



National Survey of Child
and Adolescent Well-Being

NSCAW II BASELINE REPORT

Children's Services

OPRE Report 2011-27f
September 22, 2011

NSCAW II BASELINE REPORT: CHILDREN'S SERVICES

FINAL REPORT

OPRE Report 2011-27f

September 2011

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Submitted to:

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Administration for Children and Families
U.S. Department of Health and Human Services

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TABLE OF CONTENTS

INTRODUCTION	1
GUIDE TO THE REPORT.....	1
SUMMARY OF REPORT FINDINGS.....	2
CHILD CHARACTERISTICS AT NSCAW II BASELINE.....	3
CHILD INSURANCE STATUS	3
Current Insurance Status.....	4
Uninsured During the Past Year	4
HEALTH SERVICES.....	5
Usual Place of Health Care.....	5
Preventive Health Services	5
Delayed Medical Care due to Cost	6
DENTAL CARE, URGENT MEDICAL, AND BEHAVIORAL HEALTH SERVICES.....	6
Dental Care	7
Urgent Medical Care.....	7
Behavioral Health Services.....	8
Risk for a Behavioral/Emotional or Substance Abuse Problem	8
Specialty Behavioral Health Services	10
Nonspecialty Behavioral Health Services.....	11
Any Behavioral Health Services	12
Psychotropic Medication	13
SERVICES FOR YOUNG CHILDREN	13
Child Care and Head Start Programs	13
Early Intervention Services under the Individuals with Disabilities Education Act (IDEA)	14
SPECIAL EDUCATION SERVICES	14
Individualized Education Programs.....	14
EXHIBITS	17
REFERENCES	51
APPENDIX.....	54

LIST OF EXHIBITS

Number	Page
IV-1. Child Baseline Characteristics	17
IV-2. Current Child Insurance Status by Caregiver Report	18
IV-3. Child Uninsured in the Past 12 Months by Caregiver Report	20
IV-4. Children’s Usual Place of Health Care by Caregiver Report	21
IV-5. Children’s Preventive Health Services by Caregiver Report.....	23
IV-6. Delayed Child Medical Care Due to Cost by Caregiver Report.....	25
IV-7. Dental Care for Children 2 to 17 Years Old by Caregiver Report	27
IV-8. Children’s Urgent Medical Care in the Past Year (or Since Birth) by Caregiver Report	29
IV-9. Children’s Urgent Medical Care Since Start of Living Arrangement by Caregiver Report	31
IV-10. Risk of a Behavioral/Emotional Problem Among Children 1.5 to 17 Years Old.....	33
IV-11. Risk of a Behavioral/Emotional Problem and Substance Abuse Problem Among Children 11 to 17 Years Old.....	34
IV-12. Specialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report.....	36
IV-13. Nonspecialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report.....	39
IV-14. Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report.....	42
IV-14. Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report (continued)	43
IV-15. Current Use of Psychotropic Medications Among Children 1.5 to 17 Years Old by Caregiver Report.....	45
IV-16. Young Children’s Developmental Need, Participation in Child Care, Head Start, and Early Intervention Services	47
IV-17. Special Education Service Use and Risk of Behavioral/Emotional or Cognitive Problems Among Children 6 to 17 Years Old.....	49

Introduction

The second National Survey of Child and Adolescent Well-Being (NSCAW II) is a longitudinal study intended to answer a range of fundamental questions about the functioning, service needs, and service use of children who come in contact with the child welfare system. The study is sponsored by the Office of Planning, Research and Evaluation, Administration for Children and Families (ACF), U.S. Department of Health and Human Services (DHHS). It examines the well-being of children involved with child welfare agencies; captures information about the investigation of abuse or neglect that brought the child into the study; collects information about the child's family; provides information about child welfare interventions and other services; and describes key characteristics of child development. Of particular interest to the study are children's health, mental health, and developmental risks, especially for those children who experienced the most severe abuse and exposure to violence.

The study includes 5,873 children ranging in age from birth to 17.5 years old at the time of sampling. Children were sampled from child welfare investigations closed between February 2008 and April 2009 in 83 counties nationwide. The cohort includes substantiated and unsubstantiated investigations of abuse or neglect, as well as children and families who were and were not receiving services. Infants and children in out-of-home placement were oversampled to ensure adequate representation of high-risk groups. Face-to-face interviews or assessments were conducted with children, parents and nonparent adult caregivers (e.g., foster parents, kin caregivers, group home caregivers), and investigative caseworkers. Baseline data collection began in March 2008 and was completed in September 2009. Additional information about the NSCAW II history, sample design and methods, instrumentation, as well as a summary of differences between the NSCAW I and NSCAW II cohorts can be found in the first report, Introduction of this NSCAW II Baseline series.¹

Guide to the Report

The purpose of this NSCAW II Baseline Report is to describe services in the areas of health, behavioral health, services for young children, and special education that the NSCAW II cohort of children received at baseline. Also included are descriptions of children's insurance coverage as well as needs for various services. The Report is organized into several sections that include the following aspects of children's services:

- Child characteristics at NSCAW II baseline
- Insurance status (current insurance, uninsured during the past year)
- Health services (usual place of health care, preventive services, dental care, delayed medical care, urgent medical care)

¹ Comparisons between NSCAW I and NSCAW II estimates require statistical testing. Analysis for comparison purposes requires a different set of weights; these will be released with the 18-month follow-up of NSCAW II (Wave 2).

- Behavioral health services (risk of behavioral/emotional or substance abuse problems, mental health and substance abuse outpatient and inpatient services, psychotropic medication use)
- Services for young children (child care, Head Start, and early intervention services)
- Special education services (Individualized Educational Plans)

The topics covered in other NSCAW II baseline reports in this series include:

- Overview of the history and progression of the NSCAW study (detailed discussion of the sample design, methods, and instrumentation implemented for NSCAW II, and a summary of the characteristics of children and caregivers who participated in the baseline data collection effort)
- Child Well-Being (physical health and special health care needs, cognitive functioning and academic achievement, social, emotional, and behavioral health, developmental assessments of young children, and risky behavior in adolescents)
- Maltreatment (nature of alleged abuse, risk assessment, substantiation status, exposure to violence, aggression, and conflict)
- Caregiver Characteristics and Services (caregiver physical and mental health, substance use, intimate partner violence, involvement with the law, and services received by in-home parents)
- Caseworker Characteristics, Child Welfare Services, and Experiences of Children Placed in Out-of-Home Care (investigative caseworker characteristics, child and family service needs, satisfaction with caseworkers and the child welfare system, children in out-of-home placement)
- Overview of local agencies that participated in the study, the policy environment of the agencies, and their work with other agencies and services providers

The data analyzed in this report have been released through the National Data Archive for Child Abuse and Neglect (NDACAN) in NSCAW II data version 1-1.

Summary of Report Findings

This NSCAW II baseline report describes children's receipt of health care, developmental and special education services, and behavioral health services at baseline. When asked about health care, caregivers reported that most children had a usual place of health care, typically a doctor's office or clinic. Almost all children were reported as up-to-date in immunizations and most children had received a well-child checkup in the last 12 months. More than a quarter (27.8%) of children 6 to 17 years old had an active Individualized Education Program (IEP). A smaller percentage of younger children had received developmental or special education

services; less than one in 10 of young children birth to 5 years old had an Individualized Family Service Plan (IFSP) or IEP.

Many children who might be in need of services did not receive them. For instance, although children at risk for behavioral health problems were more likely to have received behavioral health services than those not at risk, many received no behavioral health services. Of those children birth to 5 years old with developmental problems only 13.1% were reported to have an IFSP or IEP. And, although need increased children's likelihood of receiving special education services, 57.0% of children determined to be in need of a referral for special education services due to cognitive problems and 72.2% needing referral for behavioral health services were not currently reported to have an active IEP.

Children's receipt of services differed most frequently by age, race/ethnicity, setting, and insurance status. Details for these comparisons may be found in the report; two salient outcomes are highlighted here. Insurance was a significant predictor of many health-related services (e.g., usual source of care, dental care, well-child visits). Lack of insurance, in particular, negatively affected a child's likelihood to have a usual source of care and recent access to well-child and dental services. Slightly more than 9% of children were uninsured at the time of the NSCAW II baseline interview, but almost twice that many (22.1%) had been uninsured at some point in the past 12 months. Children living in-home or in an informal kinship care placement were less likely to have received a recent well-child visit and developmental (IFSP/IEP) services than children living in formal kinship or foster care. Children living in informal kinship care were also less likely to receive IEP special education services than children living in-home or in foster care.

Child Characteristics at NSCAW II Baseline

Exhibit IV-1 gives an overview of some of the key characteristics of children in the NSCAW II cohort. Approximately one half of the sample was male (50.8%). One fifth (20.6%) of the children were 0 to 2 years old, 22.6% were 3 to 5 years old, 27.4% were 6 to 10 years old, and 29.5% were 11 to 17 years old. Four out of 10 children were White (41.5%), 28.3% were Hispanic, 22.4% were Black, and 7.7% described their race/ethnicity as "Other."

At the time of the baseline interview, the majority of children were living at home with biological or adoptive parents (87.3%), while 8.5% were living with a kin primary caregiver. A kin caregiver may be a grandparent, aunt or uncle, sibling, or other relative; 6.1% were in an informal kin care arrangement and 2.4% were in formal kin care. In formal kin care living arrangements, the caregiver receives some financial support. A smaller proportion of children lived in foster care (3.4%) and in group homes (0.5%).

Child Insurance Status

This NSCAW II Baseline Report *Children's Services* describes services children received across a variety of domains including physical and behavioral health. Because insurance coverage is often an important factor in predicting service receipt, the report begins with a summary of children's insurance status at NSCAW II baseline.

Current Insurance Status

Caregivers were asked about their child's current insurance status. Responses were categorized into the following groups: (1) private insurance obtained through an employer or purchased directly, (2) Medicaid, (3) state health insurance plan for uninsured children, (4) other insurance, including coverage through a military health plan, and (5) currently uninsured, including children not covered at the time of interview as well as children only covered through the Indian Health Service (IHS).² These categories were derived to provide comparability to annual child insurance status estimates provided through National Health Interview Survey (NHIS) data.

Medicaid was the most commonly held type of children's health insurance (68.3%; Exhibit IV-2). Slightly more than 15% of children were reported to have private insurance, 3.1% were insured through some other type of insurance (including military coverage), and 3.7% had coverage through a state health insurance place for uninsured children. In total, 72.0% of children were currently covered by a public insurance plan. The 2009 NHIS showed a very different distribution of insurance status in the general population of children less than 18 years of age: 55.7% of children had private insurance and 37.7% had a public plan (Cohen, Martinez, & Ward, 2010). Among children at NSCAW II baseline, 9.6% were currently uninsured, a rate only slightly higher than the national estimate for children under 18 years old (8.2%), according to the 2009 NHIS (Cohen et al., 2010). The percentage of NSCAW II children who were uninsured at baseline was notably lower than the 23.9% of *poor* or *near poor* children who did not have insurance at the time of the NHIS interview, a subgroup more similar to the socioeconomic characteristics of the NSCAW II sample (Cohen et al., 2010).

Exhibit IV-2 shows variations in current child insurance status by age, race/ethnicity and setting. For example, when compared to older children (6 to 10 years old and 11 to 17 years old), infants and toddlers (0 to 2 years old) were more likely to have Medicaid rather than be uninsured. Around two thirds of Black, White, and Hispanic children had Medicaid. Black children (77.0%) were more likely to have Medicaid than Hispanic children (66.5%). Of children who did not have Medicaid, White children (20.3%) were more likely to have private insurance, while Hispanic children (12.7%) were more likely to be uninsured. Children living in formal kin care (82.2%), foster care (93.7%), and group home or residential programs (96.5%) were more likely to have Medicaid than to be uninsured when compared to children living at home (66.6%) or in informal kin care (71.2%).

Uninsured During the Past Year

While 9.6% of children were uninsured at the time of the NSCAWII baseline interview, almost twice that many (22.1%) had been uninsured at some point in the past 12 months (see Exhibit IV-3). This percentage is higher than the 2009 NHIS national estimate of children under 18 years old who were uninsured at least part of the past year (12.8%) (Cohen et al., 2010).

² "The leading national dataset on health, the National Health Interview Survey (NHIS), categorizes children with insurance coverage exclusively through the Indian Health Service (IHS) as "uninsured." For purposes of national comparison, we established insurance coverage categories to be consistent with the NHIS. Only four NSCAW II children at baseline had insurance exclusively through the IHS and were included in the "uninsured" category.

Being uninsured in the past 12 months differed by the child's setting. Children living in-home (22.8%) or in informal kin care (28.0%) were more likely to have been uninsured in the past 12 months than children living in formal kin care (8.6%), foster care (6.0%), or group home/residential programs (2.7%). Children living in formal kin care or foster care were more likely to have been uninsured in the last 12 months than those living in a group home or residential treatment program. There were no differences in a child's likelihood to have been uninsured in the past 12 months by gender, age, race/ethnicity, or current insurance status.

Health Services

Usual Place of Health Care

Caregivers reported that most children had a usual place of health care (95.7%; Exhibit IV-4), a rate approximating that of the general population of children under 18 years old nationally (95%; Sondik, Madans, & Gentleman, 2010). The most common location of this health care was a doctor's office (66.9%) or clinic (28.9%). According to caregiver reports, 2.8% of children relied on the emergency room for their usual place of health care and less than 1% used an outpatient hospital or *some other place*. This NSCAW II baseline distribution is also similar to the 2009 NHIS findings for children under 18 years old where 75% used a doctor's office as their usual place of health care, 24% a clinic, and 1% a hospital outpatient clinic or emergency room (Sondik et al., 2010).

The percentage of children with a usual place of health care varied according to age, setting, and insurance status. Children 0 to 2 years old (98.4%) were more likely to have a usual location of health care than children 3 to 5 years old (95.5%) and 11 to 17 years old (93.3%). Children living in foster care (98.0%) were more likely to have a usual place of health care than children living in-home with their biological or adoptive parents (95.6%). Children living in a group home or residential treatment program (100%) were more likely than children living in all other settings to have a usual place of health care. Not surprisingly, uninsured children were less likely to have a usual location of care (85.1%) than children with public insurance (97.4%) or other insurance (99.8%).

Preventive Health Services

Almost all children were reported as up-to-date in immunizations (96.6%; Exhibit IV-5). Immunization status varied by age and setting. Children 0 to 2 years old were less likely to be up-to-date with their immunizations (91.5%) than all older children. Children living in formal kin care (99.1%) or in a group home or residential treatment program (100%) were more likely to be up-to-date with their immunizations than children living in-home with parents (96.4%) or those living in foster care (96.3%).

Most caregivers reported that their child had received a well-child checkup in the last 12 months (83.1%; Exhibit IV-5). The likelihood of having received a well-child checkup varied by age, race/ethnicity, setting, and insurance status. Children 0 to 2 years old were more likely to have had a well-child checkup in the past 12 months (93.7%) than all older children. Similarly, children 3 to 5 years old were more likely to have received a well-child checkup in the past 12 months (87.0%) than older children. Both Black (88.0%) and White (84.6%) children were more likely to have received a well-child checkup than Hispanic children (78.3%). Black children

were also more likely to have received a well-child checkup than children of “Other” race/ethnicity (77.9%). Children living in formal kin care (91.4%) and foster care (92.8%) were more likely to have received a well-child checkup than children living in-home with parents (82.8%) and children living in informal kin care (77.9%). Children living in a group home or residential treatment program were the most likely to have received a well-child checkup in the past year (97.9%). Uninsured children were less likely to have received a well-child checkup (61.9%) than children with either private (84.0%) or public insurance (86.1%).

Delayed Medical Care due to Cost

All caregivers were asked if their child’s medical care was ever delayed due to concerns about the cost of services and, if so, what type of care was delayed. Of caregivers, 12.8% reported that some portion of their child’s medical care in the past year was delayed due to cost (Exhibit IV-6). This percentage is higher than the national 2009 NHIS estimate, which showed that 4.7% of families delayed children’s medical care because of worry about cost (Sondik et al., 2010). Types of medical care delayed included dental care (6.5% of all children), prescription medications (5.2%), mental health care or counseling (3.4%), and eyeglasses (3.2%).

The percentage of children whose medical care was delayed due to cost varied by child age, setting, and current insurance status. Younger children (0 to 2 years old and 3 to 5 years old) were more likely to have had delayed medical care due to cost than older children (6 to 10 years old and 11 to 17 years old). Children living in-home with parents (13.5%) were more likely to have delayed medical care than children living in formal kin (5.0%), foster (2.9%), and a group home or residential treatment program (0%). Children living in informal kin care (12.1%) were more likely to have delayed medical care than children living in foster care or a group home or residential treatment program. Finally, children with private insurance (16.4%) were more likely to have delayed medical care due to cost than children with public insurance (8.8%). Uninsured children (34.5%) were more likely to have delayed medical care than all types of insured children.

Dental Care, Urgent Medical, and Behavioral Health Services

Dental care, urgent medical care, and behavioral health services were assessed by caregiver report. The time reference period for these service use questions differed depending on (1) whether a child had lived with the primary caregiver since birth, (2) whether a child had lived with the primary caregiver consistently for the past 12 months, and (3) whether a child was younger than 12 months old. Time reference periods within each survey item were tailored to fit information the caregiver was best suited to provide. If a child had lived with the primary caregiver consistently over the last 12 months, the primary caregiver was asked about the child’s dental, urgent medical, or behavioral health service use *in the past year*. If a child had not lived with the primary caregiver consistently for 12 months, the caregiver was asked about the child’s dental, urgent medical, or behavioral health service use *since the start of the living arrangement*. The date the child began to live with the caregiver was inserted into the caregiver interview to define the time period to assess service use. If the child was younger than 12 months old at the time of the interview, caregivers were asked about urgent medical care received *since the child’s birth*.

Both in-home and out-of-home caregivers were asked these various service questions. In other words, caregiver questions about service use *since start of the living arrangement* were not limited exclusively to the caregivers of children currently living out of home. Since the likelihood of service access increases over time, the exhibits in this section of the report are organized according to how the caregiver was asked about individual services. Dental, urgent medical, and behavioral health services are presented according to service use *in the past year* for children who had been with the caregiver for that entire period, and service use *since the start of the living arrangement* for two groups—children who had lived with their current caregiver for less than 6 months and children who had lived with their current caregiver for 6 to less than 12 months.

Dental Care

Use of dental care was assessed for children 2 years and older. Caregivers were asked about a child receiving dental care in the past year only if they had lived with the child consistently for the past 12 months. Sixty-seven percent of these caregivers reported that their child had received dental care in the past 12 months (Exhibit IV-7). Past-year receipt of dental care varied by child age and current insurance status. Older children (6 to 10 years old and 11 to 17 years old; 74.7% and 75.3%, respectively) were more likely to have received dental care in the past 12 months than children 2 to 5 years old (52.3%). Children with private insurance (77.6%) were more likely to have received dental care in the past 12 months than children with public insurance (68.8%) or no insurance coverage (38.1%). Children with public or some other insurance coverage (73.6%) were more likely to have received past-year dental care than uninsured children.

If the child had not lived with that caregiver consistently for the past 12 months, the caregiver was asked about a child receiving dental care since the start of the living arrangement with the child. Fifty-three percent of children living with their caregivers for less than 6 months had received dental care since the start of this living arrangement (Exhibit IV-7). Seventy-three percent of children who had been living with their caregivers between 6 to less than 12 months had received dental care since the start of this living arrangement (Exhibit IV-7). These estimates did not vary by child characteristics.

Urgent Medical Care

Caregivers were asked about child use of urgent-care services for illnesses or injuries in the past year if they had lived with the child consistently for the past 12 months (Exhibit IV-8). Infants living with the same caregiver since birth were classified in the same group as children living with the caregiver for 1 year or more. Slightly more than a third (33.1%) of these caregivers reported that their child had used the emergency room (ER) or urgent-care services for an illness or an injury in the past 12 months. This is higher than the 2009 national estimate of children under 18 years old who had an ER visit in the past year (14%; Sondik et al., 2010). Past-year overnight hospital admissions for illnesses and injuries were less common (6.2%). And, 9.7% of children had contact with a physician or nurse for serious accidents, injuries, or poisonings in the past year.

Child use of urgent-care services for illnesses or injuries varied according to age, race/ethnicity, and setting. Children 0 to 2 years old were more likely to have used the ER or

urgent care (45.9%) as well as to have been admitted overnight to a hospital in the past year for illness or injury (12.0%) than all older children. Hispanic children were less likely to have used the ER or urgent care in the past year (26.2%) than children of all other races/ethnicities. Children living in-home with biological or adoptive caregivers were more likely to have had an injury, accident, or poisoning that needed medical care (9.6%) than children living in formal kin care (3.4%) or children living in foster care (1.2%).

If the caregiver had not lived with the child consistently for the past 12 months, the caregiver was asked about a child receiving urgent medical services since the start of the living arrangement with the child (Exhibit IV-9). Of children living with their caregivers for less than 6 months, 17.6% had received ER or urgent care since the start of this living arrangement; 36.7% of children who had been living with their caregivers between 6 to less than 12 months had received ER or urgent care since the start of this living arrangement. In addition, 3.7% of children living with their caregivers for less than 6 months had been admitted overnight to a hospital since the start of this living arrangement; 7.3% of children who had been living with their caregivers between 6 to less than 12 months had been admitted overnight to a hospital since the start of this living arrangement. Finally, 4.4% of children living with their caregivers for less than 6 months had an injury, accident, or poisoning that needed medical care since the start of this living arrangement; 5.8% of children who had been living with their caregivers between 6 to less than 12 months had an injury, accident, or poisoning that needed medical care since the start of this living arrangement. Estimates of urgent medical care use for children living with their caregivers for less than a year varied by gender, age, race/ethnicity, and setting. These differences are detailed in Exhibit IV-9.

Behavioral Health Services

Caregivers were asked whether their child had received help for an emotional, behavioral, learning, attentional problem, or substance abuse problem. This NSCAW II Baseline Report summarizes behavioral health service use among children 1.5 to 17 years old. Behavioral health service use questions were framed so that caregivers could respond positively for all service providers or service settings that were applicable; consequently, caregivers could report receipt of services from more than one source. Caregivers were asked about a child's use of behavioral health services in the past year only if they had lived with the child consistently for the past 12 months. Caregivers were asked about a child receiving behavioral health services since the start of their living arrangement with the child if that caregiver had not lived with the child consistently for the past 12 months. All questions included the following phrasing: "your child received any (name of service) for emotional, behavioral, learning, attentional, or substance abuse problems *in the past 12 months or since [insert start date of child's living arrangement]?"*

Risk for a Behavioral/Emotional or Substance Abuse Problem. The behavioral health and services exhibits (see Exhibits IV-10 through IV-14) in this report also show service use by risk for a behavioral/emotional problem as well as risk for a substance abuse problem among children 11 to 17 years old. The prevalence of risk of a behavioral/emotional problem among children 1.5 to 17 years old was 41.4% (details can be found in Exhibit IV-10). The prevalence of risk of a behavioral/emotional problem or substance abuse problem specifically among children 11 to 17 years old was 60.9% (57.2% had a risk of a behavioral/emotional problem, 19.3% had a risk of a substance abuse problem; details can be found in Exhibit IV-11).

Children 1.5 to 17 years old were determined to have a risk for a behavioral or emotional problem using the following instruments: Internalizing, Externalizing, or Total Problems scales of the Child Behavior Checklist (CBCL; administered for children 1.5 to 17 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report Form (TRF; administered for children 6 to 17 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older). Scores in the clinical range on any of these standardized measures identified the child as at risk for a behavioral/emotional problem and potentially in need of mental health services. When findings from all sources of information on risk for a behavioral or emotional problem were combined, data showed that 41.4% of children 1.5 to 17 years old were determined to be at risk and potentially in need of mental health services (20.5% of children 1.5 to 5 years old, 49.5% of those 6 to 10 years old, and 57.2% of those 11 to 17 years old). Children 1.5 to 5 years old were significantly less likely to be identified as at risk for a behavioral/emotional problem than children 6 to 10 years old and 11 to 17 years old. Children 6 to 10 years old were significantly less likely to be identified as at risk for a behavioral/emotional problem than children 11 to 17 years old.

No comparable national estimates of childhood mental health problems are available for children 1.5 to 17 years old. National estimates are available only for certain age subpopulations. For instance, a recent national study using data from 2001–2004 estimated that 13.1% of U.S. children 8 to 15 years old had any mental disorder (Merikangas et al., 2010). Using slightly older national survey data, Kataoka, Zhang and Wells (2002) found that 15.2% (NHIS) to 20.8% (National Survey of American Families, NSAF) of U.S. children 6 to 17 years old met criteria for a mental health need. Slightly fewer (8.5%) of children 4 to 5 years old were determined to have a mental health need (NHIS; Kataoka et al., 2002). While the estimates are not directly comparable due to age caveats, children 1.5 to 17 years old at NSCAW II baseline appear to show much higher risk for behavioral or emotional problems than other U.S. children.

Risk of a substance abuse problem was defined by a total score of 2 or more on the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight, Sherritt, Shrier, Harris, & Chang, 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment. Nearly one fifth (19.3%) of adolescents had a score of 2 or higher indicating a potential need for substance abuse services (Exhibit IV-11). This proportion was significantly higher among adolescents 15 to 17 years old (32.5%) than among those 13 to 14 years old (19.3%) or those 11 to 12 years old (5.3%).

No national data using the CRAFFT are available for comparison. However, a study of 2,133 primary care patients in New England, 12 to 18 years old, found that the proportion of adolescents that scored 2 or higher on the CRAFFT was slightly lower (14.8%) (Knight et al., 2007). NSCAW II rates of substance use disorders based on the CRAFFT were also higher than other national estimates. The national rate of substance dependence or abuse among children 12 to 17 years old in 2009 was 7%; the rate of adolescent alcohol dependence was 4.6% (Substance Abuse and Mental Health Services Administration, 2010).

Exhibit IV-11 also shows risk among children 11 to 17 years old of either a behavioral/emotional or substance abuse problem. Taken together, 60.9% of NSCAW II children 11 to 17 years old showed some risk of either a behavioral/emotional or substance use problem, meaning that many adolescents at NSCAW II baseline showed some need for behavioral health services. This need was significantly greater among children living in informal kin care (78.1%) or in a group home or residential treatment program (73.9%) than children living in formal kin care (46.6%) or foster care (53.5%).

Specialty Behavioral Health Services. Caregivers were asked about children's use of specialty outpatient and inpatient services in the past year if they had consistently lived with their child for the past 12 months (Exhibit IV-12). Specialty outpatient behavioral health services included services from an outpatient drug or alcohol clinic, mental health or community health center, private mental health professional, or in-home counseling or crisis services. This also included the use of day treatment for emotional and substance abuse problems or use of a therapeutic nursery. Of children 1.5 to 17 years old, 18.0% received outpatient specialty behavioral health services in the past year. The two most frequently used outpatient specialty services included those from a private mental health professional (11.4%) and a mental health or community health center (6.5%). Inpatient behavioral health services included services from a psychiatric hospital or psychiatric unit within a medical hospital, services through a detox unit or inpatient unit, hospital medical inpatient unit, residential treatment center or group home, or hospital ER for emotional and substance abuse problems. In the past year 2.6% of children received inpatient behavioral services. The two most frequently used inpatient behavioral health services were a psychiatric hospital unit (1.6%) and a hospital ER for an emotional or substance abuse problem (1.2%).

Among those children 1.5 to 10 years old identified as at risk for a behavioral or emotional problem, 28.8% received any specialty outpatient behavioral health service and 3.0% received any inpatient behavioral health service in the past year. Among children 11 to 17 years old identified as at risk for either a behavioral/emotional or substance abuse problem, 36.8% received any specialty outpatient behavioral health service and 9.0% received any specialty inpatient behavioral health service in the past year.

Estimates of past-year specialty outpatient behavioral health service use differed by gender, age, race/ethnicity, and the child being identified as at risk for a behavioral or emotional problem. Males were more likely to have used specialty outpatient behavioral health services (20.3%) than females (15.8%). Older children (6 to 10 years old and 11 to 17 years old; 22.2% and 26.2%, respectively) were more likely to have used outpatient services than younger children (1.5 to 5 years old; 7.2%). White children (25.4%) were more likely to have used outpatient services than Black (12.2%) or Hispanic children (11.4%). And, children identified as at risk for a behavioral or emotional problem (33.0%) were more likely to have used outpatient services than children not identified as at risk for a behavioral or emotional problem (7.6%) Estimates of past-year specialty inpatient behavioral health service use varied by age, setting, and the child having a behavioral or emotional problem. Older children (6 to 10 years old and 11 to 17 years old; 2.2% and 6.0%, respectively) were more likely to have used inpatient services than younger children (1.5 to 5 years old; 0.0%). Children living in-home with parents (2.7%) were significantly more likely to have received inpatient services in the past 12 months than children living in informal kin care (0.5%). Children identified as at risk for a behavioral or emotional

problem or substance abuse problem were more likely to have used outpatient and inpatient behavioral health services than children not identified as at risk.

Caregivers were asked about a child receiving specialty behavioral health services since the start of their living arrangement with the child if that caregiver had not lived with the child consistently for the past 12 months. Caregivers of children who had lived with their caregiver for less than 6 months reported that 28.2% of children had used outpatient and 3.9% inpatient services since the start of this living arrangement (Exhibit IV-12). Caregivers of children who had lived with their caregivers for 6 to less than 12 months reported that 35.0% of children had used outpatient and 9.2% inpatient services since the start of this living arrangement (Exhibit IV-12). Differences in these groups by age, setting, insurance status, and behavioral health risk are detailed in the footnotes of Exhibit IV-12.

Nonspecialty Behavioral Health Services. Caregivers were asked about children's use of nonspecialty services in the past year if they had consistently lived with their child for the past 12 months. Nonspecialty services included services received by either a family or other medical doctor and school-based services (Exhibit IV-13). Findings showed that 9.2% of caregivers reported having visited a doctor for their child's emotional, behavioral, learning attention, or substance abuse problems in the past year, while 14.0% of children had reportedly received services from a school guidance counselor, social worker, or psychologist for emotional, behavioral, learning, or substance abuse problems in the past year. Among those children 1.5 to 10 years old identified as at risk for a behavioral or emotional problem, 19.5% received services from a family or other medical doctor and 21.6% received school-based mental health services in the past year. Among children 11 to 17 years old identified as at risk for a behavioral/emotion or substance abuse problem, 14.7% received services from a family or other medical doctor and 31.6% received school-based mental health services in the past year. Past-year estimates of nonspecialty behavioral health services from a family or other medical doctor differed by age, race, and the child being identified as at risk for a behavioral or emotional problem. Older children (6 to 10 years old and 11 to 17 years old; 14.0% and 9.9%, respectively) were more likely to have used services from a family or other medical doctor than younger children (1.5 to 5 years old; 4.5%). White children (13.2%) were significantly more likely to have received behavioral health services from a family or other medical doctor in the past 12 months than Black (7.3%) and Hispanic children (5.0%). Past-year estimates of nonspecialty school-based behavioral health services differed by age. Older children (6 to 10 years old and 11 to 17 years old; 17.9 % and 23.7%, respectively) were more likely to have used school-based services (1.5 to 5 years old; 2.1%). Children at risk for a behavioral/emotional problem (1.5 to 10 years old) or behavioral/emotional or substance abuse problem (11 to 17 years old) were more likely to receive assistance from a family or other medical doctor or school-based services in the past 12 months than those not identified as at risk.

Caregivers were asked about a child receiving nonspecialty behavioral health services since the start of their living arrangement with the child if that caregiver had not lived with the child consistently for the past 12 months. Caregivers of children who had lived with their caregiver for less than 6 months reported that 9.2% of children had used nonspecialty services from a doctor and 12.7% had used school-based services since the start of this living arrangement (Exhibit IV-13). Caregivers of children who had lived with their caregivers for 6 to less than 12 months reported that that 12.6% of children had used nonspecialty services from a

doctor and 16.1% had used school-based services since the start of this living arrangement (Exhibit IV-13). Age differences and differences by behavioral risk are detailed in the footnotes of Exhibit IV-13.

Any Behavioral Health Services. Slightly more than a quarter (26.9%) of caregivers reported that their 1.5- to 17-year-old children had received some kind of mental health services in the past year (including specialty outpatient services, inpatient behavioral health services, family doctor, or school-based services for emotional or behavioral problems; Exhibit IV-14). The most commonly received behavioral health services in the past year were in specialty outpatient settings, followed by school-based services, and then services by a family or other medical doctor. Children 1.5 to 10 years old at risk for a behavioral or emotional problem were more likely to have received behavioral health services in the past year (42.5%) than those not at risk (9.6%). However, more than half (57.5%) of children 1.5 to 10 years old determined to be at risk for a behavioral or emotional problem were reported to have not received any behavioral health service in the past year. The findings were similar for children 11 to 17 years old. Children 11 to 17 years old at risk for a behavioral/emotional or substance abuse problem were more likely to have received behavioral health services in the past year (51.9%) than those not at risk (21.5%). However, slightly under half (48.1%) of children 11 to 17 years old determined to be at risk for a behavioral/emotional or substance abuse problem were reported to have not received any behavioral health service in the past year.

Estimates of any behavioral health service use in the past year differed by gender, age, race/ethnicity, and need. Males (30.4%) were more likely to have used any behavioral health services in the past year than females (23.3%). Older children (6 to 10 years old and 11 to 17 years old; 33.2% and 40.1%, respectively) were more likely to have used services from a family or other medical doctor than younger children (1.5 to 5 years old; 9.5%). White children (34.8%) were significantly more likely to have used any behavioral health service in the past 12 months than Black (22.3%) and Hispanic children (18.9%). Children at risk for a behavioral/emotional problem (1.5 to 10 years old) or behavioral/emotional or substance abuse problem (11 to 17 years old) were more likely to have received any behavioral health services in the past 12 months than those not identified as at risk.

Caregivers of children who had lived with their caregiver for less than 6 months reported that 37.0% of children had used any behavioral health services since the start of this living arrangement (Exhibit IV-14). Caregivers of children who had lived with their caregivers for 6 to less than 12 months reported that 44.5% of children had used any behavioral health services since the start of this living arrangement (Exhibit IV-14). Age differences and differences by behavioral risk are detailed in the footnotes of Exhibit IV-14.

Similar to national estimates of mental health need, there are not exact national estimates of children's mental health service use comparable to the age representation of NSCAW II children at baseline. However, available national estimates suggest higher mental health service use in NSCAW II children than those in the general population. National data from the NHIS and NASF showed that 2%–3% of children 3 to 5 years old and 6%–9% of U.S. children and adolescents 6 to 17 years old used mental health services in the past year. Of children and adolescents 6 to 17 years old who were defined as having some mental health need, nearly 80% did not receive mental health care (Kataoka et al., 2002). Using national data from 2001–2004,

Merikangas et al. (2010) estimated that approximately half of children 8 to 15 years old with a mental health disorder (ADHD, Conduct, Anxiety, Eating or Mood Disorder) had received some mental health treatment (hospital, clinic or office) in the past year.

Psychotropic Medication. All caregivers of children 1.5 to 17 years old were asked about their child's current use of psychotropic medications. Exhibit IV-15 provides estimates of children whose caregivers reported that they currently used any psychotropic medication (11.7%), two psychotropic medications (2.9%), and three or more psychotropic medications (2.3%). The NSCAW II baseline rate of psychotropic medication use among children 1.5 to 17 years old (11.7%) is double the percentage for the general population of children 4 to 17 years old who were prescribed a psychotropic medication in the 12 months prior to assessment for the NHIS (6.0%; Simpson, Cohen, Pastor, & Reuben, 2008).

Use of psychotropic medications varied by gender, age, race/ethnicity, setting, and insurance status. Males were more likely than females to be using any psychotropic medications (14.8% versus 8.5%) and to be using two psychotropic medications (3.9% versus 1.8%). Children 1.5 to 5 years old (1.5%) were less likely to be using one or more psychotropic medications than all older children (6 to 10 years old and 11 to 17 years old; 19.6% and 16.0%, respectively). White children (17.1%) were more likely to be currently using any psychotropic medication than Black (10.4%), Hispanic (5.8%), and children of "Other" race/ethnicity (8.3%). Children with public insurance (13.3%) were more likely to be using one or more psychotropic medications than uninsured children (6.2%). These trends are very similar to those in other national studies showing higher rates of psychotropic medication use among White children, males, and those with public insurance compared children of "Other" race/ethnicity, females, and other types of insurance (Olfson, Marcus, Weissman, & Jensen, 2002). Children living in a group home or residential treatment program were more likely to be currently using a psychotropic medication than children living in all other settings.

Services for Young Children

Over the past decade, increasing evidence has shown that children's earliest experiences lay a biological and social foundation for future health, development, and learning (Shonkoff & Phillips, 2000). For children maltreated in these early years, developmental, mental health, and early intervention services may mean the difference between an unsuccessful transition later to the school system and academic success.

Child Care and Head Start Programs

Caregivers were asked whether their young child (0 to 59 months old) was participating in any type of child care program including a Head Start program, nursery school, or early childhood development program. More than a quarter (29.3%) of young children were participating in some kind of child care program (Exhibit IV-16). Among those in child care programs, 21.3% were participating in Head Start. In general, children 48 to 59 months old were more likely to participate in any type of child care program than younger children. Similarly, children 42 to 59 months old were more likely to participate in Head Start than younger children. Black children (41.1%) were more likely to participate in any type of child care program than White children (23.5%).

Early Intervention Services under the Individuals with Disabilities Education Act (IDEA)

For young children (0 to 59 months old, caregivers and caseworkers were asked whether the child currently had an Individualized Family Service Plan (IFSP) or if the child had an Individualized Education Program (IEP) or services for a special need or disability. Less than one in 10 of young children (6.5%; Exhibit IV-16) had an IFSP or IEP. This percentage exceeds the 2.3% of all children birth to 36 months old receiving IDEA Part C early intervention services nationwide in 2004, but is similar to the percentage of children 3 to 5 years old served under IDEA Part B (5.9%; U.S. Department of Education, 2009). Nevertheless, the percentage of children with an IFSP or IEP does not appear to match need (described below). Moreover, an IFSP or IEP likely serves as only the formal entry vehicle to Part C early intervention services or Part B special education services. The IFSP or IEP is a legal document that defines the goals of the intervention and the services that will be provided. Children with an IFSP or an IEP may receive services or they may only be monitored for developmental delay; once they show developmental delay, they are entitled to services and may receive them.

Males (8.3%) were more likely than females (4.5%) to have an IFSP or IEP. Children living in-home with parents (4.6%) were less likely to have an IFSP or IEP than all other children. Children in foster care (21.4%) were less likely to have an IFSP or IEP than children living in formal kin care (30.0%), but more likely to have an IFSP or IEP than children in informal kin care (14.3%).

Overall, 33.3% of children birth to 5 years old had a score across measures indicating some developmental problem. Of those with developmental problems, only 13.1% have an IFSP or IEP. Here, developmental problem was defined based on having a diagnosed mental or medical condition that has a high probability of resulting in developmental delay (e.g., Down syndrome) and/or being 2 standard deviations below the mean in at least one developmental area or 1.5 standard deviations below the mean in two areas. Areas included cognitive development based on the *Battelle Developmental Inventory, 2nd Edition (BDI-2)* (Newborg, 2005) or *Kaufman Brief Intelligence Test (K-BIT; Kaufman & Kaufman, 1990)*, communication development based on the *Preschool Language Scale-3 (PLS-3)* (Zimmerman, Steiner, & Pond, 1992), and adaptive development based on the Vineland Adaptive Behavior Scale (VABS) Screener—Daily Living Skills domain (Sparrow, Carter, & Cicchetti, 1993). Children with developmental problems (13.1%) were more likely to have an IFSP or IEP than children without developmental problems (3.3%).

Special Education Services

Individualized Education Programs

Teachers of children 6 to 17 years old were asked “*Is student currently receiving special education? That is, does he/she currently have an Individualized Education Program (I.E.P.) or an Individualized Family Service Plan (I.F.S.P.)?*” In the school system, an IEP is a legal document developed when a student is expected to receive special education services. In addition to teachers, caregivers were asked whether the child had an IEP or was receiving special education services. The presence of an IEP was determined by teacher’s report when available; only when a teacher’s report was unavailable was determination based on the caregiver’s report.

As shown in Exhibit IV-17, 27.8% of children were reported to currently have an active IEP, a percentage that is more than double comparable national estimates. Nationwide in 2004, 11.4% of children 6 to 11 years old and 11.8% of children 12 to 17 years old were served under IDEA Part B and were receiving special education services and related services (U.S. Department of Education, 2009).

Males (34.3%) were more likely to have received an IEP than females (21.4%). This distribution is consistent with other studies showing greater representation of boys in special education (Hodapp & Fidler, 1999). Children living in informal kin care (16.3%) were less likely to have an IEP than children living in-home with parents (28.1%), and children in foster care (35.7%).

Nationwide, eligibility for special education placement is determined through a comprehensive assessment of the children's abilities, which also forms the basis for the type and level of service he or she receives. Children may be diagnosed as having health, cognitive, or emotional challenges that must be addressed in the educational setting. To estimate the level of special education needs among this school-age (6 to 17 years old) population, "need" was operationalized as a child's having a clinically significant score on a standardized measure indicating risk for behavioral or emotional problems, cognitive delays, or limited academic achievement.³ With this procedure, 64.1% of children 6 to 17 years old were estimated as having an elevated risk for cognitive or behavioral problems: 12.0% had only a risk of cognitive problems, 40.0% had only a risk of behavioral or emotional problems, and 12.1% had both types of risk.

As expected, an active IEP was significantly more common when children were determined to have these cognitive and/or behavioral needs that might interfere with school success. Children without an identified behavioral or cognitive problem were less likely to have an IEP than any of the groups in need due to behavioral and/or cognitive problems. Although need increased a children's likelihood of receiving special education services, 57.0% of children determined to be in need of a referral for special education services due to cognitive problems were not currently reported to have an active IEP. Among children with behavioral needs, 72.2% did not have an active IEP. Children with both types of problems (behavioral and cognitive) were more likely than those with one type of problem to have an active IEP (68.2%). Estimates here of

³ Children were considered to be at risk for a cognitive problem or low academic achievement and in need of a referral for special education services if they had a score 2 standard deviations or more below the mean for the *Kaufman Brief Intelligence Test (K-BIT)* or *Woodcock-Johnson III Tests of Cognitive Abilities* (considered a cognitive need) (Kaufman & Kaufman, 2004; Woodcock, McGrew, & Mather, 2001). Children were considered to be at risk for a behavioral/emotional problems if either (1) a caregiver reported an elevated score (>1.5 standard deviations above the mean, corresponding to a T score in the Achenbach scales of 64 or more) on the Total Problems, Internalizing, or Externalizing scales of the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001); (2) an adolescent reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the Youth Self-Report (YSR) (Achenbach & Rescorla, 2001); (3) a teacher reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the Teacher Report Form (TRF) (Achenbach & Rescorla, 2001); (4) a clinically significant score was obtained on the Children's Depression Inventory (CDI) (Kovacs, 1992a), or (5) a clinically significant score was obtained on the Posttraumatic Stress subscale from the Trauma Symptom Checklist for Children Checklist (Briere, 1996).

“need” for special education services do not directly correspond to national eligibility requirements for IEP services. In fact, the exact eligibility for IEP services differs from state to state. Nonetheless, adopting criteria similar to the approach taken here, most states use clinically significant scores on quantitative measures to determine eligibility for IEP receipt.

Among the 27.8% of children described as currently having an active IEP (n=280, data not in table), teachers reported that 35.9% had a specific learning disability, 17.9% were identified as having a severe emotional disturbance, 11.9% were identified as having mental retardation, 8.6% as having a speech or language impairment, and 6.0% as having ADHD. Children might have received more than one type of service associated with their IEP. The most commonly provided services were speech-language pathology and/or audiology services (29.6%), counseling services (including rehabilitation services; 24.0%), psychological services (19.0%), and social work services (16.9%).

For More Information

This NSCAW II Baseline Report focuses on services received by children with some limited information on children’s needs for services. Complementary information on the well-being of children in the NSCAW II cohort may be found in the *NSCAW II Baseline Report: Children’s Well-Being* (OPRE Report 2011-27b). Information on caregivers, including services needed and received, may be found in the *NSCAW II Baseline Report: Caregiver Characteristics and Services* (OPRE Report 2011-27d). Other reports from NSCAW II can be found at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html.

EXHIBITS

Exhibit IV-1. Child Baseline Characteristics

	<i>N</i>	Total	
		<i>N</i> = 5,873	
		%	<i>SE</i>
Total	5,873	100.0	0.0
Gender			
Male	3,017	50.8	1.4
Female	2,856	49.2	1.4
Age (years)			
0–2	2,937	20.6	1.0
3–5	829	22.6	1.2
6–10	1,053	27.4	0.9
11–17	1,054	29.5	1.3
Race/ethnicity			
Black	1,827	22.4	2.6
White	2,004	41.5	3.9
Hispanic	1,614	28.3	3.5
Other	407	7.7	1.0
Setting			
In-home	3,636	87.3	1.1
Formal kin care	495	2.4	0.4
Informal kin care	540	6.1	0.7
Foster care	1,105	3.4	0.3
Group home or residential program	68	0.5	0.1
Other out of home	29	0.3	0.1
Insurance status ^a			
Private	549	15.3	1.5
Public	4,834	72.0	1.8
Other	130	3.1	0.7
Uninsured	324	9.6	0.9

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories.

^a“Private” includes children who had any private insurance plan at the time of interview either obtained through an employer or purchased directly. “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP). “Other” includes children who did not have private insurance or Medicaid (or other public coverage) at the time of interview, but who have any other type of insurance, including coverage through a military health plan. “Uninsured” includes children not covered at the time of interview under private, public, or other insurance. “Uninsured” also includes children only covered through the Indian Health Service (n=4).

Exhibit IV-2. Current Child Insurance Status by Caregiver Report

	<i>N</i>	Private ^a		Medicaid		State health insurance plan for uninsured children		Other insurance, including military health plan		Currently uninsured	
		%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>
Total	5,837	15.3	1.5	68.3	2.0	3.7	0.8	3.1	0.7	9.6	0.9
Gender											
Male	2,998	13.9	1.6	70.0	2.5	3.8	0.9	3.1	0.9	9.4	1.1
Female	2,839	16.8	2.0	66.6	2.3	3.6	0.9	3.2	0.9	9.8	1.5
Age (years) ***											
0–2	2,936	7.7	1.4	81.6 ^b	2.5	3.4	1.2	1.7	0.5	5.6	1.2
3–5	829	14.6	1.7	70.8 ^c	3.0	2.1	1.0	3.7	1.3	8.8	2.0
6–10	1,051	15.8	2.1	62.4	3.1	4.8	1.4	4.6	1.5	12.4	2.7
11–17	1,021	20.8	2.9	62.3	3.5	4.1	1.1	2.4	0.9	10.4	2.0
Race/ethnicity**											
Black	1,820	9.4	1.4	77.0 ^d	2.2	2.4	0.8	2.8	1.1	8.4	1.4
White	1,996	20.3 ^e	2.3	65.7	2.7	2.8	0.7	3.2	0.9	8.2	1.2
Hispanic	1,601	12.0	2.5	66.5	3.6	5.9	1.7	2.9	1.6	12.7	2.0
Other	401	18.5	4.3	63.9	5.5	4.4	1.9	4.9	3.0	8.4	2.6
Setting***											
In-home	3,618	16.9	1.7	66.6	1.9	3.6	0.7	3.1	0.7	9.9	0.9
Formal kin care	495	4.0	2.2	82.2 ^f	9.2	1.9	1.1	11.5 ^g	9.3	0.5	0.3
Informal kin care	534	5.9	2.3	71.2	5.9	6.8	3.8	1.3	1.2	14.9	5.3
Foster care	1,101	0.8	0.4	93.7 ^f	2.9	3.2	1.9	1.3	0.9	1.0	0.3
Group home or residential program	62	1.1	0.9	96.5 ^f	1.5	1.3	1.0	0.5	0.6	0.6	0.6

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for significance tests. Asterisks indicate statistical significance (** $p < .01$, *** $p < .001$) for the covariate. Follow-up pairwise tests were limited to comparisons of “currently uninsured” insurance status to private, Medicaid, state plan, and other insurance status and comparisons of Medicaid to private insurance status.

^a “Private insurance” includes children who had any private insurance plan at the time of interview either obtained through an employer or purchased directly. “Medicaid” includes children who did not have private coverage at the time of interview, but who had Medicaid. “State health insurance plan for uninsured children” includes children who did not have private coverage at the time of interview, but who had state health insurance plan for uninsured children. “Other insurance, including military health plan” includes children who do not have private insurance or Medicaid (or other public coverage) at the time of interview, but who have any other type of insurance, including coverage through a military health plan. “Currently uninsured” includes children not covered at the time of interview under private, public, or other insurance. Also includes children only covered through the Indian Health Service.

- ^b Children 0 to 2 years old were significantly more likely to have Medicaid than to be currently uninsured when compared to children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .05$). Children 0 to 2 years old were also significantly more likely to have Medicaid than private insurance when compared to children 3 to 5 years old ($p < .01$), 6 to 10 years old ($p < .001$), and 11 to 17 years old ($p < .001$).
- ^c Children 3 to 5 years old were significantly more likely to have Medicaid than private insurance when compared to children 11 to 17 years old ($p < .05$).
- ^d Black children were significantly more likely to have Medicaid than to be currently uninsured when compared to Hispanic children ($p < .05$). Black children were also significantly more likely to have Medicaid than private insurance when compared to White children ($p < .001$) and children of other races ($p < .05$).
- ^e White children were significant more likely to have private insurance than to be currently uninsured ($p < .01$) when compared to Hispanic children.
- ^f Children living in formal kin care, foster care, and a group home or residential program were significantly more likely to have Medicaid than to be currently uninsured when compared to children living in-home with parents ($p < .001$) and children living in informal kin care ($p < .01$).
- ^g Children living in formal kin care were significantly more likely to have other insurance than to be currently uninsured when compared to children living in foster care ($p < .05$).

Exhibit IV-3. Child Uninsured in the Past 12 Months by Caregiver Report

	<i>N</i>	Was uninsured at any time during the past 12 months ^a	
		%	<i>SE</i>
Total	5,837	22.1	1.3
Gender			
Male	2,998	22.3	1.8
Female	2,839	21.9	1.7
Age (years)			
0–2	2,936	18.0	2.2
3–5	829	24.7	3.0
6–10	1,051	23.2	3.0
11–17	1,021	22.0	2.4
Race/ethnicity			
Black	1,820	20.3	1.9
White	1,996	19.8	1.9
Hispanic	1,601	26.5	2.5
Other	401	22.9	4.3
Setting		***	
In-home	3,618	22.8 ^b	1.4
Formal kin care	495	8.6 ^c	2.4
Informal kin care	534	28.0 ^d	5.1
Foster care	1,101	6.0 ^e	1.1
Group home or residential program	62	2.7	1.4
Current insurance status			
Private ^f	549	12.7	2.4
Public	4,834	14.4	1.3
Other	130	6.5	3.1

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for significance tests. Asterisks indicate statistical significance (***) $p < .001$ and apply to the subsequent results for the covariate.

^a Includes children who were reported to be uninsured at the time of the interview and those uninsured at any time in the last 12 months.

^b Children living in-home with parents were significantly more likely to have been uninsured in the last 12 months when compared to children living in formal kin care ($p < .01$), foster care ($p < .001$), and children living in a group home or residential program ($p < .001$).

^c Children living in formal kin care were significantly more likely to have been uninsured in the past 12 months when compared to children living in a group home or residential program ($p < .05$).

^d Children living in informal kin care were significantly more likely to have been uninsured in the last 12 months when compared to children living in formal kin care ($p < .01$), foster care ($p < .001$), and children living in a group home or residential program ($p < .001$).

^e Children living in foster care were significantly more likely to have been uninsured in the past 12 months when compared to children living in a group home or residential program ($p < .05$).

^f “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

Exhibit IV-4. Children’s Usual Place of Health Care by Caregiver Report

	N	Location of usual place of health care											
		Has usual place of health care		Clinic		Doctor’s office		Emergency room		Hospital outpatient		Some other place	
		%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Total	5,834	95.7	0.7	28.9	2.6	66.9	2.7	2.8	0.5	0.6	0.2	0.9	0.3
Gender													
Male	2,998	96.4	0.8	27.1	2.8	67.9	2.9	3.3	0.8	0.5	0.2	1.2	0.5
Female	2,836	95.0	1.2	30.7	3.3	65.8	3.4	2.2	0.5	0.7	0.3	0.6	0.2
Age (years)		*											
0–2	2,935	98.4 ^a	0.5	26.6	3.0	70.5	3.0	1.6	0.7	0.7	0.3	0.6	0.3
3–5	828	95.5	1.3	32.8	3.8	63.9	3.7	1.9	0.7	1.0	0.5	0.5	0.2
6–10	1,049	96.5	0.9	27.2	3.5	67.7	4.0	3.5	1.1	0.5	0.4	1.1	0.7
11–17	1,022	93.3	2.1	29.0	3.6	65.7	3.6	3.6	0.9	0.4	0.3	1.3	0.4
Race/ethnicity													
Black	1,818	96.6	0.7	29.1	2.9	66.2	3.1	3.9	1.5	0.6	0.4	0.2	0.1
White	1,996	97.5	0.7	18.9	3.1	77.3	3.3	2.1	0.6	0.4	0.2	1.2	0.3
Hispanic	1,600	93.0	2.0	39.0	5.4	56.6	5.0	2.9	0.9	0.6	0.4	0.8	0.6
Other	401	95.0	2.1	45.2	6.6	49.1	6.4	2.6	1.4	1.5	1.4	1.7	1.1
Setting		*											
In-home	3,618	95.6	0.8	28.4	2.8	67.1	2.9	3.0	0.6	0.6	0.2	0.9	0.3
Formal kin care	495	98.0	0.7	23.4	4.7	73.1	4.7	1.2	0.7	0.7	0.3	1.6	0.8
Informal kin care	535	95.1	2.1	34.3	5.3	64.2	5.3	1.3	1.0	0.1	0.0	0.1	0.1
Foster care	1,097	98.0 ^b	0.6	35.9	3.9	62.7	3.9	0.2	0.1	0.3	0.2	0.9	0.4
Group home or residential program	62	100.0 ^c	0.0	23.4	8.8	49.8	14.4	3.6	2.5	7.5	6.2	15.6	9.7
Current insurance status		**											
Private	549	93.7	3.3	18.4	4.1	80.0	4.1	0.8	0.4	0.4	0.3	0.5	0.3
Public ^d	4,828	97.4	0.5	29.5	2.8	66.9	3.0	2.2	0.6	0.5	0.2	0.8	0.2
Other	130	99.8 ^e	0.2	32.3	7.2	62.1	6.9	1.6	1.2	2.7	1.8	1.3	0.9
None	324	85.1 ^f	3.5	40.2	6.1	45.3	6.0	11.3	3.2	0.9	0.6	2.4	2.2

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for all significance tests. Significance testing was performed only on the variable “has usual place of health care.” Asterisks indicate statistical significance (**p* < .05, ***p* < .01). Asterisks in a column apply to the subsequent results for the covariate. “Location of usual health care” outcomes apply only to those cases where a caregiver reported that the child had a “usual location of care.”

- ^a Children 0 to 2 years old were significantly more likely to have a usual location of health care than children 3 to 5 years old ($p < .05$) and those 11 to 17 years old ($p < .05$).
- ^b Children living in foster care were significantly more likely to have a usual location of health care than children living in-home ($p < .05$).
- ^c Children living in a group home or residential treatment program were significantly more likely to have a usual location of health care than children living in-home with parents ($p < .01$), formal kin care ($p < .01$), informal kin care ($p < .05$), and foster care ($p < .01$).
- ^d “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).
- ^e Children with other insurance were significantly more likely to have a usual location of health care than children with public insurance ($p < .05$).
- ^f Uninsured children were significantly less likely to have a usual location of health care than children with public insurance ($p < .001$) or other insurance ($p < .01$).

Exhibit IV-5. Children’s Preventive Health Services by Caregiver Report

	Up-to-date with immunizations			Well-child checkup past 12 months		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	5,799	96.6	0.5	5,774	83.1	1.3
Gender						
Male	2,981	96.3	0.8	2,962	82.9	1.4
Female	2,818	96.8	0.6	2,812	83.3	1.8
Age (years)		**			***	
0–2	2,923	91.5 ^a	1.6	2,923	93.7 ^b	1.5
3–5	823	97.0	0.8	818	87.0 ^c	2.2
6–10	1,046	98.7	0.7	1,036	78.4	3.1
11–17	1,007	97.9	0.5	997	76.8	1.9
Race/ethnicity					**	
Black	1,803	96.6	1.0	1,795	88.0 ^d	1.3
White	1,982	96.4	0.9	1,979	84.6 ^e	1.7
Hispanic	1,595	97.9	0.7	1,586	78.3	2.4
Other	400	92.5	3.5	395	77.9	4.4
Setting		**			***	
In-home	3,614	96.4	0.6	3,605	82.8	1.4
Formal kin care	489	99.1 ^f	0.3	490	91.4 ^g	2.6
Informal kin care	522	98.2	0.9	520	77.9	5.5
Foster care	1,085	96.3	1.0	1,077	92.8 ^h	2.4
Group home or residential program	62	100.0 ⁱ	0.0	58	97.9 ^j	1.6
Current insurance status					**	
Private	549	96.4	1.2	546	84.0	2.1
Public ^k	4,799	96.8	0.6	4,777	86.1	1.4
Other	130	98.4	1.1	130	76.0	7.6
None	318	94.4	1.9	318	61.9 ^l	5.1

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for all significance tests. Asterisks indicate statistical significance (** $p < .01$, *** $p < .001$). Asterisks in a column apply to the subsequent results for the covariate.

^a Children 0 to 2 years old were significantly less likely to be up-to-date with immunizations than children 3 to 5 years old ($p < .01$), 6 to 10 years old ($p < .001$), and 11 to 17 years old ($p < .001$).

^b Children 0 to 2 years old were significantly more likely to have had a well-child checkup in the past 12 months than children 3 to 5 years old ($p < .05$), 6 to 10 years old ($p < .001$), and 11 to 17 years old ($p < .001$).

- ^c Children 3 to 5 years old were significantly more likely to have had a well-child checkup in the past 12 months than children 6 to 10 years old ($p < .05$) and those 11 to 17 years old ($p < .001$).
- ^d Black children were significantly more likely to have had a well-child check up in the past 12 months than Hispanic children ($p < .001$) and children of other races ($p < .05$).
- ^e White children were significantly more likely to have had a well-child check up in the past 12 months than Hispanic children ($p < .05$).
- ^f Children living in formal kin care were significantly more likely to be up-to-date with immunizations than children living in-home ($p < .01$) or foster care ($p < .01$).
- ^g Children living in formal kin care were significantly more likely to have had a well-child checkup in the past 12 months than children living in-home ($p < .05$) and in informal kin care ($p < .05$).
- ^h Children living in foster care were significantly more likely to have had a well-child checkup in the past 12 months than children living in-home ($p < .001$) and in informal kin care ($p < .05$).
- ⁱ Children living in a group home or residential program were significantly more likely to be up-to-date with immunizations than children living in-home ($p < .01$), formal kinship care ($p < .01$), or foster care ($p < .01$).
- ^j Children living in a group home or residential program were significantly more likely to have had a well-child checkup in the past 12 months than children living in-home ($p < .001$), formal kin care ($p < .05$), informal kin care ($p < .01$), and foster care ($p < .05$).
- ^k “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).
- ^l Uninsured children were significantly less likely to have had a well-child checkup in the past 12 months than children with private ($p < .001$) or public insurance ($p < .0001$).

Exhibit IV-6. Delayed Child Medical Care Due to Cost by Caregiver Report

	<i>N</i>	Type of medical care delayed due to cost ^a									
		Delayed medical care due to cost		Prescription medication		Mental health care or counseling		Dental care		Eyeglasses	
		%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>
Total	5,840	12.8	1.0	5.2	0.6	3.4	0.5	6.5	0.8	3.2	0.5
Gender											
Male	3,000	11.8	1.4	5.9	0.9	3.4	0.6	6.0	1.1	2.8	0.7
Female	2,840	13.7	1.4	4.4	0.6	3.3	0.9	7.1	0.9	3.7	0.9
Age (years)		***									
0–2	2,937	6.5	1.1	5.8	1.1	0.6	0.4	1.2	0.5	0.6	0.4
3–5	829	8.3	1.4	3.8	1.0	2.1	0.7	4.4	1.1	1.2	0.8
6–10	1,052	17.4 ^b	2.5	6.1	1.0	4.5	1.1	8.5	1.4	5.2	1.5
11–17	1,022	16.3 ^c	1.6	4.9	1.1	5.3	1.1	10.2	1.3	4.8	0.9
Race/ethnicity											
Black	1,820	13.4	1.8	6.2	1.2	3.4	0.8	6.6	1.3	2.2	0.7
White	1,997	10.8	1.2	4.0	0.7	3.1	0.5	6.5	1.1	3.2	0.8
Hispanic	1,603	14.1	2.1	5.8	1.1	3.1	0.8	5.6	1.1	3.4	1.1
Other	401	16.9	4.0	6.5	2.2	6.4	3.0	10.2	3.2	6.2	2.2
Setting		***									
In-home	3,619	13.5 ^d	1.1	5.6	0.6	3.7	0.6	7.2	0.8	3.2	0.5
Formal kin care	495	5.0 ^e	2.0	2.7	1.8	1.3	0.6	1.4	0.7	1.0	0.8
Informal kin care	536	12.1 ^f	4.1	3.4	1.7	1.5	1.0	3.5	1.6	6.3	4.4
Foster care	1,101	2.9 ^g	0.8	0.7	0.3	0.8	0.4	0.8	0.3	0.7	0.5
Group home or residential program	62	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Current insurance status		***									
Private	549	16.4 ^h	2.5	4.2	1.2	5.4	1.6	8.2	1.9	3.3	1.0
Public ⁱ	4,834	8.8	0.9	4.3	0.5	2.1	0.4	3.5	0.5	2.0	0.4
Other	130	18.4	5.0	5.4	3.5	9.3	5.2	4.9	2.8	3.6	1.7
None	324	34.5 ^j	4.3	13.3	3.1	7.9	2.6	27.6	4.4	11.7	3.7

Note: All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *Ns* vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for all significance tests. Asterisks indicate statistical significance (***) $p < .001$ and apply to the subsequent results for the covariate. Significance testing was performed only for the variable “delayed medical care due to cost.”

^a Estimates of the “type of medical care delayed due to cost” are for all sampled children.

^b Children 6 to 10 years old were significantly more likely to have delayed medical care due to cost than children 0 to 2 years old ($p < .001$) and 3 to 5 years old ($p < .01$).

^c Children 11 to 17 years old were significantly more likely to have delayed medical care due to cost than children 0 to 2 years old ($p < .001$) and 3 to 5 years old ($p < .01$).

^d Children living in-home with parents were significantly more likely to have delayed medical care due to cost than children living in formal kin care ($p < .01$), foster care ($p < .001$), and in a group home or residential program ($p < .001$).

^e Children living in formal kin care were significantly more likely to have delayed medical care due to cost than children living in a group home or residential program ($p < .05$).

^f Children living in informal kin care were significantly more likely to have delayed medical care due to cost than children living in foster care ($p < .05$), group home, or residential program ($p < .01$).

^g Children living in foster care were significantly more likely to have delayed medical care due to cost than children living in a group home or residential program ($p > .01$).

^h Children with private insurance were significantly more likely to have delayed medical care due to cost than children with public insurance ($p < .01$).

ⁱ “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

^j Uninsured children were significantly more likely to have delayed medical care due to cost than children with private ($p < .001$), public ($p < .001$), or other insurance ($p < .05$).

Exhibit IV-7. Dental Care for Children 2 to 17 Years Old by Caregiver Report

	Dental care in the past year ^a			Dental care since start of living arrangement ^b : children living with caregivers < 6 months			Dental care since start of living arrangement ^b : children living with caregivers 6 to < 12 months		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	2,304	67.3	1.7	730	53.2	3.6	181	73.5	5.9
Gender									
Male	1,165	64.6	2.4	370	55.4	6.2	105	81.7	6.3
Female	1,139	70.0	2.0	360	50.9	5.8	76	57.1	10.2
Age (years)		***							
2–5	813	52.3	2.7	272	56.4	5.7	63	63.2	12.9
6–10	764	74.7 ^c	2.6	221	57.6	8.7	66	75.9	7.8
11–17	726	75.3 ^d	2.5	236	45.7	5.0	52	87.6	5.4
Race/ethnicity									
Black	590	65.7	3.5	251	49.2	6.5	60	57.3	11.1
White	958	67.9	2.5	240	53.7	7.4	54	72.1	12.4
Hispanic	575	69.2	3.2	186	56.0	7.4	53	83.7	5.7
Other	178	61.4	7.7	52	61.8	9.3	13	81.0	15.1
Setting									
In-home	2,085	67.8	1.7	95	46.2	10.7	40	67.8	9.3
Formal kin care	63	71.4	7.7	133	64.1	7.4	46	70.8	16.7
Informal kin care	109	54.3	9.5	116	46.2	8.1	35	75.5	11.7
Foster care	42	94.4	3.1	329	56.6	7.5	51	83.0	5.8
Group home or residential program	—	—	—	48	81.5	8.5	—	—	—
Current insurance status		***							
Private	373	77.6 ^e	3.3	36	24.4	10.7	—	—	—
Public ^f	1,670	68.8 ^g	2.0	662	54.2	4.0	155	69.8	6.6
Other	69	73.6 ^h	8.9	—	—	—	—	—	—
None	191	38.1	5.8	23	69.0	17.5	10	74.3	15.6

Note: All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *Ns* vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for significance tests. Asterisks indicate statistical significance (***) $p < .001$ and apply to the subsequent results for the covariate. Estimates are not provided for subpopulations where there were fewer than 10 cases.

^a Caregivers were asked about a child receiving dental care in the past year *only if* they had lived with the child consistently for the past 12 months.

^b Caregivers were asked about a child receiving dental care since the start of the living arrangement if they had not lived with the child consistently for the past 12 months.

^c Children 6 to 10 years old were significantly more likely to have received dental care in the past 12 months than children 2 to 5 years old ($p < .001$).

^d Children 11 to 17 years old were significantly more likely to have received dental care in the past 12 months than children 2 to 5 years old ($p < .001$).

^e Children with private insurance were significantly more likely to have received dental care in the past 12 months than children with public insurance ($p < .05$) and children who currently had no insurance coverage ($p < .001$).

^f “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

^g Children with public insurance were significantly more likely to have received dental care in the past 12 months than children who currently had no insurance coverage ($p < .001$).

^h Children with other insurance were significantly more likely to have received dental care in the past 12 months than children who currently had no insurance coverage ($p < .01$).

Exhibit IV-8. Children’s Urgent Medical Care in the Past Year (or Since Birth) by Caregiver Report

	ER or urgent care for illness or injury			Overnight hospital admission for illness or injury			Had an injury, accident, or poisoning that needed care from a doctor or nurse		
	<i>N</i>	%	<i>SE</i>		%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	3,389	33.1	1.5	3,391	6.2	0.7	3,394	9.7	0.9
Gender									
Male	1,730	35.6	1.9	1,732	7.0	0.8	1,735	10.0	1.4
Female	1,659	30.6	2.2	1,659	5.3	1.0	1,659	9.3	1.1
Age (years)		***			***				
0–2	1,290	45.9 ^a	3.7	1,289	12.0 ^b	1.8	1,292	8.6	2.0
3–5	605	34.2	3.4	606	3.2	0.9	606	10.7	1.8
6–10	765	29.6	2.2	765	6.6	1.7	765	9.1	1.8
11–17	729	27.5	2.7	731	4.3	0.8	731	10.1	1.8
Race/ethnicity		*							
Black	939	34.3	2.4	938	7.7	1.5	940	11.0	1.9
White	1,269	35.1	2.3	1,271	5.6	0.8	1,271	10.8	1.0
Hispanic	937	26.2 ^c	3.1	937	6.0	1.1	938	7.4	1.9
Other	239	44.1	6.1	240	5.6	2.0	240	8.3	2.9
Setting								*	
In-home	3,100	33.5	1.5	3,103	6.0	0.6	3,104	9.6 ^d	0.9
Formal kin care	80	14.3	5.7	80	4.6	2.9	80	3.4	2.1
Informal kin care	146	27.3	5.6	146	8.7	7.4	146	13.5	5.2
Foster care	52	51.8	13.4	51	15.6	9.8	53	1.2	1.3
Current insurance status									
Private	454	32.1	4.5	454	5.2	1.6	454	10.8	2.4
Public ^e	2,597	35.1	2.0	2,598	6.1	0.7	2,601	9.9	1.2
Other	89	31.5	7.9	89	3.6	2.0	89	14.9	6.3
None	248	21.0	4.4	249	9.4	3.8	249	4.5	1.7

Note: All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *Ns* vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for initial significance tests. No significant differences in use of urgent services were found by type of maltreatment at baseline or by number of types of maltreatment. Asterisks indicate statistical significance (* $p < .05$, *** $p < .001$). Asterisks in column apply to the subsequent results for the covariate. ER = emergency room. Estimates specific to children currently living a group home or residential treatment program were not included in this exhibit since there were less than 10 cases asked about urgent medical service use in the past 12 months. Caregivers were asked about use of child urgent medical care in the past year *only if* they had lived with the child consistently for the past 12 months.

This exhibit includes cases where children were less than 12 months old (both those living in-home and out of home); these caregivers were asked about urgent medical care use *since the child's birth*.

^a Children who were 0 to 2 years old were significantly more likely to have used the ER or urgent care for an illness or injury in the past 12 months than children who were 3 to 5 ($p < .01$), 6 to 10 years old ($p < .001$), and 11 to 17 years old ($p < .001$).

^b Children 0 to 2 years old were significantly more likely to have been admitted to a hospital overnight for an injury or illness in the past 12 months than children 3 to 5 years old ($p < .001$), 6 to 10 years old ($p < .05$), and 11 to 17 years old ($p < .001$).

^c Hispanic children were significantly less likely to have used the ER or urgent care for an illness or injury in the past 12 months than Black ($p < .05$), White ($p < .05$), and children of "Other" race/ethnicity ($p < .05$).

^d Children living in-home with parents were significantly more likely to have had an injury/accident or poisoning that needed care from a doctor or nurse in the past 12 months than children living in formal kin care ($p < .05$) and children living in foster care ($p < .01$).

^e "Public" includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children's Health Insurance Plan (SCHIP).

Exhibit IV-9. Children’s Urgent Medical Care Since Start of Living Arrangement by Caregiver Report

	ER or urgent care for illness or injury since start of living arrangement						Overnight hospital admission for illness or injury since start of living arrangement						Had an injury, accident or poisoning that needed care from a doctor or nurse since start of living arrangement					
	Children living with caregivers < 6 months			Children living with caregivers 6 to < 12 months			Children living with caregivers < 6 months			Children living with caregivers 6 to < 12 months			Children living with caregivers < 6 months			Children living with caregivers 6 to < 12 months		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE
Total	1,956	17.6	2.3	480	36.7	5.5	1,950	3.7	1.2	481	7.3	2.4	1,959	4.4	1.6	480	5.8	2.0
Gender											*							
Male	993	15.0	2.7	263	36.6	8.4	990	4.7	2.3	264	2.3	0.7	995	2.9	1.0	263	2.7	1.0
Female	963	20.4	3.7	217	36.9	6.0	960	2.5	0.9	217	15.0	5.8	964	6.0	3.1	217	10.4	5.1
Age (years)		**						**			*							
0–2	1,319	20.2	2.4	321	44.1	7.5	1,316	5.0 ^b	1.0	323	13.9 ^c	4.6	1,320	1.0	0.6	321	5.0	2.9
3–5	179	21.7	7.0	41	39.6	19.0	178	0.3	0.3	41	0.0	0.0	180	11.5	6.2	41	0.1	0.1
6–10	221	4.8 ^a	1.8	66	21.6	7.3	221	2.2	2.0	65	0.2	0.2	221	0.5	0.4	66	2.1	1.2
11–17	237	20.9	4.2	52	41.5	14.1	235	6.1	3.8	52	15.1	9.2	238	5.5	2.2	52	21.2	9.2
Race/ethnicity		*			**													
Black	700	26.0 ^d	4.7	174	17.9	6.9	694	5.6	3.6	173	6.6	4.8	702	9.6	4.1	174	1.5	0.7
White	591	13.8	2.5	134	37.3	7.6	591	1.8	0.4	135	5.5	3.4	591	2.7	1.6	134	4.7	3.4
Hispanic	523	11.5	2.6	139	40.1	10.9	523	4.6	2.3	140	7.1	3.9	524	0.8	0.4	139	7.0	4.0
Other	130	26.3	7.2	31	86.2 ^e	6.7	130	3.6	2.4	31	21.6	17.0	130	2.4	1.8	31	20.5	17.1
Setting		*												*				
In-home	336	24.1 ^f	5.6	175	37.4	6.4	337	7.0	3.4	176	7.6	3.0	337	9.8 ^g	4.4	175	6.1	3.0
Formal kin care	328	15.3	2.9	86	61.1	15.5	328	2.9	1.3	85	0.3	0.3	329	2.5	1.0	86	2.2	1.6
Informal kin care	313	15.6	4.3	77	25.9	11.4	313	1.2	0.6	77	2.6	2.1	313	1.9	1.8	77	2.4	2.2
Foster care	914	11.6	1.5	130	23.9	4.7	908	2.3	0.6	131	15.6	10.0	915	0.6	0.3	130	6.2	2.9
Group home or residential program	52	24.5	8.8	—	—	—	51	2.9	1.6	—	—	—	52	7.3	4.4	—	—	—
Current insurance status																		
Private	73	13.5	6.3	22	22.6	13.0	73	1.1	1.2	22	16.1	12.0	73	7.0	5.1	22	14.7	11.9
Public ^h	1,802	17.4	2.1	422	34.0	4.6	1,797	4.4	1.4	422	7.9	3.0	1,805	2.2	0.7	422	6.1	2.7
Other	27	11.4	4.3	14	72.4	4.6	27	3.8	1.8	14	0.0	0.0	27	0.0	0.0	14	0.0	0.0
None	53	23.6	14.0	22	34.8	19.7	52	0.0	0.0	22	1.7	1.4	53	20.4	13.6	22	0.1	0.1

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for initial significance tests. No significant differences in use of urgent services were found by type of maltreatment at baseline or by number of types of maltreatment. Asterisks indicate statistical significance (* $p < .05$, ** $p < .01$). Asterisks in column apply to the subsequent results for the covariate. ER = emergency room. Estimates are not provided for subpopulations where there were fewer than 10 cases.

Caregivers were asked about use of urgent medical care since start of living arrangement if they had not lived with the child consistently for the past 12 months.

^a Children 6 to 10 years old were significantly less likely to have used the ER or urgent care for an illness or injury since the start of their living arrangement (< 6 months) than children 0 to 2 years old ($p < .001$), 3 to 5 years old ($p < .05$), and 11 to 15 years old ($p < .01$).

^b Children 0 to 2 years old were significantly more likely to have been admitted to a hospital overnight for an illness or injury since the start of their living arrangement (< 6 months) than children 3 to 5 years old ($p < .001$).

^c Children 0 to 2 years old were significantly more likely to have been admitted to a hospital overnight for an illness or injury since the start of their living arrangement (6 to < 12 months) than children 3 to 5 years old ($p < .001$) and 6 to 10 years old ($p < .01$).

^d Black children were significantly more likely to have used the ER or urgent care for an illness or injury since the start of their living arrangement (<6 months) than White ($p < .05$) and Hispanic children ($p < .05$).

^e Children of “Other” race/ethnicity were significantly more likely to have used the ER or urgent care for an illness or injury since the start of their living arrangement (6 to <12 months) than Black ($p < .01$), White ($p < .05$), and Hispanic children ($p < .05$).

^f Children living with in-home biological or adoptive parents for less than 6 months were significantly more likely have used the ER or urgent care for an illness or injury since the start of their living arrangement than children living in foster care ($p < .05$).

^g Children living in-home with parents for less than 6 months were significantly more likely to have had an injury, accident, or poisoning that required care from a doctor or nurse since the start of their living arrangement than children living in foster care ($p < .05$).

^h “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

Exhibit IV-10. Risk of a Behavioral/Emotional Problem Among Children 1.5 to 17 Years Old

	<i>N</i>	Risk of a behavioral/emotional problem ^a	
		%	<i>SE</i>
Total	3,451	41.4	1.8
Gender			
Male	1,772	43.0	2.4
Female	1,679	39.7	2.1
Age (years)		***	
1.5–5	1,352	20.5 ^b	1.9
6–10	1,049	49.5 ^c	2.4
11–17	1,050	57.2	3.3
Race/ethnicity			
Black	980	38.6	2.5
White	1,317	43.4	2.5
Hispanic	891	40.6	3.4
Other	257	43.5	6.0
Setting			
In-home	2,359	40.9	2.0
Formal kin care	257	35.6	7.8
Informal kin care	286	46.6	5.4
Foster care	467	42.7	4.0
Group home or residential program	64	61.2	12.0
Insurance status			
Private	435	44.3	3.9
Public ^d	2,670	40.5	2.2
Other	87	51.6	10.3
Uninsured	229	40.1	4.5

Note: All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *Ns* vary slightly across analyses because of missing data in some variable categories.

^a Risk of a behavioral/emotional problem was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL; administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report Form (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

^b Children 1.5 to 5 years old were significantly less likely to be identified as at risk for a behavioral/emotional problem than children 6 to 10 years old ($p < .001$) and children 11 to 17 years old ($p < .001$).

^c Children 6 to 10 years old were significantly less likely to be identified as at risk for a behavioral/emotional problem than children 11 to 17 years old ($p < .05$).

^d “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

Exhibit IV-11. Risk of a Behavioral/Emotional Problem and Substance Abuse Problem Among Children 11 to 17 Years Old

	Risk of a behavioral/emotional problem ^a			Risk of a substance abuse problem ^b			Risk of a behavioral/emotional or substance abuse problem		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	1,050	57.2	3.3	1,009	19.3	2.3	1,050	60.9	3.3
Gender									
Male	470	56.2	4.2	443	17.8	3.6	470	62.1	4.5
Female	580	57.9	3.9	566	20.3	2.8	580	60.1	3.7
Age (years)					***				
11–12	324	58.1	4.8	310	5.3 ^c	2.2	324	59.3	4.7
13–14	330	57.9	4.9	317	19.3 ^d	3.7	330	59.6	4.9
15–17	396	55.7	5.7	382	32.5	5.1	396	63.6	5.6
Race/ethnicity									
Black	285	53.6	3.9	270	18.7	4.5	285	56.2	4.1
White	400	55.8	4.7	388	17.6	2.9	400	58.8	4.6
Hispanic	253	59.3	6.9	242	20.6	4.3	253	64.6	6.7
Other	109	68.7	5.8	107	25.3	8.4	109	72.8	5.6
Setting		*						*	
In-home	709	56.6	3.4	685	17.2	2.0	709	59.6	3.4
Formal kin care	67	36.4 ^e	9.9	66	16.4	8.9	67	46.6	11.5
Informal kin care	79	70.6	7.1	73	39.7	11.8	79	78.1 ^f	6.4
Foster care	130	43.9 ^g	7.3	126	28.5	6.9	130	53.5	8.0
Group home or residential program	56	68.8	9.5	51	21.9	5.6	56	73.9	9.4
Insurance status									
Private	169	59.3	7.7	165	22.8	4.8	169	63.0	7.7
Public ^h	742	59.2	3.8	714	17.0	2.6	742	61.6	3.8
Other	28	59.3	10.4	27	16.6	12.8	28	59.3	10.4
Uninsured	82	45.7	9.4	79	25.6	7.7	82	57.7	9.7

Note: All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *Ns* vary slightly across analyses because of missing data in some variable categories.

^a Risk of a behavioral/emotional problem was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL), Youth Self Report (YSR), or the Teacher Report Form (TRF); the Child Depression Inventory (CDI); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist.

- ^b Risk of a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight et al., 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment.
- ^c Children 11 to 12 years old were significantly less likely to be at risk of a substance abuse problem than children 13 to 14 years old ($p < .01$) and 15 to 17 years old ($p < .001$).
- ^d Children 13 to 14 years old were significantly less likely to be at risk of a substance abuse problem than children 15 to 17 years old ($p < .05$).
- ^e Children living in formal kin care were significantly less likely to be at risk of a behavioral/emotional problem than children living in informal kin care ($p < .05$) and children living in a group home or residential treatment program ($p < .05$).
- ^f Children living in informal kin care were significantly more likely to be at risk for a behavioral/emotional or substance abuse problem than children living in-home ($p < .01$), children living in formal kin care ($p < .05$) or children living in foster care ($p < .05$).
- ^g Children living in foster care were significantly less likely to be at risk of a behavioral/emotional problem than children living in informal kin care ($p < .05$) and children living in a group home or residential treatment program ($p < .05$).
- ^h "Public" includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children's Health Insurance Plan (SCHIP).

Exhibit IV-12. Specialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report

	Outpatient services ^a in the past year ^b			Outpatient services since start of living arrangement ^c : children living with caregivers less than 6 months			Outpatient services since start of living arrangement ^c : children living with caregivers 6 to less than 12 months			Inpatient services ^c in the past year			Inpatient services since start of living arrangement ^d : children living with caregivers less than 6 months			Inpatient services since start of living arrangement ^d : children living with caregivers 6 to less than 12 months		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE
	Total	2,435	18.0	1.6	793	28.2	3.0	194	35.0	7.5	2,438	2.6	0.4	792	3.9	1.3	194	9.2
Gender		*																
Male	1,245	20.3	2.1	401	30.4	5.6	111	38.3	10.5	1,247	2.2	0.5	399	5.7	2.7	111	8.2	3.9
Female	1,190	15.8	1.7	392	26.0	3.7	83	28.5	8.0	1,191	3.1	0.7	393	2.2	0.7	83	11.2	7.0
Age (years)		***			***			**			***			*			*	
1.5–5	940	7.2 ^e	1.8	335	11.2 ^f	2.8	76	22.9 ^g	16.8	941	0.0 ^h	0.0	334	0.0 ⁱ	0.0	76	0.0 ^j	0.0
6–10	765	22.2	2.6	221	33.6	7.5	66	28.8 ^g	8.9	765	2.2 ^k	0.6	220	1.6 ^l	0.7	66	1.0 ^j	1.0
11–17	730	26.2	2.4	237	47.4	5.8	52	67.1	8.9	732	6.0	1.1	238	11.3	3.4	52	39.2	10.5
Race/ethnicity		***																
Black	633	12.2	2.2	274	26.3	5.8	65	31.2	9.8	635	1.1	0.5	273	10.2	4.7	65	10.2	7.6
White	995	25.4 ^m	1.9	261	28.0	4.9	56	29.2	11.5	995	3.1	0.7	261	1.1	0.5	56	0.8	0.9
Hispanic	619	11.4	2.5	203	29.0	6.2	59	40.2	14.3	619	3.2	0.8	203	0.7	0.5	59	8.7	4.9
Other	185	19.3	4.7	54	36.9	8.8	13	49.5	21.1	186	2.5	1.4	54	4.4	3.2	13	53.4	20.8
Setting											**			**				
In-home	2,202	17.6	1.6	102	14.3	5.0	43	18.4	6.1	2,204	2.7 ⁿ	0.5	102	6.6	4.6	43	13.8	7.1
Formal kin care	64	35.0	8.5	144	25.9	8.2	49	56.8	21.2	64	1.8	1.4	144	0.0	0.0	49	0.0	0.0
Informal kin care	115	21.0	5.9	131	24.8	6.3	37	25.6	11.2	115	0.5	0.4	131	0.0	0.0	37	1.1	1.2
Foster care	46	43.1	14.6	358	39.7	5.6	56	42.9	10.7	47	6.9	5.7	357	1.2 ^o	0.6	56	5.1	3.2
Group home or residential program	—	—	—	49	71.8 ^p	9.6	—	—	—	—	—	—	49	29.4 ^p	9.7	—	—	—
Insurance					**													
Private	387	22.7	3.8	39	11.8	6.5	—	—	—	387	3.4	1.2	39	5.8	5.5	—	—	—
Public ^q	1,779	17.7	2.0	721	33.4 ^r	3.4	168	32.2	6.1	1,782	2.7	0.6	720	4.2	1.6	168	10.1	4.0
Other	72	22.0	7.9	—	—	—	—	—	—	72	2.2	1.3	—	—	—	—	—	—
None	196	11.1	3.2	24	1.9	1.5	10	25.4	20.6	196	1.2	0.8	24	0.0	0.0	10	21.9	20.3
Risk of a behavioral/emotional problem (1.5- to 10-year-olds only)^s		***			**			*			***			*				
Yes	575	28.8	2.9	230	32.4	6.9	56	51.6	14.1	576	3.0	0.8	228	1.7	0.7	56	1.0	1.1
No	1,125	6.9	1.6	326	12.6	3.6	86	3.1	1.3	1,125	0.0	0.0	326	0.0	0.0	86	0.0	0.0

(continued)

Exhibit IV-12. Specialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report (continued)

	Outpatient services ^a in the past year ^b			Outpatient services since start of living arrangement ^c : children living with caregivers less than 6 months			Outpatient services since start of living arrangement ^c : children living with caregivers 6 to less than 12 months			Inpatient services ^c in the past year			Inpatient services since start of living arrangement ^d : children living with caregivers less than 6 months			Inpatient services since start of living arrangement ^d : children living with caregivers 6 to less than 12 months		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE
Risk of a behavioral/emotional problem or substance use problem (11- to 17-year-olds only)^f																		
Yes	452	36.8	3.5	146	55.9	7.3	32	68.8	10.4	454	9.0	1.7	146	15.2	5.2	32	46.3	12.1
No	278	9.6	2.5	91	34.5	9.9	20	58.4	13.0	278	1.2	0.8	92	5.2	3.8	20	1.5	1.5

Note: Behavioral health services were reported by caregivers and measured with an adapted version of the Child and Adolescent Services Assessment (Burns, Angold, Magruder-Habib, Costello, & Patrick, 1994). All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Pearson χ^2 tests for cluster samples were used for initial significance tests. Asterisks indicate statistical significance (* $p < .05$, ** $p < .01$, *** $p < .001$). Asterisks in a column apply to the subsequent results for the covariate. Estimates are not presented for subpopulations with fewer than 10 cases.

- ^a Specialty outpatient includes use of services from an outpatient drug or alcohol clinic, mental health or community health center, private mental health professional, or in-home counseling or crisis services. This also includes day treatment for emotional and substance abuse problems or use of a therapeutic nursery.
- ^b All caregivers were asked about child behavioral health service use. Caregivers were asked about use of behavioral health services *in the past year* if they had lived with the child consistently for the past 12 months.
- ^c Inpatient services includes use of psychiatric hospital or psychiatric unit within a medical hospital, services through a detox unit or inpatient unit, hospital medical inpatient unit, residential treatment center or group home, or hospital emergency room for emotional and substance abuse problems.
- ^d All caregivers were asked about child behavioral health service use. Caregivers were asked about use of behavioral health services *since start of living arrangement* if they had not lived with the child consistently for the past 12 months.
- ^e Children 1.5 to 5 years old were significantly less likely to have received outpatient behavioral services in the past 12 months than children 6 to 10 years old ($p < .001$) and 11 to 17 years old ($p < .001$).
- ^f Children 1.5 to 5 years old living with their caregiver for less than 6 months were significantly less likely to have received outpatient behavioral health services since the start of this living arrangement than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .001$).
- ^g Children 1.5 to 5 years old ($p < .01$) and 6 to 10 years old ($p < .01$) living with their caregiver for 6 to less than 12 months were significantly less likely to have received outpatient behavioral health services since the start of this living arrangement than children 11 to 17 years old ($p < .01$).
- ^h Children 1.5 to 5 years old were significantly less likely to have received inpatient behavioral services in the past 12 months than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .001$).
- ⁱ Children 1.5 to 5 years old living with their caregiver for less than 6 months were significantly less likely to have received inpatient behavioral health services since the start of this living arrangement than children 6 to 10 years old ($p < .05$) and 11 to 17 years old ($p < .01$).

- ^j Children 1.5 to 5 years old ($p < .01$) and 6 to 10 years old ($p < .01$) living with their caregiver for 6 to less than 12 months were significantly less likely to have used inpatient behavioral health services since the start of this living arrangement than children 11 to 17 years old.
- ^k Children 6 to 10 years old were significantly less likely to have received inpatient behavioral health services in the past 12 months than children 11 to 17 years old ($p < .01$).
- ^l Children 6 to 10 years old living with their caregivers for less than 6 months were significantly less likely to have received inpatient behavioral health services since the start of this living arrangement than children 11 to 17 years old ($p < .05$).
- ^m White children were significantly more likely to have received outpatient behavioral health services in the past 12 months than Black and Hispanic children ($p < .001$).
- ⁿ Children living in-home with parents were significantly more likely to have received inpatient behavioral health services in the past 12 months than children living in informal kin care ($p < .01$).
- ^o Children living in foster care for less than 6 months were significantly more likely to have used inpatient behavioral health services since the start of this living arrangement than children living in formal kin care ($p < .05$).
- ^p Children living in a group home or residential treatment program for less than 6 months were significantly more likely to have used inpatient behavioral health services since the start of this living arrangement than children living in-home with their biological or adoptive parents ($p < .05$), informal kin ($p < .01$), formal kin ($p < .01$), or foster care ($p < .01$).
- ^q “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).
- ^r Children with public ($p < .01$) insurance living with their caregiver for less than 6 months were significantly more likely to have used specialty outpatient behavioral health services since the start of this living arrangement than uninsured children.
- ^s Risk of a behavioral/emotional problem for children 1.5 to 10 years was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report Form (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).
- ^t Risk of a behavioral/emotional problem or substance abuse problem for children 11 to 17 years old was defined as either meeting criteria for a behavioral/emotional problem (identical to the definition for children 1.5 to 10 years old) or a substance abuse problem. Risk for a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (Care, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight et al., 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment. The CRAFFT was only administered to children 11 to 17 years old.

Exhibit IV-13. Nonspecialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report

	Family doctor ^a in the past year ^b			Family doctor since start of living arrangement ^c : children living with caregivers less than 6 months			Family doctor since start of living arrangement ^c : children living with caregivers 6 to less than 12 months			School-based services ^d in the past year			School-based services since start of living arrangement: children living with caregivers less than 6 months			School-based services since start of living arrangement: children living with caregivers 6 to less than 12 months		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE
Total	2,438	9.2	1.3	793	9.2	3.7	194	12.6	4.2	2,426	14.0	1.1	787	12.7	2.0	192	16.1	4.2
Gender																		
Male	1,247	11.2	2.0	400	14.5	6.9	111	12.8	5.7	1,242	15.8	1.6	395	15.7	3.0	109	17.6	5.4
Female	1,191	7.2	1.2	393	4.1	0.9	83	12.1	7.0	1,184	12.3	1.4	392	9.7	3.5	83	13.2	7.1
Age (years)		**						*			***		**				*	
1.5–5	941	4.5 ^c	1.7	335	2.7	0.8	76	0.6 ^f	0.6	940	2.1 ^e	0.6	335	1.8 ^h	0.6	75	2.2 ⁱ	1.8
6–10	765	14.0	2.6	220	21.7	11.9	66	14.8	7.5	760	17.9	2.4	216	22.0	6.1	65	22.4	8.3
11–17	732	9.9	1.5	238	8.1	1.9	52	30.9	9.6	726	23.7	2.5	236	20.6	4.8	52	30.5	9.3
Race/ethnicity		*																
Black	635	7.3	2.0	274	6.5	1.7	65	2.3	1.7	634	13.0	2.2	273	11.8	3.1	64	22.9	11.6
White	995	13.2 ^j	2.1	261	14.2	7.8	56	11.9	7.3	989	15.1	1.8	258	12.7	3.4	55	11.5	7.5
Hispanic	619	5.0	1.8	203	3.2	0.9	59	11.5	6.9	615	12.7	2.2	201	13.2	7.0	59	11.9	5.7
Other	186	9.0	2.4	54	10.6	4.3	13	64.0	18.4	185	16.4	4.3	54	15.5	5.1	13	40.3	21.1
Setting																		
In-home	2,204	9.1	1.4	102	15.9	10.6	43	9.1	5.6	2,193	14.1	1.2	102	8.0	3.0	42	15.5	7.3
Formal kin care	64	7.8	4.7	144	3.6	1.5	49	0.0	0.0	63	16.7	7.2	144	8.7	3.0	49	3.9	1.3
Informal kin care	115	9.9	4.7	131	3.1	1.4	37	21.1	11.2	115	11.6	2.6	130	15.0	6.6	37	19.8	10.3
Foster care	47	14.6	6.9	358	8.0	1.7	56	14.9	6.7	47	17.0	8.5	354	16.1	3.3	55	20.7	7.1
Group home or residential program	—	—	—	49	15.0	7.5	—	—	—	—	—	—	48	24.8	10.7	—	—	—
Insurance																		
Private	387	8.2	1.8	39	3.3	2.1	—	—	—	385	15.7	2.7	39	21.0	9.7	—	—	—
Public ^k	1,782	9.9	1.8	721	6.4	1.0	168	16.9	5.8	1,773	13.4	1.2	716	12.0	1.8	166	16.5	4.8
Other	72	15.5	6.9	—	—	—	—	—	—	72	24.8	8.5	—	—	—	—	—	—
None	196	3.9	2.2	24	35.4	23.9	10	0.0	0.0	195	12.7	3.2	24	9.2	8.4	10	39.8	22.3
Risk of a behavioral/emotional problem (1.5- to 10-year-olds only)^l		***						*			***		**				*	
Yes	576	19.5	2.8	229	24.4	12.3	56	15.5	8.3	571	21.6	3.0	227	18.9	5.0	54	22.6	9.5
No	1,125	3.7	1.5	326	1.8	0.7	86	0.0	0.0	1,124	3.4	0.7	324	3.6	1.8	86	3.1	1.8

(continued)

Exhibit IV-13. Nonspecialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report (continued)

	Family doctor ^a in the past year ^b			Family doctor since start of living arrangement ^c : children living with caregivers less than 6 months			Family doctor since start of living arrangement ^c : children living with caregivers 6 to less than 12 months			School-based services ^d in the past year			School-based services since start of living arrangement: children living with caregivers less than 6 months			School-based services since start of living arrangement: children living with caregivers 6 to less than 12 months		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE	N	%	SE
Risk of a behavioral/emotional problem or substance use problem (11- to 17-year-olds only)^m		***			*					***								
Yes	454	14.7	2.4	146	11.5	3.3	32	32.3	11.4	449	31.6	3.8	144	22.9	6.6	32	31.3	10.8
No	278	2.4	1.0	92	2.9	1.8	20	23.2	13.2	277	11.4	2.4	92	17.1	6.6	20	26.6	13.0

Note: Behavioral health services were reported by caregivers and measured with an adapted version of the Child and Adolescent Services Assessment (Burns, Angold, Magruder-Habib, Costello, & Patrick, 1994). All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Pearson χ^2 tests for cluster samples were used for initial significance tests. Asterisks indicate statistical significance (* $p < .05$, ** $p < .01$, *** $p < .001$). Asterisks in a column apply to the subsequent results for the covariate. Estimates are not presented for subpopulations with fewer than 10 cases.

- ^a Includes child having seen a family doctor or other medical doctor for emotional, behavioral, learning attention, or substance abuse problems.
- ^b All caregivers were asked about child behavioral health service use. Caregivers were asked about use of behavioral health services *in the past year* if they had lived with the child consistently for the past 12 months.
- ^c Includes child having received services from a school guidance counselor, social worker, or psychologist for emotional, behavioral, learning, or substance abuse problems.
- ^d All caregivers were asked about child behavioral health service use. Caregivers were asked about use of behavioral health services *since start of living arrangement* if they had not lived with the child consistently for the past 12 months.
- ^e Children 1.5 to 5 years old were significantly less likely to have received behavioral health services from a family doctor in the past 12 months than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .05$).
- ^f Children 1.5 to 5 years old living with their caregiver for 6 to less than 12 months were significantly less likely to have received behavioral health services from a family doctor since the start of this living arrangement than children 11 to 17 years old ($p < .01$).
- ^g Children 1.5 to 5 years old were significantly less likely to have received school-based behavioral health services in the past 12 months than children 6 to 10 years old ($p < .001$) and 11 to 17 years old ($p < .001$).
- ^h Children 1.5 to 5 years old living with their caregiver for less than 6 months were significantly less likely to have received school-based services since the start of this living arrangement than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .001$).
- ⁱ Children 1.5 to 5 years old living with their caregiver for 6 to less than 12 months were significantly less likely to have received school-based services since the start of this living arrangement than children 6 to 10 years old ($p < .05$) and 11 to 17 years old ($p < .01$).
- ^j White children were significantly more likely to have received behavioral health services from a family doctor in the past 12 months than Black ($p < .05$) and Hispanic children ($p < .01$).

^k“Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

^lRisk of a behavioral/emotional problem for children 1.5 to 10 years old was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL: administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report Form (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

^mRisk of a behavioral/emotional problem or substance abuse problem for children 11 to 17 years old was defined as either meeting criteria for a behavioral/emotional problem (identical to the definition for children 1.5 to 10 years old) or a substance abuse problem. Risk for a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (Care, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight et al., 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment. The CRAFFT was only administered to children 11 to 17 years old.

Exhibit IV-14. Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report

	Any behavioral health service ^a in the past year ^b			Any behavioral health service since start of living arrangement ^c : children living with caregivers less than 6 months			Any behavioral health service since start of living arrangement ^c : children living with caregivers 6 to less than 12 months		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	2,438	26.9	1.6	794	37.0	3.7	194	44.5	7.0
Gender		**							
Male	1,247	30.4	2.2	401	43.1	7.4	111	52.2	9.3
Female	1,191	23.3	1.7	393	30.9	4.4	83	29.2	8.1
Age (years)		***			***			**	
1.5–5	941	9.5 ^d	1.9	335	12.6 ^e	2.9	76	25.1 ^f	16.3
6–10	765	33.2	2.8	221	56.5	8.8	66	44.9 ^f	10.1
11–17	732	40.1	2.6	238	54.8	5.3	52	79.7	7.0
Race/ethnicity		***							
Black	635	22.3	2.6	275	30.5	5.9	65	46.4	11.3
White	995	34.8 ^g	2.4	261	43.0	6.9	56	37.2	12.6
Hispanic	619	18.9	2.7	203	33.8	8.0	59	43.3	13.3
Other	186	26.8	5.7	54	37.9	9.0	13	84.8	8.0
Setting									
In-home	2,204	26.5	1.6	102	31.6	10.3	43	30.3	7.7
Formal kin care	64	37.1	8.5	144	28.8	8.2	49	58.1	20.6
Informal kin care	115	30.2	6.4	131	32.4	7.3	37	42.3	12.9
Foster care	47	46.1	16.0	359	42.6	5.6	56	47.1	10.6
Group home or residential program	—	—	—	49	82.8	8.0	—	—	—
Insurance									
Private	387	30.1	4.3	39	25.8	11.0	—	—	—
Public ^h	1,782	26.6	2.1	722	37.0	3.2	168	40.4	6.5
Other	72	38.2	8.1	—	—	—	—	—	—
None	196	19.8	3.6	24	44.6	21.9	10	61.7	22.2

(continued)

Exhibit IV-14. Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report (continued)

	Any behavioral health service ^a in the past year ^b			Any behavioral health service since start of living arrangement ^c : children living with caregivers less than 6 months			Any behavioral health service since start of living arrangement ^c : children living with caregivers 6 to less than 12 months		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Risk of a behavioral/ emotional problem (1.5- to 10-year-olds only)ⁱ		***			**			**	
Yes	576	42.5	3.5	230	53.5	9.3	56	67.6	11.2
No	1,125	9.6	1.7	326	15.6	3.5	86	5.3	1.9
Risk of a behavioral/ emotional problem or substance use problem (11- to-17-year-olds only)^j		***							
Yes	454	51.9	4.1	146	60.7	7.3	32	83.0	8.1
No	278	21.5	2.4	92	45.8	9.0	20	61.9	13.0

Note: Behavioral health services were reported by caregivers and measured with an adapted version of the Child and Adolescent Services Assessment (Burns et al., 1994). All analyses were on weighted NSCAW II baseline data; *Ns* are unweighted and, therefore, direct percentages cannot be calculated by hand. Pearson χ^2 tests for cluster samples were used for initial significance tests. Asterisks indicate statistical significance (* $p < .05$, ** $p < .01$, *** $p < .001$). Asterisks in a column apply to the subsequent results for the covariate. Estimates are not presented for subpopulations with fewer than 10 cases.

^a “Any behavioral health service” includes any use of specialty outpatient, inpatient, family doctor, or school-based services.

^b All caregivers were asked about child behavioral health service use. Caregivers were asked about use of behavioral health services *in the past year* if they had lived with the child consistently for the past 12 months.

^c Caregivers were asked about use of behavioral health services *since start of living arrangement* if they had not lived with the child consistently for the past 12 months.

^d Children 1.5 to 5 years old were significantly less likely to have used any behavioral health service in the past 12 months than children 6 to 10 years old ($p < .001$) and 11 to 17 years old ($p < .001$).

^e Children 1.5 to 5 years old living with their caregiver for less than 6 months were significantly less likely to have used any behavioral health service since the start of this living arrangement than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .001$).

^f Children 1.5 to 5 years old ($p < .01$) and 6 to 10 years old ($p < .01$) living with their caregiver for 6 to less than 12 months were significantly less likely to have used any behavioral health services since the start of this living arrangement than children 11 to 17 years old ($p < .01$).

^g White children were significantly more likely to have used any behavioral health service in the past 12 months than Black ($p < .001$) and Hispanic children ($p < .001$).

^h “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).

ⁱRisk of a behavioral/emotional problem for children 1.5 to 10 years old was defined as scores in the clinical range on any of the following standardized measures: Internalizing, Externalizing or Total Problems scales of the Child Behavior Checklist (CBCL; administered for children 1.5 to 18 years old), Youth Self Report (YSR; administered to children 11 years old and older), or the Teacher Report Form (TRF; administered for children 6 to 18 years old); the Child Depression Inventory (CDI; administered to children 7 years old and older); or the PTSD section Intrusive Experiences and Dissociation subscales of the Trauma Symptoms Checklist (administered to children 8 years old and older).

^jRisk of a behavioral/emotional problem or substance abuse problem for children 11 to 17 years old was defined as either meeting criteria for a behavioral/emotional problem (identical to the definition for children 1.5 to 10 years old) or a substance abuse problem. Risk for a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (Care, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight et al., 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment. The CRAFFT was only administered to children 11 to 17 years old.

Exhibit IV-15. Current Use of Psychotropic Medications Among Children 1.5 to 17 Years Old by Caregiver Report

	<i>N</i>	Current use of any psychotropic medication		Current use of two psychotropic medications		Current use of three or more psychotropic medications	
		%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>
Total	3,325	11.7	1.0	2.9	0.4	2.3	0.5
Gender		***		**			
Male	1,706	14.8	1.3	3.9	0.6	2.7	0.6
Female	1,619	8.5	1.2	1.8	0.5	2.0	0.6
Age (years)		***		***		***	
1.5–5	1,341	1.5 ^a	0.5	0.3 ^b	0.2	0.2 ^c	0.1
6–10	1,023	19.6	2.1	5.7	1.1	2.3	0.6
11–17	961	16.0	2.6	3.2	0.8	4.9	1.3
Race/ethnicity		***		**			
Black	949	10.4 ^d	1.9	2.0	0.8	1.3	0.7
White	1,270	17.1 ^e	1.6	4.4 ^f	0.8	3.4	1.0
Hispanic	860	5.8	1.0	1.3	0.4	1.5	0.5
Other	241	8.3	2.6	2.8	1.4	2.7	1.5
Setting		*					
In-home	2,313	10.9	1.0	2.7	0.4	2.3	0.6
Formal kin care	246	11.8	3.0	5.1	2.6	0.8	0.5
Informal kin care	270	19.5	4.6	2.2	1.1	0.9	0.4
Foster care	428	13.6	2.2	3.6	1.0	3.8	1.4
Group home or residential program	52	48.2 ^g	12.8	14.0	4.1	21.5	11.8
Insurance status		*		*		**	
Private	423	7.8	1.7	1.9	0.8	1.3	0.7
Public ^h	2,590	13.3 ⁱ	1.3	3.4 ^j	0.5	2.9 ^k	0.7
Other	85	14.0	6.8	2.6	1.8	2.2	1.8
None	225	6.2	3.1	0.7	0.7	0.1	0.1

Note: All analyses were on weighted NSCAW II baseline data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for initial significance tests. Asterisks indicate statistical significance (* $p < .05$, ** $p < .01$, *** $p < .001$). Asterisks in column apply to the subsequent results for the covariate. Psychotropic medication use is only reported for children 1.5 years and older.

- ^a Children 1.5 to 5 years old were significantly less likely to be currently using any psychotropic medication than children 6 to 10 years old ($p < .001$) and 11 to 17 years old ($p < .001$).
- ^b Children 1.5 to 5 years old were significantly less likely to be currently using two psychotropic medications than children 6 to 10 years old ($p < .001$) and 11 to 17 years old ($p < .001$).
- ^c Children 1.5 to 5 years old were significantly less likely to be currently using three or more psychotropic medications than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .01$).
- ^d Black children were significantly more likely to be currently using any psychotropic medication than Hispanic children ($p < .05$).
- ^e White children were significantly more likely to be currently using any psychotropic medication than Black ($p < .01$), Hispanic ($p < .001$), and children of “Other” race/ethnicity ($p < .01$).
- ^f White children were significantly more likely to be currently using two psychotropic medications than Hispanic children ($p < .001$).
- ^g Children living in a group home or residential treatment program were significantly more likely to be currently using psychotropic medication than children living in-home with their biological or adoptive parents ($p < .01$), formal kin care ($p < .01$), informal kin care ($p < .05$), and foster care ($p < .01$).
- ^h “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a State Children’s Health Insurance Plan (SCHIP).
- ⁱ Children with public insurance were significantly more likely to be using any psychotropic medication than children with private insurance ($p < .01$) and children with no current insurance ($p < .05$).
- ^j Children with public insurance were significantly more likely to be currently using two psychotropic medications than children with no current insurance ($p < .01$).
- ^k Children with public insurance were significantly more likely to be currently using three or more psychotropic medications than children with no current insurance ($p < .001$).

Exhibit IV-16. Young Children’s Developmental Need, Participation in Child Care, Head Start, and Early Intervention Services

	Developmental need			Any type of day care program ^a			Head Start ^b			IFSP/IEP ^c		
	N	%	SE	N	%	SE	N	%	SE	N	%	SE
Total	3,503	33.3	2.5	3,501	29.3	3.0	858	21.3	4.0	3,48990	6.5	1.0
Gender											*	
Male	1,833	38.1	4.0	1,831	29.2	3.2	454	17.2	3.9	1,828	8.3	1.5
Female	1,670	27.7	3.2	1,670	29.4	3.5	404	25.8	6.2	1,661	4.5	0.7
Age (months)		***			**			***				
0–5	839	4.7 ^d	1.1	838	18.0	10.4	122	0.03	0.04	836	11.1	2.6
6–11	1,005	5.9	1.6	1,005	12.6 ^g	3.2	178	2.5	1.1	1,004	5.7	1.3
12–17	567	24.5 ^e	7.3	567	22.3	5.2	144	4.9	3.5	564	4.3	1.0
18–23	196	46.2	9.3	195	25.6	5.9	59	1.6	1.5	193	9.5	3.5
24–29	171	39.7	7.0	171	24.9	7.2	41	1.6	1.3	170	9.3	3.2
30–35	158	49.7	7.3	158	29.0	6.5	48	1.9	1.4	158	7.1	2.2
36–41	136	45.3	6.8	136	26.2	5.8	41	30.9	15.4	135	2.4	1.9
42–47	154	44.2	7.3	154	33.7	7.4	79	41.8 ^h	11.0	153	10.1	5.1
48–53	134	21.5 ^f	6.3	134	55.7 ⁱ	9.8	73	31.7	9.6	134	3.8	2.1
54–59	1434	41.6	6.5	143	45.3	6.6	73	33.3	7.6	142	3.7	1.7
Race/ethnicity		*			*							
Black	1,180	27.0	4.3	1,177	41.1 ^k	4.7	355	21.7	4.7	1,175	5.4	0.9
White	1,097	31.3	3.3	1,097	23.5	3.5	255	18.3	5.9	1,090	7.3	1.4
Hispanic	1,012	43.9 ^j	4.2	1,013	26.0	7.5	206	17.5	8.5	1,011	7.3	2.1
Other	198	18.0	6.0	198	27.6	8.7	37	32.3	14.4	197	3.6	1.5
Setting											***	
In-home	1,994	33.2	2.7	1,995	28.2	2.8	437	22.8	4.3	1,988	4.6 ^l	0.7
Formal kin care	324	36.7	14.0	324	46.4	14.45	85	8.0	5.0	324	30.0	15.3
Informal kin care	357	30.7	6.7	356	35.8	6.9	111	15.3	5.9	354	14.3	5.0
Foster care	809	35.4	4.2	807	33.0	5.5	219	13.4	4.7	804	21.4 ⁱ	3.7
Developmental need^m											***	
Yes	—	—	—	841	32.4	4.5	239	28.6	7.8	835	13.1	2.5
No	—	—	—	2,659	27.8	2.9	619	16.9	3.7	2,653	3.3	0.5

Note: All analyses were on weighted data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Reported *N*s vary slightly across analyses because of missing data in some variable categories. Pearson χ^2 tests for cluster samples were used for significance tests. Asterisks indicate statistical

significance (* $p < .05$, ** $p < .01$, *** $p < .001$). An asterisk in a column applies to the subsequent results for the covariate. IFSP = Individualized Family Service Plan; IEP = Individualized Education Program. This table has been revised since its original posting on November 15, 2011. A problem was identified in the basal score calculation for a subset of children receiving the Battelle Developmental Inventory (BDI) or Kaufman Brief Intelligence Test (K-BIT). The current version includes the corrected scores and also reflects the removal of one case in the baseline cohort identified as ineligible during Wave 2 data collection.

^a Any type of day care program including a Head Start program, nursery school, early childhood development program, or any center-based program. Home-based baby-sitting or home day care is not included.

^b Column represents percentage in Head Start program among children 59 months old or less that participated in any type of day care program.

^c IFSP/IEP reported by caregiver or caseworker.

^d Children 0 to 5 months old and 6 to 11 months old were significantly less likely to have a developmental need than children 12 to 17 months old ($p < .05$), 18 to 23 months old ($p < .001$), 24 to 29 months old ($p < .001$), 30 to 35 months old ($p < .001$), 36 to 41 months old ($p < .001$), 42 to 47 months old ($p < .001$), 48 to 53 months old ($p < .05$), and 54 to 59 months old ($p < .001$).

^e Children 12 to 17 months old were significantly less likely to have a developmental need than children 30 to 35 months old ($p < .05$) and 36 to 41 months old ($p < .05$).

^f Children 48 to 53 months old were significantly less likely to have a developmental need than children 18 to 23 months old ($p < .05$), 30 to 35 months old ($p < .05$), 36 to 41 months old ($p < .05$), and 42 to 47 months old ($p < .05$).

^g Children 6 to 11 months old were significantly less likely to participate in any type of day care program than children 18 to 23 months old ($p < .05$), 30 to 35 months old ($p < .05$), 42 to 47 months old ($p < .01$), 48 to 53 months old ($p < .001$), and 54 to 59 months old ($p < .001$).

^h Children 42 to 47 months old, 48 to 53 months old, and 54 to 59 months old were significantly more likely to participate in Head Start than children 6 to 11 months old ($p < .01$, $p < .05$, $p < .01$), 12 to 17 months old ($p < .01$, $p < .05$, $p < .01$), 18 to 23 months old ($p < .01$, $p < .01$, $p < .001$), 24 to 29 months old ($p < .01$), and 30 to 35 months old ($p < .01$, $p < .01$, $p < .001$).

ⁱ Children 48 to 53 months old and 54 to 59 months old were significantly more likely to participate in any type of day care program than children 0 to 5 months old ($p < .05$), 12 to 17 months old ($p < .01$), 18 to 23 months old ($p < .05$), 24 to 29 months old ($p < .05$), 30 to 35 months old ($p < .05$), and 36 to 41 months old ($p < .01$, $p < .05$).

^j Hispanic children were significantly more likely to have a developmental need than Black children ($p < .05$), White children ($p < .05$) and children of "Other" race/ethnicity ($p < .05$).

^k Black children were significantly more likely to participate in any type of day care program than White children ($p < .01$).

^l In-home children were significantly less likely to have an IFSP or IEP than children living in foster care ($p < .001$).

^m Developmental need was defined based on young children having a diagnosed mental or medical condition that has a high probability of resulting in developmental delay (e.g., Down syndrome) and/or being 2 standard deviations below the mean in at least one developmental area or 1.5 standard deviations below the mean in two areas. Areas included cognitive development based on the Battelle Developmental Inventory (BDI) or Kaufman Brief Intelligence Test (K-BIT), communication development based on the Preschool Language Scale-3 (PLS-3), and adaptive development based on the Vineland Daily Living Skills.

Exhibit IV-17. Special Education Service Use and Risk of Behavioral/Emotional or Cognitive Problems Among Children 6 to 17 Years Old

	Risk of any behavioral/emotional or cognitive problems			Children with IEP ^a		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	1,981	64.1	2.0	1,868	27.8	2.4
Gender					***	
Male	982	66.7	3.0	919	34.3	2.6
Female	999	61.6	2.4	949	21.4	2.8
Age (years)					*	
6–10	939	58.6	2.5	984	23.7	2.4
11–17	1,042	68.9	2.6	884	32.3	3.4
Race/ethnicity						
Black	540	62.6	3.8	491	28.0	3.3
White	763	67.4	2.7	717	32.2	3.0
Hispanic	491	61.3	3.8	489	22.1	4.1
Other	184	61.7	5.9	168	24.3	4.0
Setting					*	
In-home	1,375	64.2	2.3	1,295	28.1	2.6
Informal kin care	149	61.8	7.0	143	16.3 ^b	3.6
Formal kin care	137	56.8	5.5	133	30.9	10.7
Foster care	246	63.5	5.8	229	35.7	6.8
Group home or residential program	61	80.2	7.5	54	47.2	12.8
Risk of behavioral/emotional or cognitive problems^c					***	
Cognitive only	—	—	—	152	43.0 ^d	6.1
Behavioral/emotional only	—	—	—	722	27.8 ^e	3.3
Both cognitive and behavioral/emotional	—	—	—	221	68.2	6.2
Neither cognitive or behavioral	—	—	—	655	10.5 ^f	2.1

Note: All analyses were on weighted data; *N*s are unweighted and, therefore, direct percentages cannot be calculated by hand. Pearson χ^2 tests for cluster samples were used to test statistical significance. Statistical significance is noted by asterisks in the column above the statistically significant result (* $p < .05$, *** $p < .001$). IEP = Individualized education program. This table has been revised since its original posting on November 15, 2011. A problem was identified in the basal score calculation for a subset of children receiving the Kaufman Brief Intelligence Test (K-BIT) and Woodcock-Johnson III Tests of Cognitive Abilities (WJ-III). The current version includes the corrected scores and also reflects the removal of one case in the baseline cohort identified as ineligible during Wave 2 data collection.

^a Presence of an active IEP was determined by either teacher or caregiver, or caseworker or emancipated child report (i.e., by teacher interview, if available; by caregiver or caseworker or emancipated child interview if teacher's input was missing).

^b Children living in informal kin care were significantly less likely to have an IEP than children living in-home with parents ($p < .05$), children living in foster care ($p < .05$) and children living in a group home or residential program ($p < .05$).

^c Children 6 to 17 years old were considered to be at risk for a cognitive problem or low academic achievement and in need of a referral for special education services if they had a score 2 standard deviations or more below the mean for the Kaufman Brief Intelligence Test (K-BIT) or Woodcock-Johnson III Tests of Cognitive Abilities (WJ-III (considered a cognitive need) (Kaufman & Kaufman, 2004; Woodcock et al., 2001). Children were considered to be at risk for a behavioral/emotional problems if either (1) a caregiver reported an elevated score (>1.5 standard

deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the Child Behavior Checklist (CBCL) (Achenbach & Rescorla, 2001); (2) an adolescent reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the Youth Self Report (YSR) (Achenbach & Rescorla, 2001); (3) a teacher reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the T Teacher Report Form (TRF) (Achenbach & Rescorla, 2001); (4) a clinically significant score was obtained on the Child Depression Inventory (Kovacs, 1992a), or (5) a clinically significant score was obtained on the PTSD scale of the Trauma Symptoms Checklist (Briere, 1996).

^d Children with only cognitive problems were significantly less likely to have an IEP than children with cognitive and behavioral problems ($p < .01$).

^e Children with only behavioral problems were significantly less likely to have an IEP than children with only cognitive problems ($p < .05$) and children with cognitive and behavioral problems ($p < .001$).

^f Children without cognitive or behavioral problems were significantly less likely to have an IEP than children with only behavioral problems ($p < .001$), only cognitive problems ($p < .001$) and children with cognitive and behavioral problems ($p < .001$).

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APPENDIX

Scales. Following is a descriptive list of the instruments used as measures of children's services in NSCAW II and to determine need for behavioral health, early intervention, and special education services.

- *Battelle Developmental Inventory & Screening Test, 2nd Edition (BDI-2)*. The BDI-2 is a standardized, individually administered assessment battery of key developmental skills in children (Newborg, 2005). The Cognitive domain was administered, which consists of the following three subdomains: (1) Attention and Memory for children 0 to 47 months old, (2) Perception and Concepts for children 0 to 47 months old, and (3) Reasoning and Academic Skills for children 24 to 47 months old. A Cognitive Development Quotient is estimated based on the subdomains. It is normed to have a mean of 100 and standard deviation of 15.
- *Child and Adolescent Services Assessment (CASA)*. Data on the use of mental health services were based on an adapted version of CASA (Ascher, Farmer, Burns, & Angold, 1996; Burns et al., 1995; Farmer, Angold, Burns, & Costello, 1994). This instrument gathers information from caregivers and children about an array of child-focused services for emotional or behavioral problems, including outpatient and residential care. Outpatient services include (1) clinic-based specialty mental health services; (2) private practice professionals, including psychiatrists, psychologists, social workers, and psychiatric nurses and drug or alcohol clinics; (3) in-home mental health services (e.g., family preservation); and (4) therapeutic nursery/day treatment. Residential services include (1) hospitalization in a psychiatric hospital or psychiatric unit of a general hospital, (2) hospitalization in a medical inpatient unit for emotional or behavioral problems, and (3) inpatient drug or alcohol detoxification.
- *Child Behavior Checklist for Ages 1.5–5 (CBCL 1.5–5)*. CBCL was “designed to provide standardized descriptions of behavior rather than diagnostic inferences” (Achenbach, 1991b, p. iii) about competencies, problem behaviors, and other problems. It contains 100 items for 1.5- to 5-year-olds, the problem scale is composed of seven syndromes (Emotionally Reactive (1), Anxious/Depressed (2), Somatic Complaints (3), Withdrawn (4), Sleep Problems (5), Attention Problems (6) Aggressive Behavior (7)) and an Other Problems category. Behaviors are categorized as Externalizing (containing the Attention Problems and Aggressive Behavior syndromes) or Internalizing (containing the Emotionally Reactive, Anxious/Depressed, Somatic Complaints, and Withdrawn syndromes). A Total Problems score is derived from the total of the syndromes and Other Problems items (Achenbach, 1991b), behavior ratings were considered clinically significant if scale *T* scores were at or above 64.
- *Child Behavior Checklist for Ages 6–18 (CBCL 6-18)*. The checklist for children 6 to 18 years old consists of 118 items related to behavioral problems. For each item, the child's caregiver indicates how well the behavior describes the child, either now or within the past 6 months, on a 3-point scale: 0, *not true* of the child; 1, *somewhat/sometimes true*; or 2, *very/often true*. The caregiver also reports on 20

social competency items, such as the amount and quality of the child's participation in sports, hobbies, jobs and chores, and organizations; friendships; and school functioning. For this report, the CBCL Total Problem, Internalizing, and Externalizing behavior standardized (*T*) score was used to measure the behavioral well-being of children. In keeping with recommended procedures for classifying the Total Problems, Internalizing, and Externalizing scales (Achenbach, 1991b; Achenbach & Rescorla, 2001), behavior ratings were considered clinically significant if scale *T* scores were at or above 64.

- *Children's Depression Inventory (CDI)*. The CDI measures depression by asking various questions of children 7 to 17 years old about their engagement in certain activities or their experience of certain feelings (e.g., sad, enjoyment around other people). CDI contains 27 items, each with a 3-point Likert-type scale (0 = *absence of symptom*, 1 = *mild symptom*, 2 = *definite symptom*) that addresses a range of depressive symptoms as indicated by five factors: Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia, and Negative Self-Esteem. Children were determined to have a clinically significant total score on CDI if the total depression standard *T* score was greater than or equal to 65. This clinical cutoff is based on the CDI normative sample's rates of depression in the CDI manual (Kovacs, 1992b); it corresponds to a raw score of 19 for girls and 24 for boys; CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble). Risk of a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (CRAFFT; Knight, Sherritt, Shrier, Harris, & Chang, 2002). There are six CRAFFT items: have you ridden in a Car driven by someone (including yourself) who had been drinking? Do you use alcohol to Relax, feel better about yourself, or fit in? Do you use alcohol while you are by yourself, Alone? Do you Forget things you did while using alcohol? Do your family or Friends tell you that you should cut down on your drinking? Have you gotten into Trouble while using alcohol? Each item endorsed is given a score of "1." The total number of item endorsed is the score. The CRAFFT has been found to perform best at a cut score of 2 when used to identify adolescents with a DSM-IV substance use disorder in a medical clinic setting.
- *Kaufman Brief Intelligence Test (K-BIT)*. The K-BIT is a brief, individually administered screener of verbal and nonverbal intelligence; it is designed for individuals 4 years old or older (Kaufman & Kaufman, 1990). It includes two subtests: Vocabulary (expressive vocabulary and definitions) and Matrices (ability to perceive relationships and complete analogies). NSCAW II used the standard score for Vocabulary, Matrices, and Total IQ Composite. Each is normed to have a mean of 100 and standard deviation of 15.
- *Preschool Language Scale-3*. (Zimmerman et al., 1992). The PLS-3 measures language development, and precursors of language development, in infants and young children (2 weeks old to 6 years, 11 months old. In this study it was administered to children from birth to 5 years old). PLS-3 measures language development of children from birth to 6 years old (in this study it was administered to children from birth to 5 years old). The Auditory Comprehension subscale measures receptive communication skills. The Expressive Communication subscale measures expressive

communication skills. A Total Language score combines these two subscales. Each is normed to have a mean of 100 and standard deviation of 15.

- *Teacher Report Form (TRF)*. The TRF, from the Achenbach System of Empirically Based Assessment, uses the same constructs as the CBCL to evaluate a child's behavioral problems (Achenbach, 1991c; Achenbach & Rescorla, 2001). The TRF is different in that it is completed by the child's teacher, rather than a caregiver, and it includes some items specifically related to behaviors displayed in school. As with the CBCL, two versions of the form have been developed: one for children 1.5 to 5 years old and another for children 6 to 18 years old. Each item on the Problem Section of the TRF contains a statement about a child's behavior. The teacher selects the response that assesses how well each statement describes the child, either currently or within the previous 2 months. Response options include *not true* (0), *somewhat or sometimes true* (1), and *very true or often true* (2). For this report, the TRF Total Problem, Internalizing, and Externalizing behavior standardized (*T*) scores were used. In keeping with recommended procedures for classifying the Total Problems, Internalizing, and Externalizing scales, behavioral ratings were considered clinically significant if scale *T* scores were at or higher than 64.
- *Trauma Symptom Checklist for Children (TSCC)*. The TSCC evaluates posttraumatic symptomatology in children and adolescents (8 to 16 years old, with normative adjustments for 17-year-olds), including the effects of child abuse (sexual, physical, and psychological) and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters. Each symptom item is rated according to its frequency of occurrence using a four point scale ranging from 0 ("never") to 3 ("almost all of the time"). All clinical scales yield gender- and age-normed *T* scores. One clinical scale was used: Post Traumatic Stress (PTS). Clinically significant scores on the PTSD subscale were defined as those standardized scale scores at or higher than 65 (Briere, 1996).
- *Vineland Screener*. (Sparrow et al., 1993). For this report, we used the daily-living skills domain of the Vineland Screener, a shortened version of the Vineland Adaptive Behavior Scale. The scale is administered via a structured interview with the child's caregiver to determine the frequency with which the child typically performs a given behavior. Skills assessed include basic eating and drinking, dressing, toileting, hygiene, housekeeping, time and money concepts, telephone use, and basic safety. Standardized scores are based on a mean of 100, with a standard deviation of 15.
- *Woodcock-Johnson III Tests of Cognitive Abilities*. The W-J is a brief, wide-range test of basic skills and knowledge, including tests of reading, mathematics, writing, and factual knowledge (science, social studies, and humanities). The following three tests were utilized: Word Identification; Passage Comprehension; and Applied Problems. Children 5 to 11 years old were administered all three tests. Children 11 years old and older were administered the Word Identification and Applied Problems tests only. (Woodcock et al., 2001). Letter-Word Identification is a basic reading skill involving naming letters and reading words aloud from a list. Passage Comprehension is a measure of reading comprehension in which the individual has to orally supply

the missing word removed from each sentence or very brief paragraph. Applied Problems is a test of math reasoning requiring the individual to solve oral word-problems. Standardized scores are based on a mean of 100, with a standard deviation of 15.

- *Youth Self-Report (YSR)*. The YSR was designed to assess self-reported feelings and behavior for comparison to normative groups of 11- to 18-year-olds (Achenbach, 1991a; Achenbach & Rescorla, 2001). The YSR is almost identical to the CBCL in content and structure, including the competence scales, problem syndromes, and other problems. For this report, the YSR Total Problem, Internalizing, and Externalizing behavior standardized (*T*) scores were used to measure adolescent behavioral well-being. In keeping with recommended procedures for classifying the Total Problems, Internalizing and Externalizing scales (Achenbach, 1991a; Achenbach & Rescorla, 2001), behavioral ratings were considered clinically significant if scale *T* scores were at or higher than 64.

Derived Variables. Following is a descriptive list of the variables derived for the NSCAW II Children's Services Brief Report.

- *Any Behavioral Health Service*. This service use category included children's use of any specialty outpatient, inpatient, family doctor, or school-based services for an emotional, behavioral, learning, attentional problem or substance abuse problem.
- *Child Insurance Status*. Child insurance status includes four types: *private*, *public*, *other*, and *uninsured*. *Private* includes children who have any private insurance plan obtained through an employer or purchased directly. *Public* includes children covered by Medicaid or any other state-sponsored programs. *Other* includes children who do not have private insurance or Medicaid (or other public coverage), but who have any other type of insurance, including coverage through a military health plan. *Uninsured* includes children who were not covered at the time of interview under private, public, or other insurance. This category also includes children only covered through the Indian Health Service. Consistent with the National Health Interview Survey insurance status categories, *uninsured* also includes children only covered through the Indian Health Service (n=4).
- *Developmental Need*. Developmental problems was defined based on children birth to 5 years old having a diagnosed mental or medical condition that has a high probability of resulting in developmental delay (e.g., Down syndrome) and/or being 2 standard deviations below the mean in at least one developmental area or 1.5 standard deviations below the mean in two areas. Areas included cognitive development based on the BDI or K-BIT, communication development based on the PLS-3, and adaptive development based on the Vineland Daily Living Skills.
- *IEP Children 6 to 17 Years Old*. Teachers of children 6 to 17 years old were asked "Is student currently receiving special education? That is, does he/she currently have an Individual Education Plan (I.E.P.) or an Individualized Family Services Plan (I.F.S.P.)?" Caregivers were asked "Does CHILD currently have an Individual

Education Plan (IEP) or is he/she receiving special education or other services for a special need or disability?” This variable relied on teacher report of an IEP to determine the presence of special education services. Where teacher report data were missing, the caregiver report was used to positively identify IEP receipt.

- *IFSP/IEP Children Birth to 5 Years Old:* Legislation establishing Part C services requires that an IFSP be developed in collaboration with the child’s caregiver as a first step in the delivery of Part C services. Because NSCAW II includes a variable measuring provision of an IFSP but not a variable on Part C services *per se*, receipt of an IFSP was used as a proxy for receipt of Part C services. A legal document, the IFSP identifies goals and individualized supports and services that will enhance the child’s development. Early intervention services are usually provided at the child’s home and include speech/language therapy, special instruction, occupational therapy, developmental monitoring, and physical therapy (Hebbeler et al., 2007). In some cases the assessment reveals that children are developing adequately, and the IFSP specifies that children will be monitored and evaluated every 6 months. For children 3 to 5 years old, those who need special education services receive an IEP, addressed by Part B of IDEA (Danaher, 2005). For IFSP identification, both caregiver and caseworkers reports were used. Caseworkers were asked, “Was an Individual Family Service Plan developed for child?” If the child was more than 36 months of age, caseworkers were asked, “Was an Individual Educational Plan developed for child?” Caregivers were asked, “Does CHILD currently have an Individual Family and Service Plan (IFSP) or is he/she receiving special education or other services for a special need or disability?” If the child was older than 36 months, caregivers were asked Does CHILD currently have an Individual Education Plan (IEP) or is he/she receiving special education or other services for a special need or disability?” Children birth to 5 years old were classified as having an IFSP or an IEP if *either* the caseworker or the caregiver responded affirmatively to these questions.
- *Inpatient Behavioral Health Services.* This service use category included children’s use of a psychiatric hospital or psychiatric unit within a medical hospital, services through a detox unit or inpatient unit, hospital medical inpatient unit, residential treatment center or group home, or hospital emergency room for emotional and substance abuse problems.
- *Risk of Cognitive or Behavioral/Emotional Problems.* Children 6 to 17 years old were considered to be at risk for a cognitive problem or low academic achievement if they had a score 2 standard deviations or more below the mean for the K-BIT or Woodcock-Johnson III (considered a cognitive need) (Kaufman & Kaufman, 2004; Woodcock et al., 2001). Children were considered to be at risk for a behavioral/emotional problems if either (1) a caregiver reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the CBCL (Achenbach & Rescorla, 2001); (2) an adolescent reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the YSR (Achenbach & Rescorla, 2001); (3) a teacher reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the TRF

- (Achenbach & Rescorla, 2001); (4) a clinically significant score was obtained on the CDI (Kovacs, 1992a), or (5) a clinically significant score was obtained on the PTSD scale of the Trauma Symptoms Checklist (Briere, 1996).
- *Risk of Behavioral/Emotional Problems.* Children 1.5 to 17 years were considered to be at risk for a behavioral/emotional problems if either (1) a caregiver reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the CBCL (Achenbach & Rescorla, 2001); (2) an adolescent reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the YSR (Achenbach & Rescorla, 2001); (3) a teacher reported an elevated score (>1.5 standard deviations above the mean) on the Total Problems, Internalizing, or Externalizing scales of the TRF (Achenbach & Rescorla, 2001); (4) a clinically significant score was obtained on the CDI (Kovacs, 1992a), or (5) a clinically significant score was obtained on the PTSD scale of the Trauma Symptoms Checklist (Briere, 1996).
 - *Risk of Substance Abuse Problems.* Risk for a substance abuse problem was defined by a Total score of 2 or more on the CRAFFT (Care, Relax, Alone, Forget, Friends, Trouble) substance abuse screening test (CRAFFT; Knight et al., 2002). A CRAFFT total score of 2 or more is highly correlated with having a substance-related diagnosis and the need for substance abuse treatment. The CRAFFT was only administered to children 11 to 17 years old.
 - *Setting.* The setting variable includes six levels: in-home, formal kin care, informal kin care, foster care, group home/residential program, or other out of home. *In-home* caregivers include living situations where the primary caregiver is either a biological, adoptive, or stepmother/father. *Formal kin care* includes situations where the primary caregiver has a kin relationship to the child and where the caregiver is receiving payments from the Child Welfare System. *Informal kin care* is where the primary caregiver has a kin relationship to the child, but is not receiving payments from the Child Welfare System. *Foster care* indicates that the child primary caregiver was identified as a foster parent. *Group home/residential program* indicates that a child was currently living in a group home or residential facility. *Other out of home* includes situations where the primary caregiver was identified as “other nonrelative” and where the primary caregiver was not receiving foster parent payments.
 - *Specialty Outpatient Behavioral Health Services.* This service use category refers to children’s use of services received from an outpatient drug or alcohol clinic, mental health or community health center, private mental health professional, or in-home counseling or crisis services. This also includes the use of day treatment for emotional and substance abuse problems or use of a therapeutic nursery.