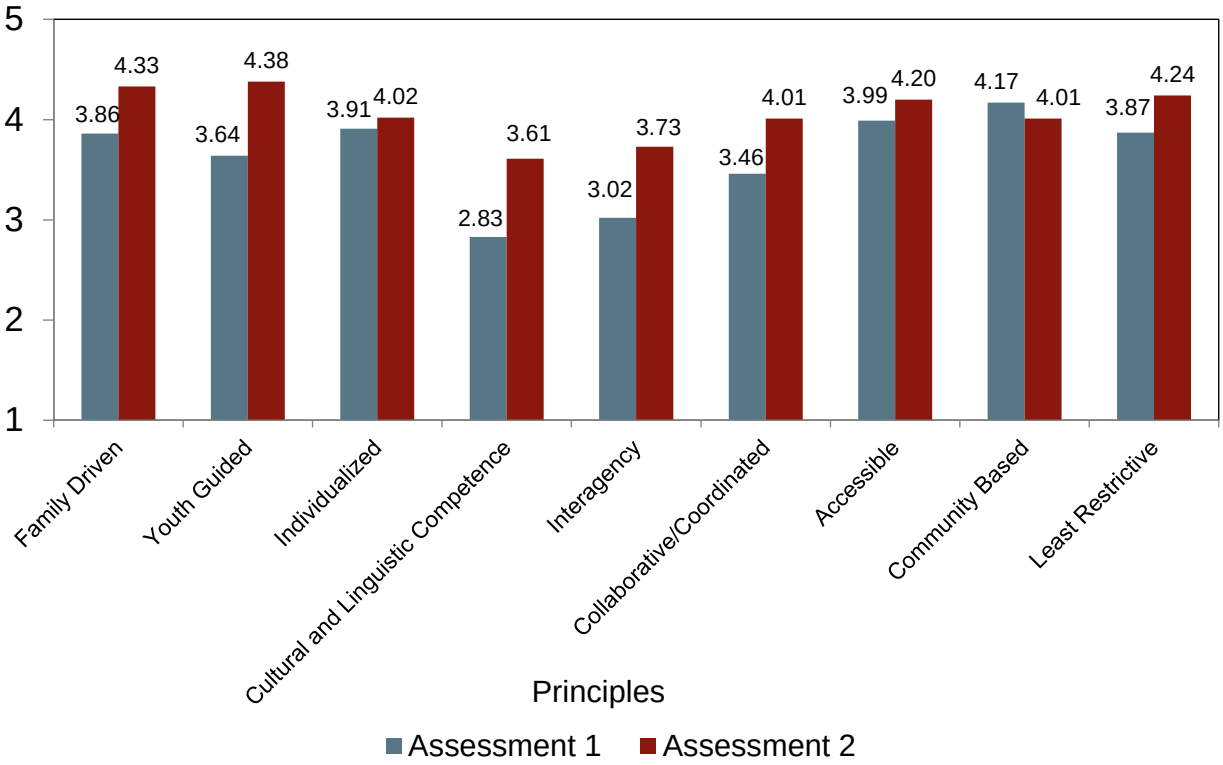
(*n* = 16 grantees)

Service Delivery Domain

As Figure 9 shows, system of care grantees initially funded in 2008 improved in implementing their programs according to system of care principles in eight of nine areas assessed in the service delivery domain, and received overall higher ratings in the service delivery domain than in the infrastructure domain. The principle of providing youth-guided care received the highest rating at the second assessment. Activities in this domain include those that support youth-guided care such as creating a youth-friendly process to enter the service system; supporting children, youth, and young adults to be fully involved in and guide their own service planning as well as the provision of treatments and services; and supporting youth and young adults to be involved in and guide the care review processes.

This cohort of grantees showed the most improvement from the first assessment to the second in the principle of cultural and linguistic competence. Activities that support the provision of culturally and linguistically competent care include engaging in active outreach to specific cultural groups; conducting intake and planning and providing services in the preferred languages of children, youth, and families; systematically assessing families' culture; and then developing and providing services according to those identified cultural values and traditions.

Figure 9. Overall Service Delivery Ratings for System of Care Grantees Initially Funded in 2008, Assessment Points 1 and 2



(*n* = 16 grantees)

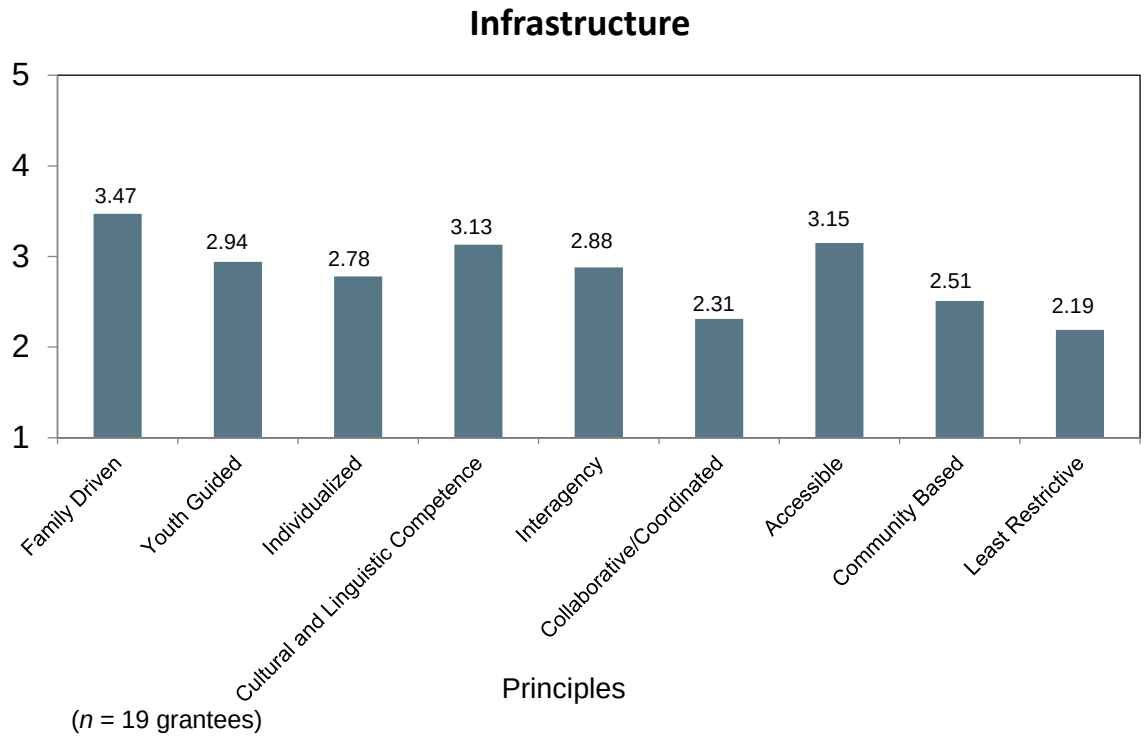
Grantees Funded in 2009

As Figure 10 shows, system of care grantees initially funded in 2009 had higher overall ratings in the service delivery domain than in the infrastructure domain at the first assessment, which was conducted in their second year of funding.

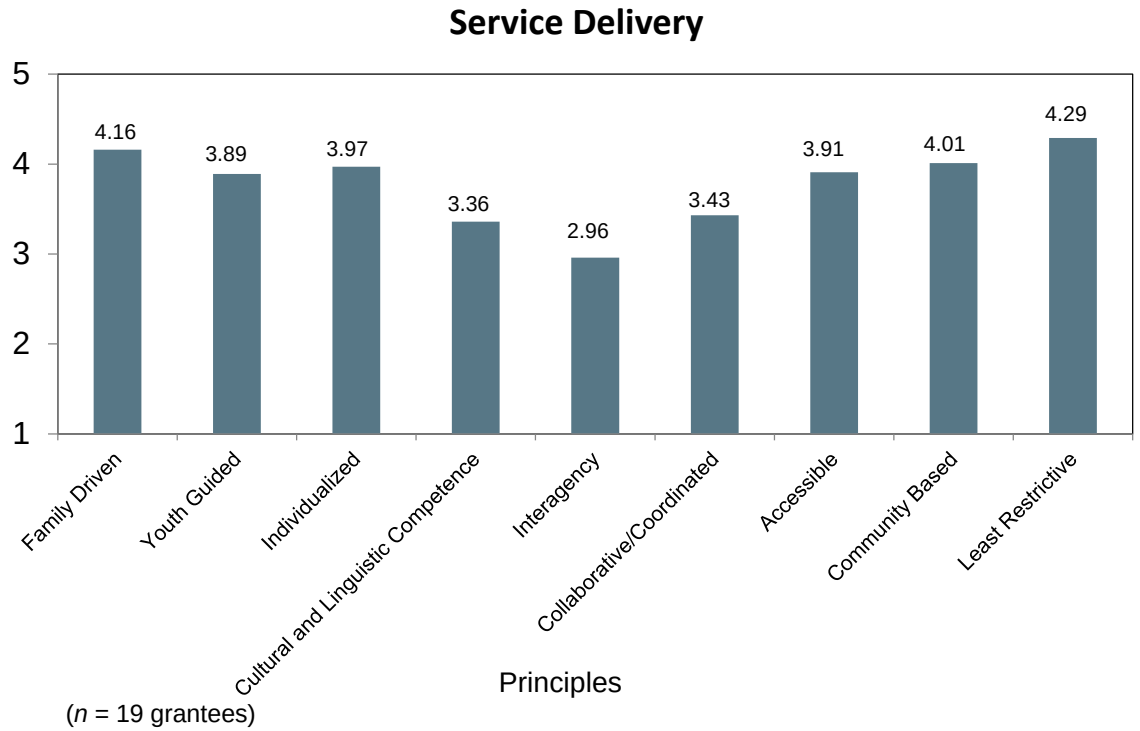
Within the infrastructure domain, the principle of family-driven care received the highest rating. These activities include actively involving family members in governance bodies, program management, staff training, and program evaluation efforts; hiring family members as staff; ensuring that family advocacy and peer supports are available in the service array; and collecting information on family outcomes and service experience.

Figure 10 also shows that within the service delivery domain, the principle of least restrictive care received the highest rating. Activities that support this principle include the use of care reviews to ensure that all less restrictive care options are exhausted before more restrictive services or placements are considered, and making efforts to use progressively less restrictive service options as soon as therapeutically appropriate when restrictive care or placements are necessary.

Figure 10. Overall Infrastructure and Service Delivery Ratings for System of Care Grantees Initially Funded in 2009, Assessment Point 1



(*n* = 19 grantees)



(*n* = 19 grantees)

Summary

- The findings from the system-level assessments of these two cohorts of grantees are consistent with findings from assessments of previously funded grantees: higher ratings are obtained in the service delivery domain than in the infrastructure domain; improvement is realized across almost all principles in both domains over time. The findings illustrate the developmental nature of system change: it is incremental, dynamic, and uneven.
- Grantees initially funded in 2008 received the highest scores on ratings of service accessibility and improved the most on providing care individualized to the unique needs of children and youth.
- Grantees in the 2008-funded group also scored highly on implementing youth-guided services and improved greatly on providing cultural and linguistically competent services.
- Grantees who were initially funded in 2009 received their highest ratings in making services family-driven and stressing services that included the least-restrictive care setting for children and youth.

Report Summary

The goal of the Children's Mental Health Initiative (CMHI) has been to address the needs of children and youth who experience serious mental health challenges and their families. This *2012–2013 Report to Congress* provides critical information about the characteristics of children, youth, and families served in CMHI-funded systems of care; the outcomes attained for children and youth and their families, as well as their service use and service experience; and how well grantees have implemented system of care principles. Overall, short- and long-term outcomes for children and youth served in systems of care and their caregivers demonstrate improvement after intake into services, and continued improvement over time. Data from the national evaluation of systems of care demonstrate that the system of care grantees:

- **Reach many children and youth typically underserved by the mental health system:** System of care services primarily reach children, youth, and families of color and those impacted by poverty. Access to behavioral health services for children and youth with serious mental health conditions—including those receiving system of care services—will likely be enhanced in states that choose to expand Medicaid coverage under the provisions of the Patient Protection and Affordable Care Act. Because the system of care philosophy aligns well with Health Homes under the Affordable Care Act (section 2703), there is the potential for the system of care approach to be used as a model for designing medical homes and making services more readily accessible for children, youth, and families.
- **Improve outcomes for children and youth:** Among the improved outcomes for children and youth were
  - improvements in interpersonal relationships, behavioral concerns, and emotional issues;
  - improvements in functional impairment, including improvements in school and home behaviors, and being able to interact with peers;
  - lower levels of anxiety;
  - a decline in suicide attempts and thoughts of suicide;
  - fewer instances of suspension or expulsion from school and better grades;
  - more stable living situations.
- **Enhance family outcomes:** Caregivers' levels of strain associated with caring for their children decreased, and caregivers were able to work more days in their employment situations. Caregivers reported that the average number of days of work missed due to behavioral and emotional problems fell from 4.0 to 1.8 after 18 months. The majority of caregivers and youth reported that the services they received helped to improve functioning within the home.
- **Expand the availability of effective supports and services:** Children, youth, and families had access to a broad array of mental health services, including assessment and evaluation, care management services, and community support services.
- **Save money by reducing the amount spent on inpatient hospitalization and juvenile justice services:** For the grantees studied, an average estimated reduction of $1,896 per child or youth served (whose caregivers provided

information during their intake and 12-month interviews related to their children's inpatient service use) was achieved for inpatient hospital care during the first 12 months in services. In addition, an estimated reduction of $1,057 per youth aged 11 and older (who provided information during their intake and 12-month interviews related to their arrest histories), on average, was achieved in relation to arrests during their first 12 months in services. Overall, this represents a 40.9 percent reduction in average per-child inpatient hospitalization costs.

- **Implement and maintain fidelity to the principles of accessible, community-based services:** The system of care assessment demonstrates that grantees are providing accessible community-based services to support the principles of systems of care and, over time, they are increasingly implementing these activities. Grantees received high ratings for service accessibility and provision of youth-guided services. Grantees realized greatest improvement in individualized care for children and youth, and provision of cultural and linguistically appropriate services over time.
- **Promote satisfaction through the use of engagement and evidence-based treatments:** Overall, 84.7 percent of caregivers and 95.2 percent of youth engaged in treatment reported that they were satisfied with the services they received. Caregivers were more likely to report being satisfied if they were told about the evidence that supported the treatments that were being used in services.

Recommendations

The CMHI has served as an important resource for developing and refining approaches to effectively serving children and youth with serious mental health conditions and their families. These activities have provided the knowledge to enable SAMHSA to bring the system of care approach to scale nationally by expanding these cooperative agreements into grants to states and to large jurisdictions. The outcomes discussed in this report demonstrate the positive impact that the system of care services have had on the lives of children and families. Recommendations for the future of children's mental health include:

- **Fostering the integration of primary and behavioral health care:** Integration of behavioral health and primary care, and continued development of the evidence base for effective preventive and treatment strategies, remain urgent concerns in children's mental health. To fully integrate primary and behavioral health care for children and youth, the future focus must include prevention and health promotion, early intervention, and treatment. Models for integrating primary care and behavioral health should allow providers to consult with child psychiatrists via telemedicine or other means, or through co-location. By co-locating behavioral health specialists within primary care settings, or vice versa, access to care can be improved and care coordination and treatment planning enhanced. A collaborative care model like the medical home model establishes treatment partnerships between behavioral health and primary care providers through cross-disciplinary case conferencing, co-management of care, and care coordination. Some system of care grantees are already practicing these models with varying degrees of success. Primary and behavioral health care integration can be fostered through the promotion of partnerships between health plans, providers, federal agencies, researchers, and policymakers in achieving more coordinated, effective behavioral health care for children and youth in the primary care setting.

- **Ensuring that behavioral health is included in all aspects of health reform:** Health care reform is one of SAMHSA's strategic initiatives. Looking ahead, it is expected that health reform will increase access to appropriate high-quality prevention, treatment, and recovery services; reduce existing disparities between the availability of services for mental and substance use disorders compared with the availability of services for other medical conditions; and support integrated, coordinated care, especially for people with behavioral health and other co-occurring health conditions. It is also expected that health reform will lead to the implementation of programs that draw on the science of behavioral health promotion and of prevention, treatment, and recovery support services. Over the years, systems of care have moved closer to a public health framework, focused on individual treatment and also on prevention of serious illness, early intervention, and education to improve outcomes and overall health.

- **Assuring that services are delivered within a family-driven, youth-guided framework by involving families and youth in the governance and oversight of grant activities:** System of care grantees have made significant strides in incorporating the voices of families and youth in decision-making at the governance and service delivery levels. As a result, programs have been more effective. System-level assessments consistently show that systems of care are rated highly on family and youth engagement and participation. The goal should be to expand family and youth involvement in ways that reinforce that youth and families are integral partners in planning and implementation at all levels of systems of care.
- **Continuing to engage individuals in recovery and their families in self-directed care, shared decision-making, and person-centered planning:** To engage individuals and families in their recovery, it will be necessary to promote cross-agency policies on participant-directed care that foster individual and family choice. This will be possible if youth and families are allowed to choose their behavioral health services and their providers across a range of available traditional and nontraditional recovery supports. Some areas in which families have been able to contribute in systems of care have been through family organizations and participation in the development of treatment goals in individualized plans of care. Systems of care have also engaged faith-based communities, particularly in their outreach to populations that experience health disparities, and have embraced the cultural and spiritual needs of the populations they serve in the delivery of services.
- **Strengthening collaborations across child-serving agencies (e.g., child welfare, juvenile justice, primary care, education, substance abuse, early childhood) and among critical providers and programs to build bridges among partners, including relationships between community and residential treatment settings:** Collaboration is a key principle of the system of care philosophy. Since children, youth, and families depend on multiple agencies, providers, community supports, and funders, it is important that efforts are made to continue to build and maintain trust among these groups. According to Pires (2010), collaboration allows partners to draw on the resources of communities or work in coordination with other programs to provide a range of services, whether in-house or through interagency agreements. However, it is also important that there is collaboration between child-serving and adult-serving systems when serving older youth who are transitioning to adult services, to avoid the gaps in service provision. The information provided should be used to track the clinical and functional outcomes of children and youth post-implementation of the Affordable Care Act.
- **Expanding systems of care technical assistance to non-grantee states and communities:** To continue efforts to expand and sustain systems of care across America it is recommended that technical assistance be provided to states and communities whether they have a current system of care grant or not. State Children's Mental Health Directors, County and City Directors, Territorial governments and Tribal Councils are all encouraged to implement systems of care, and to assist in their efforts it would be helpful to expand technical

assistance efforts to these entities, irrespective of whether they have a current grant. By doing so, these non-federally funded jurisdictions will be in a better position to develop, enhance and grow the system of care approach, and apply for future funding.

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[1] 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.

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

[3] Poverty categories are based on the U.S. Department of Health and Human Services (HHS) poverty guidelines. The categories take into account calendar year, state, family income, and household size. For example, according to these guidelines, in 2010, a family of four residing in the 48 contiguous states was living in poverty if its income was below $22,050 (HHS, 2012).

[4] $p < .001$
[5] $p < .001$
[6] $p < .001$
[7] $p < .01$
[8] $p < .001$
[9] $p < .001$
[10] Some children and youth received coverage from multiple sources.
[11] $p < .001$
[12] 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.
[13] Throughout this report, the term *child* refers to someone younger than 11 years old, whereas the term *youth* refers to someone aged 11–21 years.
[14] Interviews for the national evaluation are conducted even if the child or youth has left services.
[15] Being interviewed for the national evaluation is not equivalent to receiving services.
[16] Gender and age data are taken from *Annual Estimates of the Resident Population by Single Year of Age and Sex: April 1, 2010 to July 1, 2012* (U.S. Census Bureau, 2013b). Race/Ethnicity data taken from *Annual Estimates of the Resident Population by Sex, Single Year of Age, Race, and Hispanic Origin: April 1, 2010 to July 1, 2012* (U.S. Census Bureau, 2013a).
[17] Legal custody comparison data are derived from *America's Families and Living Arrangements: 2010* (U.S. Census Bureau, n.d.).
[18] Poverty categories are based on the U.S. Department of Health and Human Services (HHS) poverty guidelines. The categories take into account calendar year, state, family income, and household size. For example, according to these guidelines, in 2010 a family of four residing in the 48 contiguous states was living in poverty if its income was below $22,050 (HHS, 2012).
[19] Other adults in the household may have been employed.
[20] $p < .01$
[21] $p < .01$
[22] $p < .05$
[23] $p < .001$
[24] $p < .001$
[25] $p < .001$
[26] $p < .001$
[27] $p < .05$
[28] $p < .05$
[29] $p < .001$
[30] $p < .001$
[31] $p < .01$
[32] $p < .001$
[33] $p < .001$
[34] $p < .001$
[35] Some children and youth received coverage from multiple sources.
[36] $p < .001$
[37] $p < .001$
[38] Community-based support services include caregiver support/family support, respite care, advocacy, legal support, recreational activity, training/tutoring/education/mentoring, social work service, vocational/life skills training, transportation, child protective service, case evaluation and monitoring, family preservation, adoption service).
[39] Community-based therapeutic services include intake/screening/diagnosis/assessment, evaluation, consultation/meeting, case management/clinical coordination, service planning, crisis intervention/crisis stabilization, emergency room psychiatric service, early intervention/prevention, medication treatment/monitoring/administration, medical care/physical health care, day treatment, partial day treatment, individual therapy/counseling, group therapy/group counseling, family therapy/family counseling, psychosocial rehabilitation, diversion/prevention service, probation/monitoring, early intervention, preschool special education program, special education classes, physical/occupational/speech service, teacher aide service. (Note: Medication treatment/monitoring/administration does not include the costs of prescription medications.)
[40] The cost estimate is provided by the Healthcare Cost and Utilization Project's 2011 Nationwide Inpatient Sample (NIS) of the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2011), and adjusted to 2013 dollars using the September 2013 Bureau of Labor Statistics Consumer Price Index Calculator (http://www.bls.gov/data/inflation_calculator.htm).
[41] The estimated cost comes from 2000 data from the Bureau of Justice Statistics (National Center on Addiction and Substance Abuse, 2004), and adjusted to 2013 dollars using the September 2013 Bureau of Labor Statistics Consumer Price Index Calculator (http://www.bls.gov/data/inflation_calculator.htm).

Appendices

Appendix A
SAMHSA Strategic Initiatives

1. Prevention of Substance Abuse and Mental Illness

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

2. Trauma and Justice

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

3. Military Families

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

4. Recovery Support

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

5. Health Reform

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

6. Health Information Technology

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

7. Data, Outcomes, and Quality

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

8. Public Awareness and Support

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

Appendix B

System of Care Grantees of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, 1993–2010

Grants Awarded in 1993 and 1994

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

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

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

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

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

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

Kansas: *COMCARE;* Sedgwick County

Kansas: *KanFocus;* 13 southeastern counties

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

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

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

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

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

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

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

Oregon: *New Opportunities;* Lane County

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

Rhode Island: *Project REACH Rhode Island;* Statewide

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

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

Vermont: *ACCESS;* Statewide

Wisconsin: *Wraparound Milwaukee;* Milwaukee County

Grants Awarded in 1997 and 1998

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

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

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

Kentucky: *Kentucky Bridges Project;* 3 Appalachian regions

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

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

Michigan: *Southwest Community Partnership;* Detroit

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

Nebraska: *Families First and Foremost;* Lancaster County

Nebraska: *Nebraska Family Central;* 22 central counties

Nevada: *Neighborhood Care Centers;* Clark County

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

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

Oregon: *Clackamas Partnership;* Clackamas County

Pennsylvania: *Community Connections for Families;* Allegheny County

Rhode Island: *Project Hope;* Statewide

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

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

Vermont: *Children's UPstream Services;* Statewide

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

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

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

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

Grants and Cooperative Agreements Awarded in 1999 and 2000

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

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

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

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

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

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

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

Georgia: *KidsNet;* Rockdale and Gwinnett Counties

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

Indiana: *Dawn Project;* Marion County

Maryland: *Community Kids;* Montgomery County

Massachusetts: *Worcester Communities of Care;* Worcester

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

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

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

New Jersey: *Burlington Partnership;* Burlington County

New York: *Westchester Community Network;* Westchester County

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

South Carolina: *Gateways to Success;* Greenwood County

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

Tennessee: *Nashville Connection;* Nashville

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

Cooperative Agreements Awarded in 2002, 2003, and 2004

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

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

California: *La Familia Sana;* Monterey County

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

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

California: *Urban Trails;* Oakland

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

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

Florida: *One Community Partnership;* Broward County

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

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

Illinois: *System of Care Chicago;* Chicago

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

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

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

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

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

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

New York: *Family Voices Network;* Erie County

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

Ohio: *Tapestry*, Cuyahoga County

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

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

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

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

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

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

Texas: *Community Solutions;* Fort Worth

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

Cooperative Agreements Awarded in 2005 and 2006

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

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

California: *Connecting Circles of Care;* Butte County

California: *Seven Generations;* Los Angeles County

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

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

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

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

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

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

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

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

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

Michigan: *Impact;* Ingham County

Michigan: *Kalamazoo Wraps;* Kalamazoo County

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

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

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

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

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

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

North Carolina: *MeckCARES;* Mecklenburg County

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

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

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

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

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

Tennessee: *Mule Town Family Network;* Maury County

Texas: *Systems of Hope;* Harris County

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

Cooperative Agreements Awarded in 2008

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

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

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

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

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

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

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

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

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

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

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

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

Tennessee: *JustCare Family Network;* Shelby County

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

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

Vermont: *Youth in Transition Project;* Statewide

Washington: *Lummi System of Care;* Lummi Nation

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

Cooperative Agreements Awarded in 2009 and 2010

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

California: *Early Connections;* Alameda County

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

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

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

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

Florida: *Jacksonville System of Care Initiative;* Jacksonville

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

Guam: *Project Kariñu;* Territorywide

Hawaii: *Project Kealahou;* Honolulu County

Idaho: *Madison CARES;* Madison County

Illinois: *Illinois ACCESS Initiative;* Champaign County

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

Maryland: *Rural CARES;* Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester Counties

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

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

Michigan: *Saginaw MAX System of Care;* Saginaw County

Mississippi: *Mississippi Transitional Outreach Program;* Statewide

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

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

New York: *OnCare;* Onondaga County

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

Ohio: *FAST TRAC;* Clermont County

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

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

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

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

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

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

Appendix C
Glossary of Terms

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

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

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

Cultural competence: requires systems and organizations to

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

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

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

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

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

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

Fiscal year (FY): a term that is used to differentiate a budget year from the calendar year. The Federal fiscal year runs from October 1 of one year through September 30 of the following year. For example, FY 2013 ran from October 1, 2012, through September 30, 2013.

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

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

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

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

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

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

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

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

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

Serious mental health condition: defined by the CMHI program as

- an emotional, socio-emotional, behavioral, or mental disorder diagnosable under the DSM-IV-TR or its ICD-9-CM equivalents, or the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised (DC:0–3R; ZERO TO THREE, 2005);
- a disability in functioning at home, school, or community, or in a combination of these settings; or a level of functioning such that intervention is required that involves two or more community agencies providing services in the areas of mental health, education, child welfare, juvenile justice, substance abuse, or primary health care;
- the identified disability present for at least 1 year or, on the basis of diagnosis, severity, or multiagency intervention, expected to last longer than 1 year.

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

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

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

diagnosed with serious mental health conditions and their families.

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

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

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

Appendix D
Description of Study Components

Core Components of the National Evaluation

Cross-Sectional Descriptive Study

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

Longitudinal Child and Family Outcome Study

The primary purpose of the Outcome Study is to assess changes over time among children, youth, and families participating in system of care services. Outcome data collected from caregivers included the child's clinical and social functioning, behavioral and emotional strengths, restrictiveness of living situation, educational performance, and satisfaction with services. Assessments of family functioning, family resources, and caregiver strain also were obtained from caregivers. In addition, youth 11 years or older reported on their own 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 E for detailed descriptions of these instruments. In addition to meeting the eligibility for enrollment, children enrolled in system of care programs must meet all the following criteria to be enrolled in the Outcome Study:

- Enter the CMHI-funded system of care (child has completed intake, descriptive information has been collected, and caregiver has consented to treatment).
- Be receiving or on the verge of receiving services in the community by the time of the baseline Outcome Study interview. Services can be considered to include clinical assessment, contact with a service coordinator (care manager), and initial efforts to plan additional services.
- Have a caregiver who legally can grant consent to participate in the evaluation (can grant consent for treatment), or a legal custodian who will grant consent for the child and the child's primary caregiver to participate in the Outcome Study.
- Have a caregiver who can provide the information requested and is capable of

completing a data collection interview (e.g., no severe cognitive impairment).
- Not be the sibling of a child already enrolled in the Outcome Study.
- If applicable, be selected through the sampling method used at the community.

Service Experience Study

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

Services and Costs Study

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

Data were submitted by grantees via an online tool, where grantees either entered data directly into the system or uploaded data files that are structured according to the dictionary developed for the national evaluation.

System of Care Assessment

This study examines whether programs have been implemented in accordance with system of care program theory and documents how systems develop over time to meet the needs of the children and families they serve. Of particular interest is whether services are delivered in an individualized, family-focused, culturally relevant, and coordinated manner, and whether the system involves multiple child-serving agencies. Please see Appendix E for a detailed description of this assessment tool. Grantees funded in 2008–2009 will receive a maximum of two assessments. Information was collected through a combination of document reviews, review of randomly selected case records, semistructured interviews, observations made onsite, and follow-up telephone interviews to clarify information.

Separate semistructured interview guides were used to collect data from each grantee's key constituencies, including the project director, representatives from core agencies, family organization representatives, direct service providers,

youth coordinators, youth who are being served, and caregivers whose families are being served. Each respondent was asked questions that they would be most able to answer given their function and perspective. For example, service planning questions were asked of caregivers and care managers and not of the project director. Some of the items in the interviews were for context or descriptive purposes, while others were linked to indicators on the framework. For items that are rated, interviewers used the response provided by the individual respondent to rate the system on a 5-point scale using the established criteria for that item. That is, the qualitative data collected in the semistructured interviews were used to rate the system of care grantee on each item. The responses of the various constituent informants were rated separately.

Appendix E
Measures

Descriptive, Outcome, and Service Experience Study Measures

Descriptive data were collected primarily from caregivers as their children entered system of care services, and some data such as diagnostic assessments were drawn from intake records. For children enrolled in the Longitudinal Child and Family Outcome Study, caregivers reported on children's strengths, behavioral and emotional problems, cultural competence of services, caregiver strain, social functioning, educational history, family functioning, stability of the child's living situation, service utilization, and child development. Youth aged 11 or older reported on their behavioral and emotional problems, 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.

Table E-1 provides a summary of the instruments used in each of these studies by domain. Many of these measures also were used to evaluate grantees during earlier phases of program funding. See previous *Reports to Congress* for report of findings on earlier cohorts.

Table E-1. National Evaluation Instruments

Domain	Instrument
Cross-Sectional Descriptive Study	
Descriptive Characteristics	Enrollment and Demographic Information Form (EDIF)
	Child Information Update Form (CIUF)
Longitudinal Child and Family Outcome Study	
Additional Descriptive Information: Demographics, Medications, Chronic Illnesses	Caregiver Information Questionnaire, Revised (CIQ–R)
	Youth Information Questionnaire, Revised (YIQ–R)
Caregiver Strain	Caregiver Strain Questionnaire (CGSQ; Brannan et al., 1998)
	Parenting Stress Index (PSI; Abidin, 1990)
Child and Youth Behavior	Child Behavior Checklist 1½–5 (CBCL 1½–5; Achenbach & Rescorla, 2000)
	Child Behavior Checklist 6–18 (CBCL 6–18; Achenbach & Rescorla, 2001)
Child Development	Devereux Early Childhood Assessment (DECA; LeBuffe & Naglieri, 1999)
Child and Youth Social Functioning	Columbia Impairment Scale (CIS; Bird et al., 1993)

Table E-1. National Evaluation Instruments (continued)

Domain	Instrument
Longitudinal Child and Family Outcome Study (continued)	
Child and Youth Strengths	Behavioral and Emotional Rating Scale—Second Edition, Parent Rating Scale (BERS–2C; Epstein, 2004)
	Behavioral and Emotional Rating Scale—Second Edition, Youth Rating Scale (BERS–2Y; Epstein, 2004)
	Preschool Behavioral and Emotional Rating Scale (PreBERS; Epstein, Synhorst, Cress, & Allen, 2009)
Delinquent Behaviors	Delinquency Survey, Revised (DS–R)
Education	Education Questionnaire, Revision 2 (EQ–R2)
Stability of Living Situation	Living Situations Questionnaire (LSQ)
Substance Use and Dependency	GAIN Quick–R: Substance Problem Scale (GAIN; Titus & Dennis, 2005)
	Substance Use Survey, Revised (SUS–R)
Youth Anxiety	Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS–2; Reynolds & Richmond, 2008)
Youth Depression	Reynolds Adolescent Depression Scale, Second Edition (RADS–2; Reynolds, 1986)
Service Experience Study	
Cultural Competence of Services	Cultural Competence and Service Provision Questionnaire, Revised (CCSP–R)
Satisfaction with Services	Youth Services Survey (YSS; Brunk, Koch, & McCall, 2000)
	Youth Services Survey for Families (YSS–F, Brunk et al., 2000)
Service Use	Multi-Sector Service Contacts, Revised (MSSC–R)

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, each containing four service system components that form the columns of the table. The domains are infrastructure and service delivery. The infrastructure domain is comprised of four components that address governance, management and operations, service array, and program evaluation. The service delivery domain is comprised of four components that address intake into services, service planning, service provision, and care review. Definitions of the components are provided in Table E-2.

Table E-2. Definition of Service System Components

Infrastructure	
Governance	The governing structure responsible for explicating the system's goals, vision, and mission; strategic planning and policy development; and establishing formal arrangements among agencies. Governance structures may be boards of directors, oversight or steering committees, interagency boards, or management teams.
Management and Operations	The administrative functions and activities that support direct service delivery. For this study, this component focuses primarily on staff development, funding approaches, and procedural mechanisms related to the implementation of the system of care service delivery system.
Service Array	The range of service and support options available to children and their families across the system of care.
Program Evaluation	Program evaluation conducted through the integration of process assessment and outcome measurement, and the use of continuous feedback loops to improve service delivery.
Service Delivery	
Entry into Service System (i.e., intake)	The processes and activities associated with children, youth, and families' initial contact with the service system, including eligibility determination.
Service Planning	The identification of services for children, youth, and families through initial development as well as periodic updating of initial service plans.
Service Provision	The processes and activities related to the ongoing receipt of and participation in services.
Care Review	Processes and activities related to the formal review of care of individual children and youth to address complex issues and challenging problems, to prevent the use of more restrictive services or settings.

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

Table E-3. Definitions of System of Care Principles

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

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

Principle	Definition
Culturally and Linguistically Competent	Sensitivity and responsiveness to, and acknowledgment of, the inherent value of differences related to race, religion, language, national origin, gender, socioeconomic background and community-specific characteristics.
Interagency	The involvement and partnership of core agencies in multiple child-serving sectors, including child welfare, health, juvenile justice, education, mental health, and substance abuse.
Collaborative/ Coordinated	Professionals working together in a complementary manner to avoid duplication of services, eliminate gaps in care, and facilitate child and family movement through the service system.
Accessible	The minimizing of barriers to services in terms of physical location, convenience of scheduling, and financial constraints.
Community Based	The provision of services within close geographical proximity to the targeted community.
Least Restrictive	The provision of services in settings that maximize freedom of choice and movement, and that present opportunities to interact in normative environments (e.g., school and family).

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

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

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

The qualitative data are derived from a narrative report that organizes and describes all information obtained from the grantee. The report includes a summary of service component areas, as well as a brief and preliminary synopsis of observed salient strengths and challenges. The report is

entered into the ATLAS.ti qualitative analysis software that organizes and classifies all information. The data are analyzed according to a set of defined codes that are assigned to segments of the text. The codes are identified a priori, and represent components of the system of care service structure.

Services and Costs Study

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

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

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

Appendix F
Data Analysis Techniques Used in This Report

General Linear Model Repeated Measures Analysis of Variance

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

Generalized Estimating Equations (GEE)

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

Zero-Inflated Poisson

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

Appendix G
Descriptive, Outcomes, and Service Experience Data Tables

The tables included in this appendix provide an overview of descriptive, outcome, and service experience data for grantees funded in 2008–2010.

Data Sources and Sample

The Longitudinal Child and Family Outcome Study of grantees initially funded in 2008–2010 assesses children and their families every 6 months, for up to 24 months, regardless of whether the children continued to receive services through system of care programs. These assessments allow comparison of clinical and functional outcomes for all children who participated in the Outcome Study, regardless of whether they remained in or exited system of care services. The number of children enrolled in the evaluation is impacted by variation in level and focus of funding as grantees may be funded to serve smaller numbers of children (e.g., some grantee funding may be directed primarily toward infrastructure development, or the number of children meeting service criteria for serious emotional disturbance may be lower). While in most communities all willing families need to be recruited into the Outcome Study, in some larger communities, sampling strategies may need to be employed to select only a sufficient number of families at random from the pool of children who enter the system of care program. Sample size in analyses conducted in this report fluctuates due to differences in enrollment and data completion rates among grantees. Table G-1 presents study enrollment and data completion rates through June 11, 2013, for each grantee initially funded in 2008–2010. In this table, the Descriptive Sample was based on the number of cases with at least one piece of descriptive information, and the Outcome Sample was based on the number of cases with data from at least one of the required outcome instruments at baseline.

Organization of Data Tables

Table G-2 presents detailed information on the baseline child, youth, and family demographics and enrollment information of children, youth, and families enrolled by grantees initially funded in 2008–2010.

Baseline child and youth history and family characteristics are shown in Table G-3 for children, youth, and families enrolled by grantees initially funded in 2008–2010.

Information on child, youth, and family clinical and functional outcome indicators at intake, 6 months, 12 months, 18 months, and 24 months and service experience (at follow-up only) are presented for children, youth, and families enrolled by grantees initially funded in 2008–2010 in Table G-4. These data tables provide *descriptive* information on each clinical and functional outcome measure at each data collection point and do not represent analysis of change over time. Some children, youth, and families may not have data collected across all data collection points.

Table G-1. Study Enrollment and Program Interview Completion for Grantees Initially Funded in 2008-2009

Grantee	Descriptive Sample[a]	Outcome Sample[b]	Eligible for Interview at Each Assessment Point[c]				Completed Interview at Each Assessment Point[d]				Interview Completion Rate at Each Assessment Point[e]			
			6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month
130	253	82	56	39	26	18	72	57	49	39	77.78	68.42	53.06	46.15
131	362	181	115	81	56	41	161	140	105	89	71.43	57.86	53.33	46.07
132	502	138	60	32	24	17	125	103	61	34	48.00	31.07	39.34	50.00
133	771	108	29	17	10	7	94	76	54	39	30.85	22.37	18.52	17.95
134	206	88	39	22	6	1	63	37	16	5	61.90	59.46	37.50	20.00
135	398	113	39	12	8	2	97	57	42	29	40.21	21.05	19.05	6.90
136	157	90	37	19	14	6	79	74	59	51	46.84	25.68	23.73	11.76
137	637	165	113	89	70	52	150	132	116	103	75.33	67.42	60.34	50.49
138	486	212	162	112	67	38	195	168	134	95	83.08	66.67	50.00	40.00
139	512	138	26	11	8	3	129	94	47	30	20.16	11.70	17.02	10.00
140	697	226	140	52	30	10	226	201	158	105	61.95	25.87	18.99	9.52
141	114	54	33	26	14	11	51	46	35	26	64.71	56.52	40.00	42.31
142	455	88	48	33	24	22	76	64	47	45	63.16	51.56	51.06	48.89
143	139	36	13	8	4	3	26	14	7	5	50.00	57.14	57.14	60.00
144	178	169	118	79	52	34	146	116	80	61	80.82	68.10	65.00	55.74
145	518	206	121	99	62	52	183	150	109	79	66.12	66.00	56.88	65.82
146	219	51	16	8	0	0	51	30	12	0	31.37	26.67		
147	194	76	51	33	20	21	63	56	41	32	80.95	58.93	48.78	65.63
Aggregate Number for Grantees Funded in 2008[f]	**6,798**	**2,221**	**1,216**	**772**	**495**	**338**	**1,987**	**1,615**	**1,172**	**867**	**61.20**	**47.80**	**42.24**	**38.99**
148	643	53	5	6	0	0	53	41	15	5	9.43	14.63		
149	166	88	52	28	13	0	88	72	47	22	59.09	38.89	27.66	
150	60	35	22	17	9	3	34	31	27	17	64.71	54.84	33.33	17.65
151	167	97	61	30	10	1	85	51	18	3	71.76	58.82	55.56	33.33
152	280	119	54	31	11	7	90	52	33	11	60.00	59.62	33.33	63.64
153	133	77	42	28	6	0	69	40	30	3	60.87	70.00	20.00	
154	117	66	24	9	1	0	53	39	12	0	45.28	23.08	8.33	
155	578	123	62	21	6	3	92	40	16	6	67.39	52.50	37.50	50.00
156	121	86	39	17	3	0	69	41	20	0	56.52	41.46	15.00	
157	382	205	91	51	28	16	180	145	110	71	50.56	35.17	25.45	22.54
158	135	41	19	11	11	5	31	22	16	6	61.29	50.00	68.75	83.33
159	204	64	18	13	2	0	46	28	14	1	39.13	46.43	14.29	

Table G-1. Study Enrollment and Program Interview Completion for Grantees Initially Funded in 2008-2009 (continued)

Grantee	Descriptive Sample[a]	Outcome Sample[b]	Eligible for Interview at Each Assessment Point[c]				Completed Interview at Each Assessment Point[d]				Interview Completion Rate at Each Assessment Point[e]			
			6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month	6-Month	12-Month	18-Month	24-Month
160	229	89	38	7	0	0	62	27	0	0	61.29	25.93		
161	248	110	27	5	0	0	82	33	3	0	32.93	15.15		
162	218	136	61	34	9	0	98	71	32	1	62.24	47.89	28.13	
163	581	57	17	2	0	0	36	19	0	0	47.22	10.53		
164	247	139	57	33	9	0	111	89	67	37	51.35	37.08	13.43	
165	453	222	130	77	18	3	196	147	53	6	66.33	52.38	33.96	50.00
166	270	13	1	0	0	0	3	2	1	0	33.33			
167	132	98	74	50	29	15	93	84	66	47	79.57	59.52	43.94	31.91
168	224	78	9	0	0	0	27	0	0	0	33.33			
169	80	6	0	0	0	0	0	0	0	0				
170	38	0	0	0	0	0	0	0	0	0				
171	93	28	7	0	0	0	10	0	0	0	70.00			
172	64	10	2	0	0	0	5	0	0	0	40.00			
173	167	27	2	0	0	0	9	0	0	0	22.22			
174	46	40	1	0	0	0	27	0	0	0	3.70			
175	21	9	0	0	0	0	1	0	0	0				
176	56	33	4	0	0	0	16	0	0	0	25.00			
Aggregate Number for Grantees Funded in 2009/2010[f]	**6,153**	**2,149**	**919**	**470**	**165**	**53**	**1,666**	**1,074**	**580**	**236**	**55.16**	**43.76**	**28.45**	**22.46**

[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: (1) 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), or 24 months or longer (for 24-month follow-up), and (2) 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: (1) 6-month outcome sample: cases with 6-month data on at least one of the required outcome instruments; (2) 12-month outcome sample: cases with 12-month data on at least one of the required outcome instruments; (3) 18-month outcome sample: cases with 18-month data on at least one of the required outcome instruments; (4) 24-month outcome sample: cases with 24-month data on at least one of the required outcome instruments;

[e] Interview Completion Rate at Each Assessment Point was calculated as follows: (Completed interview at each assessment point/Eligibility for interview at each assessment point) x 100.

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

Table G-2. Baseline Characteristics: Child and Youth Demographic and Enrollment Information

Grantees Funded in 2008–2010			
	Overall Sample (*n* = 12,951)	Descriptive Sample (*n* = 8,554)	Outcome Sample (*n* = 4,397)
Gender	(*n* = 12,741)	(*n* = 8,550)	(*n* = 4,191)
Male	59.2%	59.1%	59.5%
Female	40.0%	39.9%	40.3%
Transgender (male to female)	0.1%	0.1%	0.0%
Transgender (female to male)	0.0%	0.0%	0.0%
Don't Know/Not Sure	0.4%	0.7%	0.0%
Other	0.1%	0.1%	0.0%
Refused	0.1%	0.2%	0.1%
Age in Years	(*n* = 12,543)	(*n* = 8,359)	(*n* = 4,184)
Mean (*SD*)	11.08 (5.67)	10.89 (5.69)	11.46 (5.62)
0–5 Years	25.9%	26.6%	24.7%
6–11 Years	19.7%	20.6%	17.9%
12–15 Years	26.5%	25.9%	27.7%
16–22 Years	27.9%	26.9%	29.8%
Race and Ethnicity	(*n* = 12,309)	(*n* = 8,182)	(*n* = 4,127)
American Indian or Alaska Native Alone	7.8%	8.7%	6.1%
Asian Alone	0.9%	0.9%	0.9%
Black or African American Alone	22.3%	23.0%	20.9%
Native Hawaiian or Other Pacific Islander Alone	0.9%	0.6%	1.5%
White Alone	47.0%	47.8%	45.4%
Of Hispanic Origin	15.0%	13.6%	17.7%
Multiracial	6.1%	5.4%	7.5%
Participating in Service Plan Development[a]	(*n* = 8,620)	(*n* = 5,112)	(*n* = 3,508)
Caregiver	81.5%	81.3%	81.8%
Child	74.8%	73.9%	76.0%
Other Family Member	21.6%	20.5%	23.3%
Care Manager	63.7%	60.7%	68.1%
Therapist	39.9%	44.2%	33.6%
Other Mental Health Staff	16.9%	15.3%	19.2%
Education Staff	12.2%	11.6%	13.0%
Child Welfare Staff	8.9%	9.6%	8.0%
Juvenile Justice	4.8%	4.6%	5.2%
Health Staff	1.5%	1.1%	1.9%
Family Advocate	28.7%	24.5%	34.9%
Other Participant	14.3%	13.2%	16.0%

Table G-2. Baseline Characteristics: Child and Youth Demographic and Enrollment Information (continued)

Grantees Funded in 2008–2010			
	Overall Sample (*n* = 12,951)	Descriptive Sample (*n* = 8,554)	Outcome Sample (*n* = 4,397)
Referral Sources	(*n* = 12,741)	(*n* = 8,550)	(*n* = 4,191)
Corrections	0.6%	0.6%	0.5%
Juvenile Court	3.3%	3.2%	3.4%
Probation	3.5%	3.2%	4.2%
School	11.3%	11.1%	11.9%
Mental Health Agency, Clinic, Provider	30.8%	29.6%	33.3%
Physical Health Care Agency, Clinic, Provider	4.5%	4.6%	4.2%
Public Child Welfare	12.2%	12.6%	11.3%
Tribal Child Welfare Agency	0.1%	0.1%	0.1%
Substance Abuse Agency, Clinic, Provider	0.6%	0.4%	1.0%
Family Court	0.4%	0.4%	0.4%
Caregiver	12.0%	12.7%	10.5%
Self (youth referred himself or herself)	2.5%	2.3%	2.8%
Early Care: Early Head Start Program	0.1%	0.1%	0.1%
Early Care: Head Start Program	0.4%	0.3%	0.5%
Early Care: Early Intervention (Part C)	0.7%	0.4%	1.4%
Early Care: Preschool Special Education Program (Part B)	0.3%	0.2%	0.4%
Other Early Care and Education Programs, Providers	0.8%	0.9%	0.7%
Other	12.5%	13.1%	11.3%
Not Applicable	1.0%	1.0%	1.0%
Unknown	0.5%	0.6%	0.3%
Missing	1.9%	2.5%	0.6%
Agency Involvement[a]	(*n* = 12,741)	(*n* = 8,550)	(*n* = 4,191)
Corrections	1.9%	1.8%	2.1%
Juvenile Court	10.0%	9.3%	11.5%
Probation	9.0%	8.6%	9.8%
School	52.7%	52.7%	52.9%
Mental Health Agency, Clinic, Provider	65.9%	65.2%	67.2%
Physical Health Care Agency, Clinic, Provider	20.8%	18.9%	24.7%
Public Child Welfare	22.0%	21.9%	22.2%
Substance Abuse Agency, Clinic, Provider	3.0%	2.6%	3.7%
Family Court	4.0%	4.0%	4.0%
Early Care: Early Head Start Program	0.8%	0.8%	1.0%
Early Care: Head Start Program	2.1%	2.1%	2.1%
Early Care: Early Intervention	1.4%	1.1%	2.1%
Early Care: Preschool Special Education Program (Part B)	1.2%	0.9%	1.7%
Other Early Care and Education Programs/Providers	4.3%	4.2%	4.5%
Other	14.0%	14.5%	12.9%

Table G-2. Baseline Characteristics: Child and Youth Demographic and Enrollment Information (continued)

Grantees Funded in 2008–2010			
	Overall Sample (*n* = 12,951)	**Descriptive Sample (*n* = 8,554)**	**Outcome Sample (*n* = 4,397)**
***DSM–IV–TR* Axis I and II Diagnosis at Intake[a]**	(*n* = 9,206)	(*n* = 5,803)	(*n* = 3,403)
Substance Use Disorders	8.5%	7.5%	10.2%
Schizophrenia and Other Psychotic Disorders	2.9%	2.6%	3.4%
Mood Disorders	37.8%	36.9%	39.4%
Pervasive Developmental Disorders	4.2%	4.1%	4.3%
Anxiety Disorders *not* including PTSD or Acute Stress Disorder	8.4%	7.9%	9.4%
Adjustment Disorders	15.3%	14.8%	16.3%
Posttraumatic Stress Disorder and Acute Stress Disorder	9.7%	9.9%	9.4%
Impulse Control Disorders	2.4%	2.5%	2.2%
Oppositional Defiant Disorder	17.6%	18.4%	16.3%
Attention-Deficit/Hyperactivity Disorder (ADHD)	32.6%	32.5%	32.7%
Personality Disorders	2.6%	2.3%	3.2%
Mental Retardation	2.3%	2.1%	2.6%
Learning, Motor Skills, and Communication Disorders	2.5%	2.3%	2.9%
Conduct Disorder	5.0%	5.1%	5.0%
Disruptive Behavior Disorder	8.8%	8.6%	9.2%
Other	10.8%	10.4%	11.4%
V Code (does not include V71.09)	6.1%	5.7%	6.6%
Substance-Induced Disorders	0.4%	0.4%	0.3%
DC:0–3R Axis I Diagnosis at Intake[a]	(*n* = 325)	(*n* = 175)	(*n* = 150)
Posttraumatic Stress Disorder	10.2%	12.0%	8.0%
Deprivation/Maltreatment Disorder	2.5%	1.7%	3.3%
Disorders of Affect	4.3%	4.6%	4.0%
Prolonged Bereavement/Grief Reaction	2.2%	1.7%	2.7%
Anxiety Disorders	11.1%	9.1%	13.3%
Depressive Disorder	0.3%	0.0%	0.7%
Mixed Disorder of Emotional Expressiveness	1.2%	1.7%	0.7%
Adjustment Disorder	32.9%	33.1%	32.7%
Regulation Disorder of Sensory Processing	4.0%	4.0%	4.0%
Hypersensitivity	4.3%	3.4%	5.3%
Hyposensitivity/Underresponsive	2.2%	2.9%	1.3%
Sensory Stimulation-Seeking/Impulsive	10.2%	7.4%	13.3%
Sleep Disorder	1.5%	1.1%	2.0%
Feeding Behavior Disorders	2.2%	1.7%	2.7%
Communication Disorder	2.2%	1.7%	2.7%
Multiple Developmental Disorders	3.1%	0.6%	6.0%
Other	34.2%	36.0%	32.0%

Table G-2. Baseline Characteristics: Child and Youth Demographic and Enrollment Information (continued)

Grantees Funded in 2008–2010			
	Overall Sample (*n* = 12,951)	Descriptive Sample (*n* = 8,554)	Outcome Sample (*n* = 4,397)
Presenting Problems[a]	(*n* = 11,069)	(*n* = 7,195)	(*n* = 3,874)
Suicide-Related Problems	16.9%	15.4%	19.8%
Depression-Related Problems	35.2%	33.7%	37.9%
Anxiety-Related Problems	34.8%	32.8%	38.5%
Hyperactivity and Attention-Related Problems	42.7%	41.4%	45.2%
Conduct/Delinquency-Related Problems	49.4%	49.4%	49.3%
Substance Use, Abuse, and Dependence-Related Problems	15.2%	14.6%	16.3%
Adjustment-Related Problems	32.6%	32.2%	33.3%
Psychotic Behaviors	6.1%	5.8%	6.8%
Pervasive Development Disabilities	7.9%	7.5%	8.6%
Specific Development Disabilities	8.7%	7.8%	10.5%
Learning Disabilities	15.4%	14.4%	17.1%
School Performance	33.3%	32.5%	34.9%
Eating Disorders	2.8%	2.2%	3.8%
Gender Identity	0.7%	0.7%	0.7%
Presenting Problems Relevant for Early Childhood[a,b]	(*n* = 7,864)	(*n* = 5,088)	(*n* = 2,776)
Feeding Problems in Young Children	1.8%	1.1%	2.9%
Disruptive Behaviors in Young Children	37.4%	36.6%	38.9%
Persistent Noncompliance	29.6%	27.8%	33.0%
Excessive Crying/Tantrums	18.1%	15.8%	22.1%
Separation Problems	11.8%	10.8%	13.6%
Non-Engagement with People	8.9%	8.1%	10.4%
Sleeping Problems	19.7%	16.7%	25.2%
Excluded from Preschool or Childcare Program	2.0%	1.6%	2.6%
At Risk for or Has Failed Family Home Placement	11.2%	10.7%	12.1%
Maltreatment (child abuse and neglect)	14.5%	13.8%	16.0%
Other Problems That Are Related to Child's Health	4.5%	3.7%	5.8%
Maternal Depression	13.4%	12.5%	15.2%
Maternal Mental Health (other than depression)	13.6%	13.1%	14.6%
Paternal Mental Health	8.5%	7.9%	9.8%
Caregiver Mental Health (other than maternal or paternal)	2.7%	2.7%	2.6%
Maternal Substance Abuse/Use	11.4%	11.5%	11.1%
Paternal Substance Abuse/Use	9.2%	8.9%	9.8%
Caregiver Substance Abuse/Use	1.4%	1.6%	1.2%
Family Health Problems	8.0%	7.3%	9.3%
Other Parent/Caregiver/Family Problems	17.6%	16.8%	18.9%
Problems Related to Housing (including homelessness)	10.3%	9.8%	11.3%
Other	1.8%	1.1%	2.9%

Table G-2. Baseline Characteristics: Child and Youth Demographic and Enrollment Information (continued)

Grantees Funded in 2008–2010			
	Overall Sample (*n* = 12,951)	Descriptive Sample (*n* = 8,554)	Outcome Sample (*n* = 4,397)
Financial Resources for Services[a]	(*n* = 10,829)	(*n* = 7,054)	(*n* = 3,.757)
Medicaid	80.0%	79.2%	81.5%
Child Health Insurance Program (CHIP)	3.9%	3.3%	5.0%
Supplemental Security Income (SSI)	9.3%	8.3%	11.1%
Temporary Assistance for Needy Families (TANF)	5.8%	6.1%	5.5%
Private Insurance	13.8%	14.0%	13.4%
Other Funding	13.1%	12.5%	14.3%

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

[b] Presenting Problems of Early Childhood presents additional presenting problems that are asked only for children younger than 9.

Table G-3. Baseline Characteristics: Child and Youth History and Family Characteristics

Grantees Funded in 2008–2010	
	Outcome Sample (*n* = 4,397)
Custody Status	(*n* = 3,621)
Two Parents or One Biological Parent and One Step or Adoptive Parent	30.6%
Biological Mother Only	42.3%
Biological Father Only	4.0%
Adoptive Parent(s)	4.6%
Sibling(s)	0.2%
Aunt and/or Uncle	1.9%
Grandparent(s)	7.7%
Adult Friend	0.1%
Ward of the State	5.9%
Other	2.7%
Living Situation[a]	(*n* = 4,650)
Biological Family	61.9%
Adoptive Family	4.0%
Non-Parent Relative(s)	20.5%
Non-Relative	8.2%
Independent	5.4%
Primary Caregiver Relationship to Child	(*n* = 3,588)
Biological Parent	76.2%
Adoptive/Step-Parent	5.9%
Foster Parent	3.6%
Live-In Partner of a Parent	0.1%
Sibling	0.4%
Aunt or Uncle	2.3%
Grandparent	9.5%
Cousin	0.5%
Other Family Relative	0.5%
Adult Friend	0.3%
Other	0.7%
Primary Caregiver Gender	(*n* = 3,637)
Male	9.1%
Female	90.9%
Primary Caregiver Age in Years	(*n* = 3,619)
Mean (*SD*)	39.35 (11.3)
16–25 Years	7.6%
26–30 Years	14.6%
31–35 Years	19.5%
36–40 Years	18.1%
41–45 Years	13.2%
46–50 Years	10.1%
51 Years or Older	16.9%

Table G-3. Baseline Characteristics: Child and Youth History and Family Characteristics (continued)

Grantees Funded in 2008–2010	
	Outcome Sample (*n* = 4,397)
Primary Caregiver Race and Ethnicity	(*n* = 3,626)
American Indian or Alaska Native Only	6.3%
Asian Only	1.0%
Black or African American Only	19.5%
Native Hawaiian or Other Pacific Islander Only	1.9%
White Only	50.8%
Of Hispanic Origin	16.7%
Multiracial	3.8%
Whether Primary Caregiver Employed[b]	(*n* = 3,584)
Yes	49.3%
No	50.7%
Whether Primary Caregiver Paid for Child's Services[b]	(*n* = 1,865)
Yes	16.7%
No	83.3%
Family Income	(*n* = 3,494)
Less Than $5,000	16.6%
$5,000–$9,9999	13.2%
$10,000–$14,999	14.2%
$15,000–$19,999	9.9%
$20,000–$24,999	10.8%
$25,000–$34,999	11.6%
$35,000–$49,999	9.8%
$50,000–$74,999	7.9%
$75,000–$99,999	3.0%
$100,000 and Over	2.9%
Family Poverty Level Status	(*n* = 3,359)
Below Poverty	61.4%
At/Near Poverty	13.0%
Above Poverty	25.6%
Whether Child Uses Medication	(*n* = 3,620)
Yes	49.2%
No	50.8%

Table G-3. Baseline Characteristics: Child and Youth History and Family Characteristics (continued)

Grantees Funded in 2008–2010	
	Outcome Sample (*n* = 4,397)
Current Medications	(*n* = 1,687)
Abilify	18.9%
Adderall	13.5%
Catapres	10.7%
Celexa	7.2%
Concerta	14.9%
Daytrana	0.8%
Depakote	7.2%
Desyrel	5.7%
Dexedrine	0.8%
Effexor	0.9%
Eskalith	1.2%
Focalin	4.7%
Geodon	3.4%
Haldol	0.9%
Klonopin	1.3%
Lamictal	5.3%
Lexapro	2.8%
Lithobid	1.9%
Lithonate	2.0%
Metadate	2.0%
Neurontin	0.2%
Paxil	1.1%
Prozac	9.6%
Remeron	1.2%
Risperdal	22.6%
Ritalin	4.9%
Seroquel	9.0%
Strattera	5.3%
Symbyax	0.7%
Tegretol	0.9%
Tenex	8.0%
Topamax	2.7%
Trileptal	4.4%
Vyvanse	10.0%
Wellbutrin	5.4%
Xanax	0.5%
Zoloft	9.4%
Zyprexa	2.9%
Other	18.1%

Table G-3. Baseline Characteristics: Child and Youth History and Family Characteristics (continued)

Grantees Funded in 2008–2010	
	Outcome Sample (*n* = 4,397)
Child Risk Factors	(*n* = 3,426)
None	42.3%
One or More	57.7%
Physical Assault	25.1% (*n* = 3,468)
Sexual Assault	12.3% (*n* = 3,468)
Running Away	28.0% (*n* = 3,586)
Attempted Suicide	13.1% (*n* = 3,489)
Substance Abuse	16.3% (*n* = 3,475)
Family History of Illness	(*n* = 3,540)
Yes	85.3%
No	14.7%
Depression	70.8% (*n* = 3,468)
Other Mental Illness	52.6% (*n* = 3,443)
Alcohol or Substance Abuse	58.3% (*n* = 3,537)
Recent Caregiver History of Illness[c]	(*n* = 3,569)
Yes	50.0%
No	49.9%
Depression	43.4% (*n* = 3,589)
Other Mental Illness	19.0% (*n* = 3,576)
Alcohol or Substance Abuse	8.9% (*n* = 3,599)
Household Risk Factors	
Domestic Violence	42.1% (*n* = 3,556)
Household Member with Criminal History	35.5% (*n* = 3,563)
Household Member Depression	66.3% (*n* = 3,543)
Household Member Mental Illness	40.5% (*n* = 3,511)
Household Member Substance Abuse	43.5% (*n* = 3,569)

Table G-3. Baseline Characteristics: Child and Youth History and Family Characteristics (continued)

Grantees Funded in 2008–2010	
	Outcome Sample (*n* = 4,397)
Child Substance Use History[d]	
Number of Substances	(*n* = 2,196)
None	32.5%
One	13.7%
Two	11.4%
Three	13.4%
Four or More	29.1%
Substances Used[e]	
Alcohol	79.3% (*n* = 1,478)
Cigarettes	75.2% (*n* = 1,478)
Chewing Tobacco or Snuff	23.5% (*n* = 1,474)
Marijuana or Hashish	73.6% (*n* = 1,473)
Cocaine	16.6% (*n* = 1,476)
Hallucinogens	15.3% (*n* = 1,475)
PCP	3.2% (*n* = 1,477)
Ketamine	1.6% (*n* = 1,471)
MDMA (Ecstasy)	15.8% (*n* = 1,476)
GHB	0.5% (*n* = 1,470)
Inhalants	11.4% (*n* = 1,477)
Heroin	5.1% (*n* = 1,477)
Methamphetamine, Crystal, Ice, Glass, or Other Form of Methedrine	8.3% (*n* = 1,476)
Painkillers	26.2% (*n* = 1,475)
Ritalin, Adderall, Desoxyn	14.1% (*n* = 1,473)
Tranquilizers or Anti-Anxiety Drugs	15.0% (*n* = 1,475)
Barbiturates/Sedatives	4.6% (*n* = 1,472)
Over-the-Counter/Nonprescription Drugs	14.4% (*n* = 1,474)
Other	6.4% (*n* = 1,478)
Child Juvenile Justice Contacts[d]	
Lifetime Contacts	(*n* = 2,208)
None	43.2%
One or More	56.8%
Recent Contacts[b]	
Questioned by Police	19.2% (*n* = 2,213)
Arrested	21.6% (*n* = 2,213)
Appeared in Court	20.0% (*n* = 2,213)
Convicted of a Crime	11.3% (*n* = 2,213)
On Probation	19.7% (*n* = 2,213)

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

[b] Information pertains to the 6 months prior to intake.

[c] Caregiver with a history of illness who provided care or supervision in the 6 months prior to intake.

[d] Drug use history and juvenile justice contacts obtained only for children 11 years and older.

[e] Percentages for each substance are based on the number of adolescents who reported any substance use history. Youth may report using more than one substance; therefore, percentages may sum to more than 100%.

Table G-4. Child, Youth, and Family Outcomes and Service Experience

Grantees Funded in 2008–2010					
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Child Behavior Checklist 1½–5 (CBCL 1½–5)					
Emotionally Reactive	65.47 (11.0) (*n* = 969)	62.28 (10.1) (*n* = 502)	61.79 (10.4) (*n* = 242)	63.32 (11.8) (*n* = 110)	64.19 (11.6) (*n* = 37)
Sleep Problems	63.07 (12.4) (*n* = 969)	60.54 (11.2) (*n* = 502)	59.51 (10.8) (*n* = 242)	59.93 (11.3) (*n* = 110)	59.46 (12.2) (*n* = 37)
Withdrawn	63.65 (10.5) (*n* = 969)	60.23 (9.3) (*n* = 502)	60.11 (9.2) (*n* = 242)	61.87 (10.7) (*n* = 110)	61.78 (10.6) (*n* = 37)
Somatic Complaints	58.01 (8.4) (*n* = 969)	57.16 (8.3) (*n* = 502)	56.75 (7.8) (*n* = 242)	56.99 (8.8) (*n* = 110)	59.35 (10.3) (*n* = 37)
Anxious/Depressed	62.36 (10.2) (*n* = 969)	59.56 (9.0) (*n* = 502)	59.18 (9.1) (*n* = 242)	60.77 (9.9) (*n* = 110)	59.19 (8.6) (*n* = 37)
Attention Problems	63.42 (8.7) (*n* = 969)	60.81 (8.6) (*n* = 502)	61.27 (8.8) (*n* = 242)	60.56 (8.9) (*n* = 110)	61.70 (9.0) (*n* = 37)
Aggressive Problems	69.62 (13.7) (*n* = 967)	64.45 (13.3) (*n* = 499)	64.62 (12.6) (*n* = 239)	64.09 (13.7) (*n* = 108)	67.00 (15.2) (*n* = 36)
Internalizing Problems	63.52 (10.6) (*n* = 969)	59.90 (11.1) (*n* = 502)	59.06 (11.8) (*n* = 242)	60.35 (12.9) (*n* = 110)	59.84 (14.9) (*n* = 37)
Externalizing Problems	67.62 (12.9) (*n* = 969)	62.37 (13.2) (*n* = 502)	61.97 (14.0) (*n* = 242)	61.48 (14.4) (*n* = 110)	63.46 (15.9) (*n* = 37)
Total Problems	**66.94 (11.6) (*n* = 969)**	**62.06 (12.2) (*n* = 502)**	**61.31 (13.3) (*n* = 242)**	**61.55 (14.4) (*n* = 110)**	**61.81 (15.9) (*n* = 37)**
At/Above Clinical Level (Total Problems)	**65.2% (*n* = 969)**	**49.8% (*n* = 502)**	**45.9% (*n* = 242)**	**45.5% (*n* = 110)**	**56.8% (*n* = 37)**

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Child Behavior Checklist 6–18 (CBCL 6–18)					
Activities Competence	34.92 (9.4) (*n* = 2,410)	34.35 (9.4) (*n* = 1,220)	34.63 (9.3) (*n* = 722)	34.44 (8.7) (*n* = 419)	34.35 (8.8) (*n* = 269)
Social Competence	36.30 (9.0) (*n* = 2,363)	36.35 (9.0) (*n* = 1,208)	37.10 (8.8) (*n* = 718)	37.28 (9.0) (*n* = 413)	36.87 (9.4) (*n* = 268)
School Competence	38.00 (9.1) (*n* = 2,068)	39.38 (9.0) (*n* = 1,023)	39.10 (9.1) (*n* = 595)	39.39 (8.6) (*n* = 323)	39.44 (9.2) (*n* = 220)
Total Competence	30.81 (8.9) (*n* = 1,994)	31.04 (9.0) (*n* = 1,007)	31.58 (9.2) (*n* = 579)	31.74 (9.0) (*n* = 316)	31.56 (9.5) (*n* = 218)
Anxious/Depressed	64.88 (11.1) (*n* = 2,437)	62.66 (10.8) (*n* = 1,235)	62.11 (10.7) (*n* = 740)	61.15 (10.1) (*n* = 423)	60.67 (10.4) (*n* = 270)
Withdrawn/Depressed	65.96 (10.9) (*n* = 2,437)	63.83 (10.4) (*n* = 1,235)	63.02 (10.3) (*n* = 740)	62.37 (9.9) (*n* = 423)	61.77 (10.2) (*n* = 270)
Somatic Complaints	62.32 (10.1) (*n* = 2,437)	60.66 (9.6) (*n* = 1,235)	60.42 (9.3) (*n* = 740)	60.17 (9.9) (*n* = 423)	59.29 (9.7) (*n* = 270)
Social Problems	66.11 (10.2) (*n* = 2,437)	65.14 (10.1) (*n* = 1,235)	64.78 (10.1) (*n* = 740)	63.99 (9.8) (*n* = 423)	64.24 (11.1) (*n* = 270)
Thought Problems	67.20 (10.2) (*n* = 2,437)	65.93 (10.4) (*n* = 1,235)	65.26 (10.5) (*n* = 740)	64.14 (10.5) (*n* = 423)	63.33 (10.9) (*n* = 270)
Attention Problems	67.74 (11.1) (*n* = 2,437)	66.17 (10.9) (*n* = 1,235)	65.60 (10.6) (*n* = 740)	65.31 (10.7) (*n* = 423)	65.08 (12.0) (*n* = 270)
Rule-Breaking Behavior	66.93 (9.4) (*n* = 2,437)	65.66 (9.7) (*n* = 1,235)	64.82 (9.6) (*n* = 740)	63.66 (9.1) (*n* = 423)	63.74 (9.7) (*n* = 270)
Aggressive Behavior	70.74 (12.8) (*n* = 2,437)	69.06 (12.8) (*n* = 1,235)	67.97 (12.8) (*n* = 740)	67.31 (12.5) (*n* = 423)	67.17 (13.2) (*n* = 270)
Internalizing	65.32 (10.6) (*n* = 2,437)	62.78 (11.1) (*n* = 1,235)	61.87 (11.5) (*n* = 740)	61.08 (11.4) (*n* = 423)	59.81 (12.4) (*n* = 270)
Externalizing	68.49 (10.5) (*n* = 2,437)	66.96 (11.0) (*n* = 1,235)	65.92 (11.2) (*n* = 740)	65.07 (10.9) (*n* = 423)	64.76 (11.8) (*n* = 270)
Total Problems	**68.81 (9.8) (*n* = 2,437)**	**66.91 (10.5) (*n* = 1,235)**	**66.08 (10.9) (*n* = 740)**	**65.25 (10.7) (*n* = 423)**	**64.26 (12.1) (*n* = 270)**
At/Above Clinical Level (Total Problems)	**75.0% (*n* = 2,437)**	**67.7% (*n* = 1,235)**	**66.4% (*n* = 740)**	**61.2% (*n* = 423)**	**58.1% (*n* = 270)**
Behavioral and Emotional Rating Scale–2, Caregiver (BERS–2C)					
Intrapersonal Strengths	7.58 (3.5) (*n* = 2,715)	7.93 (3.4) (*n* = 1,392)	8.19 (3.5) (*n* = 843)	8.43 (3.5) (*n* = 483)	8.60 (3.5) (*n* = 308)
Interpersonal Strengths	6.68 (3.2) (*n* = 2,721)	7.00 (3.2) (*n* = 1,393)	7.28 (3.2) (*n* = 848)	7.47 (3.3) (*n* = 488)	7.58 (3.2) (*n* = 311)
School Functioning	6.50 (3.2) (*n* = 2,527)	6.87 (3.1) (*n* = 1,278)	6.98 (3.2) (*n* = 764)	7.21 (3.1) (*n* = 429)	7.41 (3.2) (*n* = 272)
Family Involvement	6.98 (3.0) (*n* = 2,728)	7.23 (3.0) (*n* = 1,401)	7.58 (3.0) (*n* = 846)	7.72 (3.0) (*n* = 490)	7.78 (3.0) (*n* = 309)
Affective Strengths	8.03 (3.2) (*n* = 2,734)	8.21 (3.1) (*n* = 1,400)	8.47 (3.2) (*n* = 847)	8.72 (3.1) (*n* = 491)	8.83 (3.3) (*n* = 311)
Career Strengths	8.77 (3.7) (*n* = 2,318)	8.93 (3.6) (*n* = 1,194)	9.04 (3.7) (*n* = 698)	8.92 (3.6) (*n* = 396)	8.73 (3.9) (*n* = 245)
Strengths Quotient	**80.36 (18.4) (*n* = 2,509)**	**82.16 (18.1) (*n* = 1,272)**	**84.15 (18.6) (*n* = 759)**	**85.76 (18.6) (*n* = 423)**	**86.33 (19.0) (*n* = 270)**

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Behavioral and Emotional Rating Scale–2, Youth (BERS–2Y)					
Intrapersonal Strengths	9.27 (3.0) (*n* = 2,229)	9.65 (3.0) (*n* = 1,101)	9.74 (3.1) (*n* = 660)	10.01 (3.0) (*n* = 341)	9.78 (2.9) (*n* = 215)
Interpersonal Strengths	9.34 (3.5) (*n* = 2,228)	9.87 (3.5) (*n* = 1,099)	9.98 (3.5) (*n* = 660)	10.40 (3.5) (*n* = 341)	10.37 (3.6) (*n* = 214)
School Functioning	8.47 (3.2) (*n* = 2,022)	9.14 (3.2) (*n* = 931)	8.96 (3.2) (*n* = 535)	9.09 (3.3) (*n* = 264)	8.97 (3.4) (*n* = 159)
Family Involvement	8.75 (3.0) (*n* = 2,214)	9.16 (3.1) (*n* = 1,096)	9.23 (3.0) (*n* = 657)	9.30 (3.2) (*n* = 336)	9.12 (3.0) (*n* = 211)
Affective Strengths	9.89 (3.2) (*n* = 2,234)	10.55 (3.1) (*n* = 1,102)	10.71 (3.2) (*n* = 660)	10.83 (3.1) (*n* = 341)	10.67 (3.1) (*n* = 215)
Career Strengths	9.71 (2.8) (*n* = 2,167)	9.88 (2.7) (*n* = 1,076)	9.88 (2.8) (*n* = 649)	9.89 (2.7) (*n* = 335)	9.52 (2.9) (*n* = 212)
Strengths Quotient	**94.05 (17.5) (*n* = 2,009)**	**97.59 (17.7) (*n* = 929)**	**97.84 (18.2) (*n* = 534)**	**99.87 (17.7) (*n* = 262)**	**97.96 (17.6) (*n* = 156)**
Columbia Impairment Scale (CIS)					
Overall Level of Impairment	**22.25 (10.8) (*n* = 3,423)**	**19.49 (11.0) (*n* = 1,715)**	**18.66 (10.9) (*n* = 995)**	**18.09 (10.7) (*n* = 548)**	**18.41 (11.6) (*n* = 321)**
At/Above Clinical Level	**74.0%**	**64.3%**	**61.4%**	**59.7%**	**57.9%**
Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2)					
Worry/Oversensitivity	51.51 (11.9) (*n* = 2,003)	49.68 (12.1) (*n* = 939)	49.91 (12.1) (*n* = 538)	48.59 (11.4) (*n* = 264)	47.60 (12.3) (*n* = 147)
Social Concerns/Concentration	52.06 (11.7) (*n* = 1,859)	50.12 (11.9) (*n* = 856)	50.36 (12.1) (*n* = 475)	49.46 (11.6) (*n* = 221)	48.52 (12.8) (*n* = 130)
Physiological Anxiety	51.48 (10.8) (*n* = 1,913)	49.69 (11.0) (*n* = 882)	50.46 (11.4) (*n* = 495)	48.91 (11.0) (*n* = 229)	47.97 (11.1) (*n* = 133)
Total Anxiety	**51.70 (11.7) (*n* = 1,809)**	**49.51 (12.3) (*n* = 828)**	**50.08 (12.3) (*n* = 467)**	**48.59 (11.9) (*n* = 216)**	**47.43 (12.9) (*n* = 127)**
At/Above Clinical Level (Total Anxiety)	**25.5% (*n* = 1,809)**	**20.0% (*n* = 828)**	**22.7% (*n* = 467)**	**19.0% (*n* = 216)**	**18.1% (*n* = 127)**
Reynolds Adolescent Depression Scale, Second Edition (RADS–2)					
Dysphoric Mood	50.90 (11.4) (*n* = 2,311)	49.61 (11.3) (*n* = 1,112)	49.40 (11.4) (*n* = 659)	49.25 (11.5) (*n* = 344)	47.93 (12.0) (*n* = 215)
Anhedonia/Negative Affect	50.88 (8.1) (*n* = 2,284)	49.90 (7.8) (*n* = 1,089)	49.85 (8.0) (*n* = 643)	49.08 (7.4) (*n* = 335)	50.01 (8.5) (*n* = 203)
Negative Self-Evaluation	52.89 (11.3) (*n* = 2,303)	51.17 (10.8) (*n* = 1,106)	50.95 (10.8) (*n* = 655)	50.40 (10.4) (*n* = 343)	50.24 (10.4) (*n* = 215)
Somatic Complaints	52.08 (10.8) (*n* = 2,309)	50.86 (10.9) (*n* = 1,114)	50.70 (11.2) (*n* = 659)	50.79 (11.3) (*n* = 344)	49.29 (11.6) (*n* = 215)
Total Depression	**52.29 (10.9) (*n* = 2,310)**	**50.56 (10.7) (*n* = 1,113)**	**50.33 (10.8) (*n* = 660)**	**49.87 (10.8) (*n* = 344)**	**49.33 (10.9) (*n* = 216)**
At/Above Clinical Level (Total Depression)	**24.0% (*n* = 2,310)**	**18.2% (*n* = 1,113)**	**17.9% (*n* = 660)**	**18.6% (*n* = 344)**	**14.4% (*n* = 216)**

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Caregiver Strain Questionnaire (CGSQ)					
Subjective Externalizing Strain	2.27 (1.0) (*n* = 3,601)	2.11 (0.9) (*n* = 1,776)	2.01 (0.9) (*n* = 995)	1.95 (0.9) (*n* = 541)	1.96 (0.9) (*n* = 313)
Subjective Internalizing Strain	3.40 (1.1) (*n* = 3,594)	3.04 (1.1) (*n* = 1,774)	2.91 (1.1) (*n* = 991)	2.75 (1.1) (*n* = 541)	2.71 (1.1) (*n* = 313)
Objective Strain	2.54 (1.1) (*n* = 3,604)	2.25 (1.0) (*n* = 1,777)	2.15 (1.0) (*n* = 995)	2.08 (1.0) (*n* = 543)	2.13 (1.1) (*n* = 313)
Global Strain	**8.21 (2.7) (*n* = 3,587)**	**7.40 (2.7) (*n* = 1,771)**	**7.08 (2.7) (*n* = 988)**	**6.79 (2.7) (*n* = 540)**	**6.81 (2.9) (*n* = 313)**
Parenting Stress Index (PSI)					
Total Stress Scale	**100.30 (23.6) (*n* = 1,900)**	**96.30 (23.3) (*n* = 908)**	**93.91 (24.8) (*n* = 494)**	**95.41 (25.6) (*n* = 276)**	**93.78 (27.6) (*n* = 141)**
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**
Living Situations Questionnaire (LSQ)					
Type of Living Arrangement[a]	(*n* = 4,154)	(*n* = 2,073)	(*n* = 1,198)	(*n* = 644)	(*n* = 377)
Homeless	3.5%	2.7%	3.0%	1.6%	3.4%
Home	95.0%	96.0%	95.5%	96.7%	96.3%
School Dormitory	0.5%	0.5%	0.7%	0.8%	0.3%
Recreational Camp	0.3%	0.4%	0.2%	0.3%	0.0%
Emergency Shelter	2.2%	1.1%	0.8%	0.6%	0.3%
Foster Home	3.3%	2.4%	1.9%	0.9%	0.5%
Therapeutic/Specialized Foster Home	0.7%	0.6%	0.3%	0.5%	0.5%
Group Home	1.8%	1.4%	1.0%	0.8%	1.9%
Medical Hospital	0.6%	1.0%	0.2%	0.5%	0.0%
Residential Treatment Center	4.6%	3.3%	3.3%	3.4%	2.9%
Psychiatric Hospital	6.7%	4.6%	4.2%	3.6%	2.4%
Youth Justice Related	3.4%	3.3%	2.6%	2.0%	2.4%
Adult Justice Related	0.5%	0.3%	1.2%	0.3%	0.5%
Other	2.0%	2.0%	1.9%	1.9%	1.3%
Stability in Living Arrangements	(*n* = 4,154)	(*n* = 2,073)	(*n* = 1,198)	(*n* = 644)	(*n* = 377)
One Living Arrangement	64.0%	73.2%	73.6%	77.2%	78.2%
Multiple Living Arrangements	36.0%	26.8%	26.4%	22.8%	21.8%

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Education Questionnaire, Revision 2 (EQ–R2)					
Attending School	(*n* = 4,110) 80.5%	(*n* = 2,050) 80.0%	(*n* = 1,186) 80.4%	(*n* = 638) 79.8%	(*n* = 381) 78.5%
Excused and Unexcused Absences	(*n* = 3,190)	(*n* = 1,589)	(*n* = 923)	(*n* = 495)	(*n* = 288)
No Absences	16.5%	20.2%	22.4%	24.8%	25.7%
Less Than 1 Day Per Month	21.7%	24.9%	24.9%	29.1%	25.3%
About 1 Day a Month	19.1%	19.5%	19.6%	18.4%	16.3%
About 1 Day Every 2 Weeks	14.1%	12.3%	12.9%	11.7%	13.9%
About 1 Day a Week	8.6%	8.1%	6.9%	5.1%	7.3%
2 Days Per Week	6.7%	5.1%	4.8%	5.5%	3.8%
3 or More Days Per Week	13.4%	9.8%	8.5%	5.5%	7.6%
Educational Placement	(*n* = 3,382)	(*n* = 1,589)	(*n* = 920)	(*n* = 488)	(*n* = 290)
Public Day School	82.2%	78.0%	76.1%	78.7%	76.0%
Private Day/Boarding School	2.0%	2.0%	2.0%	1.3%	1.8%
Home School	1.2%	0.9%	1.4%	0.9%	0.7%
Alternative/Special Day School	17.5%	18.3%	16.6%	16.0%	16.0%
School in 24-Hour Restrictive Setting[b]	4.0%	2.3%	2.5%	2.6%	2.9%
Postsecondary School	1.3%	2.7%	4.1%	3.7%	3.3%
Other	6.0%	6.0%	5.8%	4.0%	4.7%
School Performance	(*n* = 2,401)	(*n* = 1,145)	(*n* = 627)	(*n* = 314)	(*n* = 205)
A's	7.1%	7.4%	8.5%	7.0%	6.8%
A's and B's	21.6%	26.2%	27.6%	26.1%	31.7%
B's	6.8%	7.4%	6.5%	9.9%	8.3%
B's and C's	19.3%	21.5%	22.0%	19.1%	19.5%
C's	8.0%	7.2%	6.9%	10.8%	6.8%
C's and D's	13.0%	10.0%	11.5%	10.2%	8.3%
D's	2.6%	2.6%	1.4%	1.6%	2.0%
D's and F's	9.4%	7.9%	6.1%	8.0%	7.8%
F's	6.0%	4.5%	4.8%	2.5%	2.9%
School Does Not Give These Grades	3.4%	3.5%	3.2%	3.5%	4.9%
Other	2.8%	1.7%	1.6%	1.3%	1.0%
Individualized Education Plan (IEP)	(*n* = 3,165) 47.9%	(*n* = 1,551) 53.3%	(*n* = 893) 53.5%	(*n* = 478) 56.5%	(*n* = 274) 56.6%
Reasons for IEP[a]	(*n* = 1,506)	(*n* = 824)	(*n* = 477)	(*n* = 270)	(*n* = 155)
Behavior/Emotional Problems	70.0%	71.6%	49.5%	47.4%	49.0%
Learning Disability	53.7%	50.7%	54.9%	51.1%	49.7%
Physical Disability	2.6%	2.7%	3.8%	3.0%	2.6%
Developmental Disability or Mental Retardation	14.3%	12.5%	13.2%	15.9%	14.2%
Vision and/or Hearing Impairment	2.9%	1.9%	2.1%	2.6%	3.9%
Speech Impairment	62.0%	63.3%	63.3%	64.1%	62.6%
Other	6.0%	5.1%	3.8%	4.4%	3.9%

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Education Questionnaire, Revision 2 (EQ–R2)					
Type of Special Education Placement[a]	(*n* = 1,167)	(*n* = 625)	(*n* = 362)	(*n* = 218)	(*n* = 139)
Special education class, all children receive special education for all or most of the day	45.0%	50.9%	48.6%	54.1%	49.6%
Special education class, all children leave general education for special education	24.4%	20.2%	21.5%	19.3%	21.6%
Special education provided in general education class to some children	16.9%	14.6%	16.3%	16.1%	18.0%
Special instruction provided on basis of need	13.7%	14.4%	13.5%	10.6%	10.8%
Disciplinary Actions	(*n* = 3,042)	(*n* = 1,505)	(*n* = 865)	(*n* = 455)	(*n* = 273)
Suspended	28.4%	21.6%	19.8%	16.5%	21.2%
Expelled	2.4%	1.8%	1.6%	0.9%	0.0%
Suspended and Expelled	3.5%	1.5%	1.8%	0.7%	1.5%
Neither Suspended nor Expelled	64.0%	74.4%	76.1%	80.2%	74.7%
Delinquency Survey, Revised (DS–R)					
Lifetime Juvenile Justice Contacts					
Questioned by Police	27.1% (*n* = 2,204)	27.1% (*n* = 1,047)	27.7% (*n* = 614)	28.2% (*n* = 309)	22.6% (*n* = 190)
Arrested	21.6% (*n* = 2,213)	13.5% (*n* = 1,049)	12.1% (*n* = 614)	10.4% (*n* = 309)	7.9% (*n* = 191)
Appeared in Court	20.0% (*n* = 2,213)	16.5% (*n* = 1,049)	12.9% (*n* = 614)	9.7% (*n* = 309)	12.0% (*n* = 191)
Convicted of a Crime	10.7% (*n* = 2,200)	8.2% (*n* = 1,048)	6.5% (*n* = 614)	5.2% (*n* = 308)	4.7% (*n* = 190)
Completed Probation	18.9% (*n* = 2,192)	17.4% (*n* = 1,040)	16.1% (*n* = 608)	10.5% (*n* = 306)	9.5% (*n* = 190)
Substance Problem Urgency (GAIN)					
Substance Use and Abuse Scale (SUS–9)	(*n* = 855)	(*n* = 271)	(*n* = 154)	(*n* = 77)	(*n* = 46)
Mean (*SD*)	3.21 (2.5)	3.05 (2.5)	2.66 (2.7)	3.03 (2.4)	2.61 (2.0)
Minimal/No Urgency	46.7%	48.7%	59.5%	45.5%	54.3%
Moderate Urgency	40.7%	39.9%	32.7%	44.2%	43.5%
High Urgency	12.6%	11.4%	7.8%	10.4%	2.2%
Substance Dependence Scale (SUS–7)	(*n* = 851)	(*n* = 268)	(*n* = 153)	(*n* = 77)	(*n* = 45)
Mean (*SD*)	2.02 (2.1)	1.90 (2.0)	1.63 (2.2)	1.88 (2.1)	1.44 (1.9)
Minimal/No Urgency	51.2%	56.0%	63.2%	55.8%	64.4%
Moderate Urgency	38.9%	36.9%	30.3%	35.1%	28.9%
High Urgency	9.9%	7.1%	6.6%	9.1%	6.7%
Substance Problem Scale (SPS)	(*n* = 855)	(*n* = 271)	(*n* = 154)	(*n* = 77)	(*n* = 46)
Mean (*SD*)	5.23 (4.3)	4.94 (4.2)	4.28 (4.6)	4.91 (4.4)	4.04 (3.7)
Minimal/No Urgency	44.4%	45.8%	55.6%	45.5%	56.5%
Moderate Urgency	44.1%	43.5%	38.6%	44.2%	39.1%
High Urgency	11.5%	10.7%	5.9%	10.4%	4.3%

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake %	6 Months %	12 Months %	18 Months %	24 Months %
Multi-Sector Service Contacts, Revised (MSSC–R)					
Number of Different Services Utilized	(*n* = 3,553)	(*n* = 1,821)	(*n* = 952)	(*n* = 469)	(*n* = 231)
Mean (*SD*)	4.85 (2.8)	4.90 (2.7)	4.78 (2.8)	4.64 (2.6)	4.50 (2.7)
1–3	36.2%	34.6%	37.8%	38.2%	42.9%
4–6	39.0%	40.7%	38.9%	40.7%	37.2%
7–9	18.0%	18.2%	16.9%	14.7%	12.6%
10 or more	6.9%	6.4%	6.4%	6.4%	7.4%
Type of Services Utilized: Traditional					
Individual Therapy	62.6% (*n* = 3,626)	66.9% (*n* = 1,851)	65.3% (*n* = 968)	61.2% (*n* = 477)	62.3% (*n* = 239)
Case Management	45.8% (*n* = 3,617)	49.7% (*n* = 1,847)	46.5% (*n* = 970)	37.6% (*n* = 481)	33.8% (*n* = 240)
Assessment or Evaluation	68.0% (*n* = 3,607)	47.9% (*n* = 1,836)	38.6% (*n* = 966)	42.0% (*n* = 479)	37.9% (*n* = 240)
Medication Treatment/Monitoring	36.7% (*n* = 3,622)	41.3% (*n* = 1,851)	42.7% (*n* = 968)	47.4% (*n* = 479)	54.2% (*n* = 240)
Family Therapy	20.6% (*n* = 3,622)	21.0% (*n* = 1,847)	18.8% (*n* = 968)	14.9% (*n* = 477)	10.8% (*n* = 240)
Group Therapy	19.8% (*n* = 3,626)	16.9% (*n* = 1,847)	15.9% (*n* = 966)	18.2% (*n* = 478)	18.3% (*n* = 240)
Crisis Stabilization	13.5% (*n* = 3,618)	8.0% (*n* = 1,851)	7.5% (*n* = 966)	6.3% (*n* = 478)	3.8% (*n* = 240)
Type of Services Utilized: Innovative					
Recreational Activities	10.9% (*n* = 3,619)	14.2% (*n* = 1,849)	16.2% (*n* = 969)	14.5% (*n* = 477)	13.8% (*n* = 239)
Family Support	24.2% (*n* = 3,621)	28.5% (*n* = 1,847)	24.6% (*n* = 968)	25.4% (*n* = 477)	21.3% (*n* = 240)
Transportation	19.1% (*n* = 3,620)	22.9% (*n* = 1,849)	23.5% (*n* = 969)	16.5% (*n* = 478)	20.4% (*n* = 240)
Flexible Funds	8.0% (*n* = 3,618)	19.2% (*n* = 1,846)	19.0% (*n* = 967)	15.3% (*n* = 478)	10.4% (*n* = 241)
Behavioral/Therapeutic Aide	9.8% (*n* = 3,615)	11.4% (*n* = 1,844)	10.1% (*n* = 966)	11.1% (*n* = 478)	10.0% (*n* = 239)
Family Preservation	6.1% (*n* = 3,618)	4.5% (*n* = 1,849)	5.3% (*n* = 967)	6.1% (*n* = 477)	8.4% (*n* = 239)
Respite	4.5% (*n* = 3,621)	6.5% (*n* = 1,848)	6.6% (*n* = 968)	8.2% (*n* = 477)	7.5% (*n* = 240)
Vocational Training	4.0% (*n* = 3,619)	4.8% (*n* = 1,847)	6.5% (*n* = 969)	7.7% (*n* = 479)	4.6% (*n* = 239)
Transition Services	6.8% (*n* = 3,603)	6.8% (*n* = 1,836)	6.1% (*n* = 964)	4.6% (*n* = 476)	4.6% (*n* = 240)
Independent Living	4.8% (*n* = 3,618)	7.3% (*n* = 1,847)	8.7% (*n* = 969)	5.8% (*n* = 479)	3.8% (*n* = 239)
Afterschool Programs	10.2% (*n* = 3,618)	8.9% (*n* = 1,845)	8.7% (*n* = 965)	9.2% (*n* = 476)	7.9% (*n* = 240)

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake %	**6 Months %**	**12 Months %**	**18 Months %**	**24 Months %**
Multi-Sector Service Contacts, Revised (MSSC–R)					
Type of Services Utilized: Restrictive					
Day Treatment	4.5% (*n* = 3,577)	3.8% (*n* = 1,823)	3.0% (*n* = 963)	5.3% (*n* = 475)	3.8% (*n* = 240)
Inpatient Hospitalization	14.4% (*n* = 3,621)	8.6% (*n* = 1,849)	8.2% (*n* = 968)	7.5% (*n* = 477)	5.8% (*n* = 240)
Residential Treatment Center	7.5% (*n* = 3,571)	4.6% (*n* = 1,821)	4.5% (*n* = 962)	6.3% (*n* = 474)	5.4% (*n* = 240)
Therapeutic Group Home	1.8% (*n* = 3,572)	1.4% (*n* = 1,823)	0.9% (*n* = 962)	1.3% (*n* = 474)	1.2% (*n* = 241)
Therapeutic Foster Care	2.6% (*n* = 3,596)	1.5% (*n* = 1,833)	2.1% (*n* = 962)	2.3% (*n* = 474)	2.9% (*n* = 241)
Residential Camp	0.7% (*n* = 3,572)	1.1% (*n* = 1,822)	1.5% (*n* = 962)	2.1% (*n* = 474)	0.4% (*n* = 240)
Informal Support	33.1% (*n* = 3,619)	36.7% (*n* = 1,847)	38.2% (*n* = 968)	35.2% (*n* = 477)	35.8% (*n* = 240)
	Intake Mean (*SD*)	**6 Months Mean (*SD*)**	**12 Months Mean (*SD*)**	**18 Months Mean (*SD*)**	**24 Months Mean (*SD*)**
Youth Services Survey for Families (YSS–F)[c]					
Caregiver Perception of Services	n/a	3.45 (0.7) (*n* = 1,548)	3.49 (0.7) (*n* = 787)	3.52 (0.7) (*n* = 391)	3.42 (0.8) (*n* = 194)
Access to Services	n/a	4.24 (0.8) (*n* = 1,552)	4.24 (0.8) (*n* = 791)	4.19 (0.8) (*n* = 391)	4.11 (0.9) (*n* = 196)
Participation in Treatment	n/a	4.16 (0.8) (*n* = 1,553)	4.17 (0.8) (*n* = 785)	4.20 (0.8) (*n* = 391)	4.12 (0.9) (*n* = 194)
Cultural Sensitivity	n/a	4.44 (0.6) (*n* = 1,538)	4.45 (0.6) (*n* = 778)	4.42 (0.6) (*n* = 389)	4.40 (0.6) (*n* = 193)
Satisfaction With Services	n/a	3.99 (0.9) (*n* = 1,556)	4.01 (0.9) (*n* = 790)	4.03 (0.8) (*n* = 392)	3.91 (1.0) (*n* = 197)
Outcomes	n/a	3.50 (0.9) (*n* = 1,551)	3.58 (0.9) (*n* = 786)	3.64 (0.9) (*n* = 392)	3.54 (0.9) (*n* = 197)
Youth Services Survey (YSS)[c]					
Youth Perception of Services	n/a	3.52 (0.7) (*n* = 1,004)	3.55 (0.7) (*n* = 533)	3.58 (0.7) (*n* = 252)	3.56 (0.7) (*n* = 131)
Access to Services	n/a	4.07 (0.8) (*n* = 1,000)	4.05 (0.8) (*n* = 532)	4.08 (0.8) (*n* = 253)	4.00 (0.9) (*n* = 134)
Participation in Treatment	n/a	3.87 (0.9) (*n* = 1,006)	3.94 (0.8) (*n* = 534)	3.97 (0.8) (*n* = 252)	3.94 (1.0) (*n* = 132)
Cultural Sensitivity	n/a	4.34 (0.6) (*n* = 985)	4.35 (0.6) (*n* = 514)	4.30 (0.7) (*n* = 245)	4.28 (0.7) (*n* = 125)
Satisfaction With Services	n/a	4.06 (0.8) (*n* = 1,007)	4.09 (0.8) (*n* = 535)	4.10 (0.8) (*n* = 253)	4.09 (0.8) (*n* = 132)
Outcomes	n/a	3.86 (0.8) (*n* = 1,005)	3.91 (0.8) (*n* = 533)	3.92 (0.7) (*n* = 253)	3.92 (0.7) (*n* = 132)

Table G-4. Child, Youth, and Family Outcomes and Service Experience (continued)

Grantees Funded in 2008–2010					
	Intake Mean (*SD*)	6 Months Mean (*SD*)	12 Months Mean (*SD*)	18 Months Mean (*SD*)	24 Months Mean (*SD*)
Cultural Competence and Service Provision, Revised (CCSP–R)[c]					
Importance of Provider's Understanding of Family's Culture	n/a	2.79 (1.2) (*n* = 1,969)	2.77 (1.2) (*n* = 1,152)	2.69 (1.2) (*n* = 601)	2.72 (1.1) (*n* = 353)
Frequency of Provider's Culturally Competent Practices	n/a	4.06 (0.5) (*n* = 1,683)	4.04 (0.5) (*n* = 877)	4.01 (0.5) (*n* = 423)	4.03 (0.5) (*n* = 200)

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

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

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

Appendix H
Performance Measurement

CQI Progress Report: Aggregate for Communities Initially Funded in 2008-2010

Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2008–2010, August 30, 2013

Date Services Started: Dec-09
Number Enrolled in the Descriptive Study: 13,895
Number Enrolled in the Outcome Study: 4,695

	Change from Previous Report[1]	Previous Cumulative Raw Score[2]	Current Cumulative Raw Score	Performance Mark[3]	Current Period Raw Score	Benchmark[4]	How to Interpret Raw Score
System-Level Outcomes							
Service Accessibility							
1. Number of Children Served (with descriptive data)	Score Improved	11,270	13,135		1,886	N/A	Community defined
2. Linguistic Competency Rate	Score Improved	86.4%	86.5%		86.7%	94.7%	Closer to 100% better
3. Agency Involvement Improvement Rate (% change intake to 6 months)–Service Provision	Score Improved	67.5%	67.7%		69.1%	87.0%	Closer to 100% better
4. Caregiver Satisfaction Rate–Access to Services	No Change	4.24	4.24		4.26	4.38	Closer to 5 better
5. Timeliness of Services (average days)*	Score Worsened	13.43	13.57		14.36	6.00	Lower # better
Service Quality							
6. Agency Involvement Rate–Treatment Planning	Score Improved	24.3%	25.1%		24.9%	50.5%	Closer to 100% better
7. Informal Supports Improvement Rate (% change intake to 6 months)	Score Improved	36.5%	37.5%		42.6%	50.6%	Closer to 100% better
8. Caregiver Satisfaction Rate–Quality of Services	Score Improved	3.99	4.00		4.04	4.19	Closer to 5 better
9. Youth Satisfaction Rate–Quality of Services	Score Worsened	4.07	4.06		4.02	4.05	Closer to 5 better
10. Caregiver Satisfaction Rate–Outcomes	Score Improved	3.49	3.51		3.59	3.79	Closer to 5 better
11. Youth Satisfaction Rate–Outcomes	No Change	3.87	3.87		3.85	3.97	Closer to 5 better
Service Appropriateness							
12. Individualized Education Plan (IEP) Development (% at 6 months)	Score Worsened	56.5%	55.9%		53.4%	65.9%	Community defined
13. Substance Use Treatment Improvement Rate (% change intake to 6 months)[4]	Score Worsened	71.3%	69.1%		57.1%	74.6%	Closer to 100% better
Child and Family Outcomes							
Caregiver Report							
Child Level							
14a. School Enrollment Rate	Score Improved	88.8%	91.9%		9.1%	98.8%	Closer to 100% better
14b. School Enrollment Rate (Preschool)	Score Worsened	93.0%	92.0%		86.7%	100.0%	Closer to 100% better
15a. School Attendance Rate (80% of the time)	Score Worsened	77.5%	77.0%		74.7%	86.0%	Closer to 100% better
15b. Daycare or Afterschool Care Program Attendance Rate	Score Worsened	81.1%	80.9%		93.6%	81.9%	Closer to 100% better
16. School Performance Improvement Rate (intake to 6 months)	Score Worsened	37.3%	36.3%		31.5%	39.6%	Closer to 100% better
17. Stability in Living Situation Rate (intake to 6 months)	Score Worsened	73.6%	73.5%		73.2%	85.7%	Closer to 100% better
18. Inpatient Hospitalization Days per Child (intake to 6 months)*	Score Worsened	2.75	2.84		3.28	0.74	Lower # better

CQI Progress Report—Aggregate for Communities Initially Funded in 2008–2010 (continued)

	Change from Previous Report[1]	Previous Cumulative Raw Score	Current Cumulative Raw Score	Performance Mark[2]	Current Period Raw Score	Benchmark[3]	How to Interpret Raw Score
Child and Family Outcomes (continued)							
Caregiver Report (continued)							
Child Level (continued)							
19. Suicide Attempt Reduction Rate–Caregiver Report**	No Change	-100.0%	-100.0%		-33.3%	-60.0%	More negative % better
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	Score Worsened	29.0%	28.6%		26.8%	32.3%	Closer to 100% better
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	Score Worsened	30.7%	29.6%		2.5%	38.9%	Closer to 100% better
Family Level							
21. Average Reduction in Employment Days Lost (intake to 6 months)**	Score Improved	0.03	-0.04		-0.43	-2.73	More negative # better
22a. Adverse Childhood Experience (ACE) Reduction Rate (intake to 6 months)	Score Worsened	24.7%	23.9%		20.6%	27.2%	Higher % better
22b. No Adverse Childhood Experience (ACE) Rate (intake to 6 months)	Score Improved	26.6%	26.7%		27.2%	27.2%	Closer to 100% better
23. Caregiver Strain Improvement Rate (intake to 6 months)	Score Worsened	32.5%	32.2%		30.7%	32.7%	Closer to 100% better
Youth Report							
24. Youth No Arrest Rate (intake to 6 months)	Score Improved	7.9%	8.5%		12.7%	13.5%	Higher % better
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)**	Score Improved	-48.0%	-49.4%		-56.3%	-50.0%	More negative % better
26. Anxiety Improvement Rate (intake to 6 months)	Score Worsened	18.8%	17.4%		10.8%	20.8%	Closer to 100% better
27. Depression Improvement Rate (intake to 6 months)	Score Worsened	13.7%	13.6%		13.2%	14.6%	Closer to 100% better
Satisfaction with Services							
28. Caregiver Overall Satisfaction	Score Improved	4.09	4.10		4.00	4.14	Closer to 5 better
29. Youth Overall Satisfaction	Score Worsened	4.05	4.04		4.03	4.03	Closer to 5 better
Family and Youth Involvement							
30. Caregiver Satisfaction Rate–Participation	No Change	4.16	4.16		4.13	4.30	Closer to 5 better
31. Youth Satisfaction Rate–Participation	Score Worsened	3.88	3.87		3.82	3.75	Closer to 5 better
32. Caregiver and Other Family Involvement in Service Plan	Score Worsened	86.6%	86.5%		86.6%	99.2%	Closer to 100% better
33. Youth Involvement in Service Plan	Score Worsened	92.1%	91.8%		90.1%	95.5%	Closer to 100% better
Cultural and Linguistic Competency							
34. Caregiver Satisfaction Rate–Cultural Competency	No Change	4.44	4.44		4.46	4.56	Closer to 5 better
35. Youth Satisfaction Rate–Cultural Competency	No Change	4.34	4.34		4.35	4.34	Closer to 5 better

[1] The change from previous report is reported as Score Worsened, No Change, or Score Improved.
[2] Previous Cumulative Raw Score refers to data downloaded on April 11, 2013, for the April 2013 progress report.
[3] Performance marks are not reported in the aggregate report.
[4] The benchmark represents the 75th percentile score across all Phase IV and Phase V communities as of August 11, 2011.
* For these indicators, smaller average days represent positive outcomes. The smaller the raw score the better the outcome.
** For these indicators, a negative raw score represents a positive outcome. The more negative the raw score the better the outcome.

CQI Progress Report—Aggregate for Communities Initially Funded in 2008–2010 (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 Site Level for Current Period*	Data Source
1. Number of children served (with descriptive data)	13,135	47	194.75	1,886	EDIF**
2. Linguistic Competency Rate	155	7	.13	30	Caregiver
3. Agency Involvement Rate–Service Provision	2,008	38	.20	346	Caregiver
4. Caregiver Satisfaction Rate–Access to Services	1,703	36	.27	306	Caregiver
5. Timeliness of Services (average days)	10,794	46	11.75	1,631	EDIF**
6. Agency Involvement Rate–Treatment Planning	8,781	45	.22	1,415	EDIF**
7. Informal Supports Rate	2,021	35	.20	350	Caregiver
8. Caregiver Satisfaction Rate–Quality of Services	1,707	36	.27	307	Caregiver
9. Youth Satisfaction Rate–Quality of Services	1,089	26	.24	180	Youth
10. Caregiver Satisfaction Rate–Outcomes	1,699	36	.35	303	Caregiver
11. Youth Satisfaction Rate–Outcomes	1,086	26	.18	179	Youth
12. Increase in Individualized Education Plan (IEP) Development (intake to 6 months)	1,464	34	.15	253	Caregiver
13. Substance Use Treatment Rate	223	8	.21	35	Caregiver
14a. School Enrollment Rate	2,524	38	.10	325	Caregiver
14b. School Enrollment Rate (Preschool)	201	6	.07	30	Caregiver
15a. School Attendance Rate (80% of the time)	1,729	38	.13	289	Caregiver
15b. Daycare or Afterschool Care Program Attendance Rate	267	8	.07	47	Caregiver
16. School Performance Improvement Rate (intake to 6 months)	945	27	.15	165	Caregiver
17. Stability in Living Situation Rate (intake to 6 months)	2,270	38	.12	399	Caregiver
18. Inpatient Hospitalization Days per Child (intake to 6 months)	2,270	24	3.34	399	Caregiver
19. Suicide Attempt Reduction Rate–Caregiver Report	1,783	16	.40	294	Caregiver
20a. Emotional and Behavioral Problem Improvement Rate–Age 6–18 (intake to 6 months)	1,234	29	.11	213	Caregiver
20b. Emotional and Behavioral Problem Improvement Rate–Age 1½–5 (intake to 6 months)	527	9	.10	93	Caregiver
21. Average Reduction in Employment Days Lost (intake to 6 months)	723	26	.70	127	Caregiver
22a. Adverse Childhood Experience (ACE) Reduction Rate (intake to 6 months)	1,661	35	.08	291	Caregiver
22b. No Adverse Childhood Experience (ACE) Rate (intake to 6 months)	1,661	35	.12	291	Caregiver
23. Caregiver Strain Improvement Rate (intake to 6 months)	1,860	36	.09	329	Caregiver
24. Youth No Arrest Rate (intake to 6 months)	1,102	20	.19	179	Youth
25. Suicide Attempt Reduction Rate–Youth Report (intake to 6 months)	1,081	13	.34	179	Youth
26. Anxiety Improvement Rate (intake to 6 months)	757	22	.06	130	Youth
27. Depression Improvement Rate (intake to 6 months)	1,105	24	.06	182	Youth
28. Caregiver Overall Satisfaction	1,706	36	.37	306	Caregiver
29. Youth Overall Satisfaction	1,089	26	.19	180	Youth
30. Caregiver Satisfaction Rate–Participation	1,702	36	.17	305	Caregiver
31. Youth Satisfaction Rate–Participation	1,088	26	.34	180	Youth
32. Caregiver and Other Family Involvement in Service Plan	9,031	46	.19	1,471	EDIF**
33. Youth Involvement in Service Plan	5,819	37	.17	837	EDIF**
34. Caregiver Satisfaction Rate–Cultural Competency	1,688	36	.19	302	Caregiver
35. Youth Satisfaction Rate–Cultural Competency	1,066	26	.19	177	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 I
Tables

Table I-1. Outcomes of Children and Youth with and without Insurance Coverage at Intake

Event	Insured Group			Non-Insured Group		
	6 Months Prior to Intake	6 Months After Intake	12 Months After Intake	6 Months Prior to Intake	6 Months After Intake	12 Months After Intake
Significant Improvement in overall behavioral and emotional symptoms	—	28.7% (*n* = 719)	33.4% (*n* = 719)	—	27.6% (*n* = 58)	29.3% (*n* = 58)
Significant improvement in clinical functioning	—	16.2% (*n* = 705)	19.7% (*n* = 705)	-—	16.7% (*n* = 60)	20.0% (*n* = 60)
Experienced suicidal thoughts	22.4% (*n* = 892)	13.6% (*n* = 892)	15.2% (*n* = 892)	19.1% (*n* = 68)	13.2% (*n* = 68)	10.3% (*n* = 68)
Attempted suicide	7.2% (*n* = 890)	3.4% (*n* = 890)	3.6% (*n* = 890)	8.8% (*n* = 68)	4.4% (*n* = 68)	4.4% (*n* = 68)
Grades of C or better	66.9% (*n* = 302)	72.8% (*n* = 302)	74.2% (*n* = 302)	57.7% (*n* = 26)	69.2% (*n* = 26)	80.8% (*n* = 26)
Attended school regularly	81.0% (*n* = 558)	85.3% (*n* = 558)	86.9% (*n* = 558)	76.9% (*n* = 39)	71.8% (*n* = 39)	74.4%* (*n* = 39)
Had school suspensions or expulsions	34.1% (*n* = 511)	24.1% (*n* = 511)	24.3% (*n* = 511)	44.8% (*n* = 29)	51.7% (*n* = 29)	48.3%*** (*n* = 29)
Lived in an out-of-home placement	25.6% (*n* = 898)	16.1% (*n* = 898)	17.3% (*n* = 898)	31.9% (*n* = 72)	22.2% (*n* = 72)	19.4% (*n* = 72)
Had been arrested	17.8% (*n* = 428)	10.5% (*n* = 428)	9.8% (*n* = 428)	27.0% (*n* = 37)	24.3% (*n* = 37)	21.6%** (*n* = 37)
Engaged in at least one unlawful behavior	66.0% (*n* = 427)	52.2% (*n* = 427)	46.1% (*n* = 427)	70.3% (*n* = 37)	59.5% (*n* = 37)	62.2% (*n* = 37)

* Groups differ in trend line at $p < .05$ level
** Groups differ in trend line at $p < .01$ level
*** Groups differ in trend line at $p < .001$ level

Table I-2. Outcomes for Children and Youth in Vulnerable Populations 6 Months Prior to and 6 Months after Intake

Event	Juvenile Justice		Child Welfare		LGBTQI2-S		Youth and Young Adults		Early Childhood		Co-occurring Mental Health and Substance Use		Full Sample	
	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake	6 Months Prior to Intake	6 Months After Intake
Living in a setting other than their home	36.1% (*n* = 133)	30.1% (*n* = 133)	30.2% (*n* = 258)	20.5%*** (*n* = 258)	39% (*n* = 77)	26%* (*n* = 77)	36.4% (*n* = 253)	26.1%** (*n* = 253)	9.6% (*n* = 293)	6.5%* (*n* = 293)	58.1% (*n* = 31)	32.3% (*n* = 31)	24.6% (*n* = 984)	17.1%*** (*n* = 984)
Lived in more than one placement	46.6% (*n* = 133)	39.8% (*n* = 133)	45.3% (*n* = 258)	29.5%*** (*n* = 258)	53.2% (*n* = 77)	36.4%** (*n* = 77)	51.4% (*n* = 253)	43.9% (*n* = 253)	28% (*n* = 293)	16.7%** (*n* = 293)	67.7% (*n* = 31)	61.3% (*n* = 31)	38.0% (*n* = 984)	27.0%*** (*n* = 984)
Had an episode of homelessness	3.8% (*n* = 133)	5.3% (*n* = 133)	2.3% (*n* = 258)	2.7% (*n* = 258)	11.7% (*n* = 77)	1.3%* (*n* = 77)	7.5% (*n* = 253)	4.3% (*n* = 253)	2.4% (*n* = 293)	1.4% (*n* = 293)	12.9% (*n* = 31)	3.2% (*n* = 31)	3.9% (*n* = 984)	2.4%* (*n* = 984)
Had an average grade of C or better	58% (*n* = 88)	62.5% (*n* = 88)	69.8% (*n* = 106)	71.7% (*n* = 106)	82.1% (*n* = 39)	84.6%* (*n* = 39)	72.4% (*n* = 105)	72.4% (*n* = 105)	n/a	n/a	69.2% (*n* = 13)	84.6%* (*n* = 13)	69.2% (*n* = 422)	72.0%** (*n* = 422)
Attended school regularly	63.1% (*n* = 103)	72.8% (*n* = 103)	75.1% (*n* = 181)	82.3%** (*n* = 181)	71.4% (*n* = 49)	73.5% (*n* = 49)	68.6% (*n* = 137)	67.2% (*n* = 137)	94.7% (*n* = 133)	92.5% (*n* = 133)	63.6% (*n* = 22)	72.7% (*n* = 22)	80.0% (*n* = 670)	82.7%** (*n* = 670)
Had suspensions or expulsions	57.4% (*n* = 94)	38.3%*** (*n* = 94)	39.4% (*n* = 165)	29.7%* (*n* = 165)	37.2% (*n* = 43)	25.6% (*n* = 43)	40.2% (*n* = 127)	28.3% (*n* = 127)	15.4% (*n* = 117)	9.4%* (*n* = 117)	42.9% (*n* = 21)	19%* (*n* = 21)	64.4% (*n* = 610)	74.3%*** (*n* = 610)
Had been arrested	45.7% (*n* = 105)	26.7%*** (*n* = 105)	18% (*n* = 111)	12.6% (*n* = 111)	14.9% (*n* = 74)	12.2% (*n* = 74)	22.6% (*n* = 234)	15%** (*n* = 234)	n/a	n/a	26.5% (*n* = 34)	29.4% (*n* = 34)	19.5% (*n* = 478)	15.1%*** (*n* = 478)
Engaged in at least one unlawful behavior	83.8% (*n* = 105)	61.9%*** (*n* = 105)	64.9% (*n* = 111)	43.2%*** (*n* = 111)	66.2% (*n* = 74)	45.9%*** (*n* = 74)	65.4% (*n* = 234)	51.7%*** (*n* = 234)	n/a	n/a	94.1% (*n* = 34)	70.6%*** (*n* = 34)	66.9% (*n* = 478)	49.8%*** (*n* = 478)
Experienced suicidal thoughts	33.6% (*n* = 140)	19.3%** (*n* = 140)	19.7% (*n* = 254)	10.6%*** (*n* = 254)	43.8% (*n* = 80)	22.5%*** (*n* = 80)	25.8% (*n* = 267)	16.1%*** (*n* = 267)	n/a	n/a	35.9% (*n* = 39)	30.8% (*n* = 39)	22.7% (*n* = 979)	13.6%*** (*n* = 979)
Attempted suicide	12.9% (*n* = 124)	3.2%** (*n* = 124)	10.3% (*n* = 233)	2.6%*** (*n* = 233)	29.1% (*n* = 55)	7.3%*** (*n* = 55)	12.5% (*n* = 160)	6.9%* (*n* = 160)	n/a	n/a	21.7% (*n* = 23)	8.7%* (*n* = 23)	9.2% (*n* = 855)	4.1%*** (*n* = 855)
Experienced bullying	28.4% (*n* = 109)	18.3% (*n* = 109)	34.5% (*n* = 110)	19.1%** (*n* = 110)	39.2% (*n* = 74)	25.7% (*n* = 74)	23.3% (*n* = 227)	11%*** (*n* = 227)	n/a	n/a	22.2% (*n* = 36)	30.6% (*n* = 36)	30.7% (*n* = 475)	20.0%*** (*n* = 475)
Experienced cyber bullying	12.8% (*n* = 109)	9.2% (*n* = 109)	13.9% (*n* = 108)	11.1% (*n* = 108)	24.3% (*n* = 74)	21.6% (*n* = 74)	14.5% (*n* = 227)	13.2% (*n* = 227)	n/a	n/a	33.3% (*n* = 36)	22.2% (*n* = 36)	12.7% (*n* = 472)	11.4% (*n* = 472)

*Difference is significant a $p < .05$ level.
** Difference is significant at $p < .01$ level.
*** Difference significant at $p < .001$ level.

Table I-3. Service Group and Service Type by Mean Number of Service Events per Child/Youth per Month

Grantees Funded in 2008–2009			
Type of Service	Children with Reported Service Events		Mean Number of Service Events per Child/Youth per Month
	n	%	
Total	883	100.0%	8.01
Service Group			
Community-Based Support Services	419	47.5%	4.06
Community-Based Therapeutic Services	822	93.1%	6.47
Service Type			
Community-Based Support Services			
Caregiver Support/Family Support	133	15.1%	1.65
Advocacy	127	14.4%	0.87
Training/Tutoring/Education/Mentoring	101	11.4%	10.22
Child Protective Service	58	6.6%	1.01
Vocational/Life Skills Training/Independent Living Skills/Youth Transition	46	5.2%	0.33
Recreational Activity/Recreational Therapy	44	5.0%	0.79
Case Evaluation And Monitoring	34	3.9%	3.33
Family Preservation	31	3.5%	1.00
Transportation	24	2.7%	0.13
Social Work Service	22	2.5%	2.18
Respite Care	14	1.6%	1.25
Adoption Service	8	0.9%	—
Legal Service	2	0.2%	—
Community-Based Therapeutic Services			
Case Management/Clinical Coordination	497	56.3%	5.79
Individual Therapy/Counseling/Psycho-Social Therapy/Play Therapy	397	45.0%	2.11
Intake/Screening/Diagnosis/Assessment	348	39.4%	0.39
Medication Treatment/Monitoring/Administration	187	21.2%	0.62
Medical Care/Physical Health Care/Laboratory Related to Mental Health	157	17.8%	1.11
Service Planning	155	17.6%	1.92
Family Therapy/Family Counseling	142	16.1%	0.45
Evaluation	140	15.9%	0.44
Crisis Intervention/Crisis Stabilization/Crisis Hotline	123	13.9%	1.98
Physical Therapy/Occupational Therapy/Speech or Hearing Service	72	8.2%	2.04
Consultation/Meeting	54	6.1%	0.39
Psycho-Social Rehabilitation/Cognitive Rehabilitation	49	5.5%	2.25
Group Therapy/Counseling	47	5.3%	0.19
Probation/Monitoring	46	5.2%	0.19
Special Education Class, Self-Contained	39	4.4%	0.14
Special Education, Inclusion	23	2.6%	1.55
Preschool Special Education Program (Part B)	21	2.4%	0.24
Emergency Room Psychiatric Service	20	2.3%	0.16
Day Treatment/Partial-Day Treatment	15	1.7%	0.36
Diversion/Prevention Service	7	0.8%	—
Behavioral/Therapeutic Aide Service	6	0.7%	—
Early Intervention/Prevention	2	0.2%	—
Special Education Resource Service	2	0.2%	—

Table I-3. Service Group and Service Type by Mean Number of Service Events per Child/Youth per Month (continued)

Grantees Funded in 2008–2009			
Type of Service	Children with Reported Service Events		Mean Number of Service Events per Child/Youth per Month
	n	%	
Other Early Care and Education Programs	1	0.1%	—
Teacher Aide Service/Other Paraprofessional Service	1	0.1%	—

Grantees funded in 2008
n =58,007 service events
Note: Mean number of service events was calculated among children/youth receiving reported services within each service group or service type. Because children/youth may receive services from more than one service group or service type, percentages may sum to more than 100%. Service events are based on various units of time, ranging from minutes to months. Some services reported as only one event (e.g., a 5-day inpatient hospitalization or a 1-month residential treatment stay) may represent a combination of services or multiple days of services.
— Represents data for fewer than 10 children/youth; data are not shown to protect confidentiality.

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