



National Survey of Child
and Adolescent Well-Being

NSCAW II WAVE 2 REPORT

Children's Services

OPRE Report #2012-59
July 16, 2012

NSCAW II WAVE 2 REPORT: CHILDREN'S SERVICES

FINAL REPORT

OPRE Report #2012-59

July 2012

Cecilia Casanueva, Leyla Stambaugh, Stephen Tueller, Melissa Dolan, Keith Smith, RTI International.

Submitted to:

Mary Bruce Webb, Project Officer
Office of Planning, Research and Evaluation
Administration for Children and Families
U.S. Department of Health and Human Services

Contract Number: HHS P2320062930YC

Project Director: Kathryn Dowd
RTI International
3040 East Cornwallis Road
Post Office Box 12194
Research Triangle Park, NC 27709-2194

This report is in the public domain. Permission to reproduce is not necessary. Suggested citation: Casanueva, C., Stambaugh, L., Tueller, S., Dolan, M., & Smith, K. (2012). *NSCAW II Wave 2 Report: Children's Services*. OPRE Report #2012-59, Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Disclaimer

The views expressed in this publication do not necessarily reflect the views or policies of the Office of Planning, Research and Evaluation, the Administration for Children and Families, or the U.S. Department of Health and Human Services.

This report and other reports sponsored by the Office of Planning, Research and Evaluation are available at <http://www.acf.hhs.gov/programs/opre/index.html>.



RTI International is a trade name of Research Triangle Institute.

TABLE OF CONTENTS

INTRODUCTION TO NSCAW II, WAVE 2	1
SUMMARY OF REPORT FINDINGS	2
GUIDE TO THE NSCAW II, WAVE 2 REPORT SERIES	3
CHILD CHARACTERISTICS AT WAVE 2	4
CHILD INSURANCE STATUS	4
Current Insurance Status	4
Uninsured During the Past Year	5
HEALTH SERVICES	5
Usual Place of Health Care	5
Preventive Health Services	6
Delayed Medical Care due to Cost	7
DENTAL CARE, URGENT MEDICAL, AND BEHAVIORAL HEALTH SERVICES	7
Dental Care	8
Urgent Medical Care	8
Behavioral Health Services	9
SERVICES FOR YOUNG CHILDREN	14
Child Care and Head Start Programs	15
Early Intervention Services under the Individuals with Disabilities Education Act (IDEA)	15
SPECIAL EDUCATION SERVICES	16
Individualized Education Programs	16
FOR MORE INFORMATION	17
EXHIBITS	18
REFERENCES	47
APPENDIX	51

LIST OF EXHIBITS

Number		Page
1.	Child Characteristics at Wave 2.....	18
2.	Current Child Insurance Status by Caregiver Report at Wave 2	19
3.	Child Uninsured in the Past 12 Months by Caregiver Report at Wave 2	21
4.	Children’s Usual Place of Health Care by Caregiver Report at Wave 2	22
5.	Children’s Preventive Health Services by Caregiver Report at Wave 2	24
6.	Delayed Child Medical Care Due to Cost by Caregiver Report at Wave 2.....	26
7.	Dental Care for Children 2 to 17 Years Old by Caregiver Report at Wave 2	28
8.	Children’s Urgent Medical Care in the Past Year by Caregiver Report at Wave 2.....	29
9.	Risk of a Behavioral/Emotional Problem Among Children 1.5 to 17 Years Old at Wave 2	31
10.	Risk of a Behavioral/Emotional Problem and Substance Abuse Problem Among Children 11 to 17 Years Old At Wave 2.....	32
11.	Specialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2.....	34
12.	Nonspecialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2.....	36
13.	Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2	38
14.	Current Use of Psychotropic Medications Among Children 1.5 to 17 Years Old by Caregiver Report at Wave 2.....	40
15.	Participation in Child Care, Head Start, and Early Intervention Services Among Children 1 to 5 Years Old At Wave 2.....	42
16.	Developmental Problems Among Children 1 to 5 Years Old at Wave 2	44
17.	Special Education Service Use and Risk of Behavioral/Emotional and/or Cognitive Problems Among Children 6 to 17 Years Old At Wave 2.....	45

Introduction to NSCAW II, Wave 2

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 5,872¹ 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 of this NSCAW II Baseline series.² A series of baseline reports on these data have been published (OPRE Reports 2011-27a-g) and are publicly available at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html.

Wave 2 is a follow-up of children and families approximately 18 months after the close of the NSCAW II index investigation. The NSCAW II cohort of children who were approximately 2 months to 17.5 years old at baseline ranged from 16 months to 19 years old at Wave 2. Data collection for the second wave of the study began in October 2009 and was completed in January 2011.

Wave 2 data collection procedures mirrored the baseline data collection effort with a few notable exceptions:

¹ At the time the baseline analyses and reports were prepared, the size of the cohort was 5,873. One child case was identified as ineligible during Wave 2, resulting in a revised NSCAW II cohort size of 5,872.

² Comparisons between NSCAW I and NSCAW II estimates require statistical testing. Analysis for comparison purposes requires a different set of weights; these are available through the National Data Archive for Child Abuse and Neglect at Cornell University.

- A small number (n=90) of children in the cohort became young adults 18 years old and older prior to their Wave 2 interview. NSCAW II questionnaire modules for young adults focus on different topics and constructs than modules administered to younger children. In addition, a corresponding caregiver interview is not sought once a child turns 18. Because of these factors and the small sample size of this subgroup at Wave 2, young adults were excluded from the Wave 2 report series.
- At baseline, an *investigative* caseworker interview was pursued for every child in the cohort. At Wave 2, a *services* caseworker interview was pursued only if the child was living out of home at Wave 2 or if the child or family had received services paid for or provided by child protective services since the baseline interview date. In cases where the caregiver reported no services or was uncertain if services had been received, service use was verified with the participating county child welfare agency. If needed, a services caseworker interview was pursued even in situations where the child and/or caregiver were not interviewed for Wave 2.

Wave 2 interviews were completed with 4,750 children and 4,958 caregivers. On average, interviews with children and caregivers were conducted 18.7 months (range 14.9 to 24.7 months) and 18.6 months (range 14.9 to 24.1 months) after the investigation end date, respectively. Approximately 51% of children and families had received services since the baseline interview and thus required a services caseworker interview. Wave 2 interviews were completed with 2,843 caseworkers. On average, services caseworker interviews were conducted 19.0 months after the investigation end date (range 15.4 to 23.3 months). Wave 2 weighted response rates were 82.8% for children, 86.3% for caregivers, and 93.9% for caseworkers.

Summary of Report Findings

This NSCAW II Wave 2 report describes children's receipt of health care, developmental and special education services, and behavioral health services in the year prior to the follow-up interview. Medicaid was the most commonly held type of children's health insurance (72.1%). In total, 75.0% of children were currently covered by a public insurance plan. 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 (82.6%) had received a well-child checkup in the last 12 months. About a quarter (24.8%) 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 out of 10 of young children birth to 5 years old had an Individualized Family Service Plan (IFSP) or IEP.

Many children who might need 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 17.7% were reported to have an IFSP or IEP. And, although need increased children's likelihood of receiving special education services, 64.4% of children determined to be in need of a referral for special education services due to cognitive problems and 73.4% needing referral for behavioral health services were not currently reported to have an active IEP.

Children's receipt of services differed most frequently by gender, age, race/ethnicity, setting, and insurance status. Details for these comparisons may be found in the body of 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. While 7.7% of children were uninsured at the time of the NSCAW II Wave 2 interview, twice that many (15.7%) had been uninsured at some point in the past 12 months. Children living in-home or in an informal kinship care placement were more likely to have been uninsured in the past 12 months, compared with children living in formal kin care, foster care, or a residential treatment setting. Young children (1 to 5 years old) 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. School-age children (6 to 17 years old) living in-home or with kin were also less likely to receive IEP special education services than children in foster care or group home/residential treatment.

Guide to the NSCAW II, Wave 2 Report Series

This report is the third in a series of reports describing findings from the NSCAW II 18-month follow-up (Wave 2) data. Included are descriptions of children's health, behavioral health, and special education services. Also included are descriptions of children's medication use, insurance coverage, and need for various services.

The Wave 2 report series is not intended to describe the developmental trajectories of each individual child in the cohort, but instead to provide a snapshot of child and family well-being 18 months after the index investigation of maltreatment that brought the child into the study. At Wave 2, all children are a year and a half older and may or may not be living with the same caregiver or in the same setting as they were at baseline. Two reports in the series include an examination of constructs specifically relevant to the passage of time for these children, including permanency (e.g., placement changes, adoption) and safety (e.g., re-reports of maltreatment).

The topics covered in other NSCAW II Wave 2 reports in this series include:

- 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)
- Children and Families Receiving Child Welfare Services Post-Baseline (caseworker characteristics, child and family service needs, services received)
- Child Safety (re-reports of abuse or neglect following the baseline index investigation, exposure to violence, aggression, and conflict)
- Child Permanency (permanency planning, reunification, adoption, placement changes, contact with biological parents)

The data analyzed in this report have been released through the National Data Archive on Child Abuse and Neglect (NDACAN) in NSCAW II data version 2-1.

Child Characteristics at Wave 2

Exhibit 1 gives an overview of some of the key characteristics of children in the NSCAW II cohort at Wave 2. Approximately one half of the sample was male (50.9%). One ninth (12.8%) of the children were 16 months to 2 years old, 23.1% were 3 to 5 years old, 30.0% were 6 to 10 years old, and 34.2% were 11 to 17 years old. Four out of 10 children (41.2%) were White, 29.0% were Hispanic, 22.5% were Black, and 7.3% described their race/ethnicity as “Other.”

At the time of the Wave 2 interview, the majority of children were living at home with parents (85.5%), while 10.7% were living with a kin primary caregiver. A kin caregiver may be a grandparent, aunt or uncle, sibling, or other relative; 8.3% 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 were living in foster care (2.9%) and in group homes (0.5%).

Child Insurance Status

This NSCAW II Wave 2 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 Wave 2.

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).³ 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 (72.1%; Exhibit 2); 15.0% of children were reported to have private insurance, 2.9% had coverage through a state health insurance plan for uninsured children, and 2.3% were insured through some other type of insurance (including military coverage). In total, 75.0% of children were currently covered by a public insurance plan. The 2010 NHIS showed a very different distribution of insurance status in the general population of children less than 18 years old: 53.8% of children had private insurance and 39.8% had a public plan (Cohen, Ward, & Schiller, 2011). Among children at NSCAW II Wave 2, 7.7% were currently uninsured, a rate similar to the national estimate for children under 18 years old (7.8%), according to the 2010 NHIS (Cohen

³ 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 six NSCAW II children at Wave 2 had insurance exclusively through the IHS and were included in the “uninsured” category.

et al., 2011). The percentage of NSCAW II children who were uninsured at Wave 2 was lower than the 10.2% of *poor* or 12.6% 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., 2011).

Exhibit 2 shows variations in current child insurance status by age, race/ethnicity, and setting. For example, when compared to younger children (1 to 2 years old, 3 to 5 years old, and 6 to 10 years old), adolescents 11 to 17 years old were more likely to have private insurance rather than Medicaid. Similarly, children 6 to 10 years old were more likely to have private insurance than Medicaid when compared with younger children (1 to 2 years old and 3 to 5 years old). More than four out of five (82.1%) Black children had Medicaid coverage. Black children were more likely to have Medicaid versus private insurance, compared with White children (69.1%) and children of other races (66.2%). About 19.4% of White children had private insurance, compared with 9.5% of Black children and 11.4% of Hispanic children. Compared with Hispanic children, White children were significantly more likely to have private insurance than to be uninsured or on Medicaid.

Nearly all children living in formal kin care (96.5%), foster care (94.3%), or residential treatment settings (98.6%) had Medicaid coverage. Approximately 16% (16.4%) of children living in-home and 8.6% of children living in informal kin care had private insurance. Children in in-home and informal kin care settings were significantly less likely to have Medicaid than to have private insurance, as compared to children living in all other types of care. Children living in informal kin care were more likely to be uninsured (16.7%) than to have private insurance (8.6%), compared with children living in-home with parents or in foster care.

Uninsured During the Past Year

While 7.7% of children were uninsured at the time of the NSCAW II Wave 2 interview, twice that many (15.7%) had been uninsured at some point in the past 12 months (see Exhibit 3). This percentage is higher than the 2010 NHIS national estimate of children under 18 years old who were uninsured at least part of the past year (11.6%; Cohen et al., 2011). Being uninsured in the past 12 months differed by the child's setting. Children living in-home (16.2%) or in informal kin care (20.3%) were more likely to have been uninsured in the past 12 months than children living in formal kin care (1.1%), foster care (1.7%), or a group home or residential treatment program (0.9%). 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 (97.2%; Exhibit 4), a rate approximating that of the general population of children under 18 years old nationally (95%; Bloom, Cohen, & Freeman, 2011). The most common location of this health care was a doctor's office (68.4%) or clinic (26.7%). According to caregiver reports, 2.6% of children relied on the emergency room for their usual place of health care and 1.7% used an outpatient hospital or *some other place*.

The percentage of children with a usual place of health care did not vary by gender, age, or setting. However, some differences by race and insurance status were evident. White children were more likely to have a doctor's office as a usual place of care and less likely to have a clinic, emergency room, or hospital as a usual place of care than children of all other races. Very few children (1.7%) used "other" place of care as usual care, but among them, Black children were more likely than White children to use an "other" place of care, while Whites were more likely to use an "other" place of care than Hispanic and children of "Other" race/ethnicity. Not surprisingly, children with private insurance (99.4%), public insurance (97.7%) or other insurance (100%) were more likely than uninsured children to have a usual location of care (87.1%).

This NSCAW II Wave 2 distribution is also similar to the 2010 NHIS findings for children under 18 years old where 74.3% used a doctor's office as their usual place of health care, 23.6% a clinic, 0.9% a hospital outpatient clinic, and 0.6% emergency room (Bloom et al., 2011). In regard to insurance status, the 2010 NHIS findings revealed a similar pattern with 97.5% of privately insured, 96.2% of publically insured, and 74.6% of uninsured children having a usual place of care (Bloom et al., 2011).

Preventive Health Services

Almost all children were reported as up-to-date in immunizations (96.9%; Exhibit 5). Immunization status varied by setting. Although the percentage differences were slight, children living in-home (96.6%) were significantly less likely to be up-to-date in immunizations than children in formal kin care (99.3%), informal kin care (99.0%), foster care (98.9%), or in a group home or residential treatment program (100%).

Most caregivers reported that their child had received a well-child checkup in the last 12 months (82.6%; Exhibit 5). The likelihood of having received a well-child checkup varied by age, race/ethnicity, setting, and insurance status. children 1 to 2 years old (91.2%) and children 3 to 5 years old (89.3%) were more likely to have had a well-child checkup in the past 12 months than children 6 to 10 years old (80.5%) and adolescents 11 to 17 years old (76.7%). Black children (89.4%) were more likely to have received a well-child checkup than White children (81.7%) and Hispanic children (78.1%). Children living in formal kin care (97.2%) and a group home or residential treatment program (93.1%) were more likely to have received a well-child checkup than children living in-home with parents (82.0%) and children living in informal kin care (80.6%). Children living in formal kin care were the most likely to have received a well-child checkup in the past year (97.2%). Uninsured children were less likely to have received a well-child checkup (54.7%) than children with either private (85.2%) or public insurance (85.3%).

In regard to the proportion of children receiving a well-child checkup, national estimates provided by the 2007 National Survey of Children's Health (NSCH) are slightly higher than NSCAW (88.5% compared to 82.6%) (U.S. Department of Health and Human Services, 2009b). Similar to NSCAW patterns, differences in age, race/ethnicity, and insurance status emerged in the national estimates. Like NSCAW, the 2007 NSCH found that children 0 to 5 years old were more likely to have received a well-child check up in the past year than children 6 to 11 years old and 12 to 17 years old (96.0%, 85.5%, and 84.2% respectively). Again, like NSCAW, the NSCH

found Black children to be most likely and Hispanics to be the least likely to receive a well-child checkup (Black: 91.5%, White: 88.6%, and Hispanic: 85.9%). Lastly, when national results were stratified by insurance status, the results were similar to NSCAW with uninsured children (72.6%) least likely to receive a well-child checkup compared to publically (91.4%) and privately insured children (89.5%). Of note, uninsured children in NSCAW were substantially less likely to receive a well-child checkup than uninsured children in NSCH (54.7% compared to 72.6%).

Delayed Medical Care due to Cost

All caregivers were asked if their child's medical care was delayed in the past year due to concerns about the cost of services and, if so, what type of care was delayed. Of caregivers, 9.7% reported that some portion of their child's medical care in the past year was delayed due to cost (Exhibit 6). Types of medical care delayed included dental care (4.7% of all children), eyeglasses (3.2%), prescription medications (2.9%), and mental health care or counseling (2.5%).

The percentage of children whose medical care was delayed due to cost varied by child age, race, setting, and current insurance status. Younger children (0 to 2 years old and 3 to 5 years old) were less likely to have had delayed medical care due to cost than older children (6 to 10 years old and 11 to 17 years old). Black children were less likely to have delayed dental care and eyeglasses due to cost than all other children, while children of "Other" race/ethnicity were less likely to have delayed mental health care or counseling due to cost than all other children. Children living in-home with parents (10.1%) were more likely to have delayed medical care than children living in formal kin (2.6%), foster care (3.2%), and a group home or residential treatment program (1.1%). Children with public insurance (6.5%) were less likely to have delayed medical care due to cost than children with private insurance (15.6%) and uninsured children (23.7%).

The percentage of children in NSCAW delaying medical care due to cost (9.7%) was higher than the national 2010 NHIS estimate (4.0%; Bloom et al., 2011). Like NSCAW, NHIS found similar patterns of variation by age with children 0 to 4 years old less likely to delay medical care due to cost compared with children 5 to 11 years old or 12 to 17 years old (3.1%, 4.0%, and 4.6%, respectively) (1.5%, 2.1%, and 2.7%, respectively). Like NSCAW results, national estimates showed that uninsured children were more likely to have delayed medical care due to cost (20.3%) compared with publically (2.3%) and privately insured children (2.9%).

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 was past 12 months. This reference period may result in an underestimate of service use for children living in out-of-home care for short durations. The child's Wave 2 caregiver may only be knowledgeable about the child's service use over the duration the child had been in his or her care, which could be less than 1 year.

Dental Care

Use of dental care was assessed for children 2 years and older (Exhibit 7). Caregivers were asked about a child receiving dental care in the past year, regardless of how long the child had been living in his or her current arrangement. Nearly three quarters (72.4%) of caregivers reported that their child had received dental care in the past 12 months. Past-year receipt of dental care varied by child age, but not by gender, race/ethnicity, setting, or insurance status. Older children (6 to 10 years old and 11 to 17 years old; 81.5% and 75.6%, respectively) were more likely to have received dental care in the past 12 months than children 2 to 5 years old (60.0%).

The 2007 NSCH shows a slightly higher proportion of children receiving dental care in the past year (78.4%; U.S. Department of Health and Human Services, 2009a) compared to children in NSCAW (72.4%). Similar to NSCAW, there is a variation in 2007 NSCH data by age with older children (6 to 11 years old and 12 to 17 years old; 89.5% and 87.8%, respectively) more likely to have received dental care in the past year than younger children (1 to 5 years old; 53.5%).

Urgent Medical Care

Caregivers were asked about child use of urgent-care services for illnesses or injuries in the past year, regardless of how long the child's current caregiver had been living with the child (Exhibit 8). About a third (31.0%) of 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 percentage is higher than the 2010 national estimate of children under 18 years old who had an ER visit in the past year (14%; Bloom et al., 2011), though the NHIS estimate only includes information about use of the ER while NSCAW estimates use of the ER or urgent care services. Past-year overnight hospital admissions for illnesses and injuries were less common (4.6%). And, 8.7% 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 1 to 2 years old were more likely to have used the ER or urgent care (42.6%) than children 6 to 10 years old (25.8%) and adolescents 11 to 17 years old (30.0%). Children 1 to 2 years old were also more likely to have been admitted overnight to a hospital in the past year for illness or injury (8.6%) than children 3 to 5 years old (2.4%) and children 6 to 10 years old (3.1%). White children were more likely to have used the ER or urgent care in the past year (37.7%) than Black children (25.7%) and Hispanic children (24.2%). The 2010 NHIS estimates found slightly different proportions among groups, with 20.5% of White children, 26.9% of Black children, and 23.1% of Hispanic children reporting one or more ER visits (Bloom et al., 2011).

Children living in-home with parents (4.8%) were more likely to have an overnight hospital admission for illness or injury than children living in informal kin care (1.9%) and were also more likely to have an injury, accident, or poisoning that needed care from a doctor or nurse (in-home children: 9.1%) than children living in formal kin care (4.1%). Children living in foster

care (7.1%) were more likely to have an overnight hospital admission for illness or injury than children living in formal kin care (2.3%) and children living in informal kin care (1.9%).

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 Wave 2 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 9 through 13) in this report 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 37.1% (see Exhibit 9). The prevalence of risk of a behavioral/emotional problem or substance abuse problem specifically among children 11 to 17 years old was 55.5% (52.0% had a risk of a behavioral/emotional problem, 14.6% had a risk of a substance abuse problem; see Exhibit 10).

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 Posttraumatic Stress Disorder (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 37.1% of children 1.5 to 17 years old were determined to be at risk and potentially in need of mental health services (16.5% of children 1.5 to 5 years old, 44.3% of those 6 to 10 years old, and 52.0% 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. The 2007 NSCH asked the caregivers of children 2 to 17 years old if

their child had been diagnosed with and still had one of seven conditions related to emotions, behavior, or development. These conditions included attention deficit disorder/attention deficit hyperactivity disorder, anxiety problems, depression, oppositional defiant disorder/conduct disorder, autism spectrum disorders, developmental delay, or Tourette syndrome. At the time of the survey, 11.3% of children had at least one of these conditions (U.S. Department of Health and Human Services, 2010). To identify emotional and behavioral problems, another resource, the NHIS, used a brief version of the Strengths and Difficulties Scale and a single question to ascertain the presence of serious overall emotional and behavioral difficulties in children 4 to 17 years old (Pastor, Reuben, & Duran, 2012). Using data from 2001 to 2007, the NHIS found approximately 7.4% of children met the criteria for emotional and behavioral problems. Both NSCH and NHIS estimates for the general population were substantially lower than the 37.1% reported by NSCAW participants at Wave 2.

Other national estimates are available only for certain age subpopulations. For instance, a recent national study using data from 2001 to 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 Wave 2 appear to show much higher risk for behavioral or emotional problems than other U.S. children described in several nationally representative studies.

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. More than one adolescent in seven (14.6%) had a score of 2 or higher (Exhibit 10). This proportion was significantly higher among adolescents 15 to 17 years old (27.1%) than among those 13 to 14 years old (9.3%) or those 11 to 12 years old (3.8%). Adolescents living in formal kin care (4.3%) were less likely to have a score of 2 or higher than children living in informal kin care (34.5%), children living in foster care (18.7%), and children living in a group home or residential treatment program (46.1%). Adolescents living in informal kin care were significantly more likely to have a score of 2 or higher than those living in-home with parents, (although it should be noted that adolescents living in informal kin care were also older on average than adolescents living in other settings).

No national data using the CRAFFT are available for comparison. However, a study of 2,034 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 (14.1%; Hassan et al., 2009). 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 2010 was 7.3%; the rate of adolescent alcohol dependence or abuse was 4.5% (Substance Abuse and Mental Health Services Administration, 2011).

Exhibit 10 also shows risk among children 11 to 17 years old of either a behavioral/emotional or substance abuse problem. Taken together, 55.5% 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 18 months after their index report of maltreatment showed some need for behavioral health services. This need was significantly greater among older adolescents, and children living in a group home or residential treatment program (96.7%) than children living in-home with parents (54.0%), in formal kin care (64.0%), informal kin care (61.3%), or foster care (63.2%).

Specialty Behavioral Health Services. Caregivers were asked about children's use of specialty outpatient and inpatient services in the past year (Exhibit 11). 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 category 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, 17.9% received outpatient specialty behavioral health services in the past year. 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 3.5% of children received inpatient behavioral services.

Among those children 1.5 to 10 years old identified as at risk for a behavioral or emotional problem, 29.5% received any specialty outpatient behavioral health service and 4.6% 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, 35.0% received any specialty outpatient behavioral health service and 11.6% received any specialty inpatient behavioral health service in the past year.

Estimates of past-year specialty outpatient behavioral health service use differed by age, race/ethnicity, setting, and the child being identified as at risk for behavioral or emotional problems. Younger children (7.2%) were less likely to have used outpatient services than older children (6 to 10 years old and 11 to 17 years old; 21.7% and 25.6%, respectively). White children (25.5%) were more likely to have used outpatient services than Black (12.3%) or Hispanic children (11.3%). Children living in foster care (45.6%) were more likely to have used outpatient services than children living in-home (16.6%), with formal kin care (15.2%), and with informal kin (18.9%). Children living in a group home or residential treatment program (78.9%) were more likely to have used outpatient services than all other children. Children 1.5 to 10 years old identified as a risk for a behavioral/emotional problem were more likely to have used outpatient services (29.5%) than children not identified as at risk for a behavioral or emotional problem (7.6%). Similarly, adolescents 11 to 17 years old identified as a risk for a behavioral/emotional problem or substance use problems were more likely to have used outpatient services (35.0%) than adolescents not identified as at risk for behavioral/emotional problem or substance use (14.0%).

Estimates of past-year specialty inpatient behavioral health service use varied by age, setting, and the child having a behavioral emotional problem. Older children (6 to 10 years old and 11 to 17 years old; 3.2% and 7.3%, respectively) were more likely to have used inpatient

services than younger children (1.5 to 5 years old; 0.1%). Children living in a group home or residential treatment program (53.8%) were more likely to have used inpatient services than children living in-home with parents (3.2%), in formal kin care (4.0%), informal kin care (2.4%), or foster care (4.4%). Children 1.5 to 10 years old identified as a risk for a behavioral/emotional problem were more likely to have used inpatient services (4.6%) than children not identified as at risk for a behavioral or emotional problem (0.2%). Adolescents 11 to 17 years old identified as a risk for a behavioral/emotional problem or substance use problems were more likely to have used inpatient services (11.6%) than adolescents not identified as at risk for a behavioral/emotional problem or substance use (2.0%).

Nonspecialty Behavioral Health Services. Caregivers were asked about children's use of nonspecialty services in the past year. Nonspecialty services included services received by either a family or other medical doctor and school-based services (Exhibit 12). Findings showed that 8.0% of caregivers reported having visited a doctor for their child's emotional, behavioral, learning attention, or substance abuse problems in the past year, while 11.9% 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, 16.5% received services from a family or other medical doctor and 21.0% 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, 12.1% received services from a family or other medical doctor and 23.5% 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 gender, age, race, setting, and the child being identified as at risk for a behavioral or emotional problem. Males (10.0%) were more likely to have used services from a family or other medical doctor than females (6.0%). Older children (6 to 10 years old and 11 to 17 years old; 13.2% and 9.3%, respectively) were more likely to have used services from a family or other medical doctor than younger children (1.5 to 5 years old; 2.4%). White children (12.7%) were significantly more likely to have received behavioral health services from a family or other medical doctor in the past 12 months than Black (5.7%) and Hispanic children (3.7%). Children living in informal kin care (3.2%) were less likely to have received behavioral health services from a family doctor in the past 12 months than children living in-home with parents (8.4%) and in foster care (9.6%). Children at risk for a behavioral/emotional problem (1.5 to 10 years old) were more likely to receive assistance from a family or other medical doctor in the past 12 months than those not identified as at risk.

Past-year estimates of nonspecialty school-based behavioral health services differed by gender, age, race/ethnicity, and the child being identified as at risk for a behavioral or emotional problem. Males (15.1%) were more likely to have used school-based services than females (8.6%). Older children (6 to 10 years old and 11 to 17 years old; 16.5% and 17.3%, respectively) were more likely to have used school-based services (1.5 to 5 years old; 2.9%). Hispanic children (7.2%) were less likely to have used school-based services than Black (11.4%) and White (15.4%) children. 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 school-based services in the past 12 months than those not identified as at risk.

Any Behavioral Health Services. About a quarter (24.4%) 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 13). 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 (43.0%) than those not at risk (19.6%). However, more than half (57.0%) of children 1.5 to 10 years old determined to be at risk for a behavioral or emotional problem did not receive any behavioral health service in the past year, according to caregiver report. 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 (42.3%) than those not at risk (19.6%). However, over half (57.7%) of children 11 to 17 years old determined to be at risk for a behavioral/emotional or substance abuse problem did not receive any behavioral health service in the past year, according to caregiver report.

Estimates of any behavioral health service use in the past year differed by gender, age, race/ethnicity, setting, and need. Males (27.6%) were more likely to have used any behavioral health services in the past year than females (21.1%). Older children (6 to 10 years old and 11 to 17 years old; 33.5% and 32.2%, respectively) were more likely to have used any behavioral health services in the past year than younger children (1.5 to 5 years old; 9.2%). White children (34.1%) were significantly more likely to have used any behavioral health service in the past 12 months than Black (19.2%), Hispanic (15.3%), and children of “Other” race/ethnicity (21.9%). Children living in foster care (48.7%) were more likely to have used any behavioral health service in the past 12 months than children living in-home (23.4%), in formal kin care (18.7%), and with informal kin (23.8%). Children living in a group home or residential treatment program (81.9%) were more likely to have used any behavioral health service in the past 12 months than all other children. 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 (43.0% among children 1.5 to 10 years old and 42.3% among children 11 to 17 years old) than those not identified as at risk (11.1% among children 1.5 to 10 years old and 19.6% among children 11 to 17 years old).

Nationally, among children ages 2 to 17 years old identified by the 2007 NSCH as having ongoing emotional, developmental, or behavioral problems, 60% received mental health services in the past year; however, differences were seen by age with 42.2% of 2- to 5-year-olds, 57.8% of 6- to 11-year-olds, and 66.3% of 12- to 17-year-olds who needed services (National Survey of Children's Health (NSCH), 2007). Overall, the proportion of children in need of mental health services who received these services was higher for children in the NSCH compared with children in NCSAW.

Psychotropic Medication. All caregivers of children 1.5 to 17 years old were asked about their child's current use of psychotropic medications. Exhibit 14 provides estimates of children whose caregivers reported that they currently used any psychotropic medication (11.7%), two psychotropic medications (3.1%), and three or more psychotropic medications (3.1%). The NSCAW II Wave 2 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 2005 and

2006 NHIS (6.0%; Simpson, Cohen, Pastor, & Reuben, 2008). Another comparison comes a General Accounting Office (GAO) report using Medicaid data from five states (Florida, Massachusetts, Michigan, Oregon, and Texas) (U.S. Government Accountability Office, 2011). This study found that of children (not in foster care) receiving Medicaid, 4.8% to 10.2% were prescribed a psychotropic medication while 0.6% to 2.0% were prescribed two or more psychotropic medications.

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 (14.9% versus 8.5%) and to be using two psychotropic medications (4.4% versus 1.9%). Children 1.5 to 5 years old were less likely to be using one or more psychotropic medications (1.6%) than all older children (6 to 10 years old and 11 to 17 years old; 20.1% and 15.4%, respectively), less likely to be using two psychotropic medications than all older children (1.5 to 5 years old: 0.5%; 6 to 10 years old: 4.6%; and 11 to 17 years old: 4.8%), and less likely to be using three psychotropic medications than all older children (1.5 to 5 years old: 0.2%; 6 to 10 years old: 4.8%; and 11 to 17 years old: 4.8%). White children (18.2%) were more likely to be currently using any psychotropic medication than Black (8.8%), and Hispanic children (6.2%), and also more likely (5.0%) to be currently using three or more psychotropic medications than Black (1.1%) and Hispanic children (1.8%). Children living in-home with parents (2.9%) were more likely to be currently using three or more psychotropic medications than children living in formal kin care (0.6%). Children living in foster care (23.8%) were more likely to be using any psychotropic medications than children living in-home with parents (10.9%), and were more likely to be currently using three or more psychotropic medication (9.3%) than children living in formal kin care (0.6%). Children living in a group home or residential treatment program were more likely to be using any psychotropic medications (67.4%) and to currently be using three or more psychotropic medication (40.2%) than children in all other settings. Children with public insurance (3.7%) were more likely to be using three or more psychotropic medications than children with other insurance, including military health plan insurance (0.0%). 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). Further, data from the GAO report on children receiving Medicaid also reflected similar patterns in differences by age groups, with young children least likely to have been prescribed a psychotropic medication compared to older age groups of children (0.6% to 3.3% of children 0 to 5 years old, 6.2% to 12.3% of those 6 to 12 years old, and 11.4% to 14.7% of those 13 to 17 years old) (U.S. Government Accountability Office, 2011).

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. The next sections provide information on young children’s participation in child care and Head Start programs, and receipt of an Individualized Family Services Plan (IFSP) or an Individualized Educational Plan (IEP) funded by the Individuals With Disabilities Education Act (IDEA, 21 USC § 106(b)(2)(A)). Receipt of an IFSP

serves as the formal entry vehicle to Part C early intervention services among children 0 to 2 years old. Receipt of an IEP provides children 3 to 5 years old entry to Part B special education services.

Child Care and Head Start Programs

Caregivers were asked whether their young child (16 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 (27.2%) of young children were participating in some kind of child care program (Exhibit 15). Among those in child care programs, 28.2% were participating in Head Start. Children 3 to 5 years old (41.0%) were more likely to participate in any type of child care program than children 1 to 2 years old (20.2%). Similarly, children 3 to 5 years old (36.8%) were more likely to participate in Head Start than children 1 to 2 years old (10.3%).

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

Overall, 42.6% of children 1 to 5 years old had a score across measures indicating some developmental problem that could suggest the need for early intervention services (Exhibit 16). A small percentage of young children had an established medical condition associated with developmental problems (1.3%); 34.8% showed risk of developmental delay on standardized measures; and 6.5% had both an established medical condition and risk of developmental delay.

Here, a 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 were more likely to have an IFSP or IEP than children without developmental problems (1.7%).

Males (50.6%) were more likely than females (33.5%) to have a developmental problem. Children living in-home (44.3%) and those living in foster care (52.8%) were more likely to be identified as having developmental problem(s) than children living in formal kin care (20.2%) and children living in informal kin care (24.4%).

For young children, caregivers and caseworkers were asked whether the child currently had an IFSP, an IEP, or services for a special need or disability. Less than one in 10 children birth to 2 years old (9.5%; Exhibit 15) had an IFSP, while 7.9% of children 3 to 5 years old had an IEP. The percentage of children birth to 2 years old with an IFSP exceeds the 2.4% of all children birth to 2 years old receiving IDEA Part C early intervention services nationwide in 2006; however, the rate among children 3 to 5 years old is only slightly higher than the percentage of children 3 to 5 years old served nationwide under IDEA Part B (5.9%; U.S. Department of Education, 2011). Nevertheless, the percentage of children with an IFSP or IEP does not appear to match need. Of those with developmental problems, only 17.7% have an IFSP

or IEP. 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 (13.0%) were more likely than females (3.4%) to have an IFSP or IEP. Children living in formal kin care (10.0%) were more likely to have an IFSP/IEP than children living in informal kin care (3.7%). Children living in foster care (33.7%) were more likely to have an IFSP/IEP than children living in-home (7.9%), children living in formal kin care (10.0%), and children living in informal kin care (3.7%).

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 17, 24.8% of children were reported to currently have an active IEP, a percentage that is more than double comparable national estimates. Nationwide in 2006, 11.6% of children 6 to 17 years old were served under IDEA Part B and were receiving special education services and related services (U.S. Department of Education, 2011). Males (32.3%) were more likely to have received an IEP than females (17.4%). This distribution is consistent with other studies showing greater representation of boys in special education (Hodapp & Fidler, 1999). White children (30.3%) were more likely to have an IEP than Black (22.6%) and Hispanic children (19.2%). Children living in foster care (44.8%) were significantly more likely to have an IEP than children living in-home (24.4%) and children living in informal kin care (18.9%). Children living in group home/residential treatment (55.3%) were more likely to have an IEP than children living in informal kin care (18.9%).

Among the 24.8% of children described as currently having an active IEP (n=290), teachers reported that 30.4% had a specific learning disability, 13.8% were identified as having a severe emotional disturbance, 10.2% as having a speech or language impairment, 9.9% were identified as having mental retardation, and 2.1% 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 (31.1%), counseling services (including rehabilitation services; 21.1%), special transportation services (15.9%), physical occupational therapy (13.6%), social work services (12.7%), and psychological services (9.9%).

Nationwide, eligibility for special education placement is determined through a comprehensive assessment of children’s abilities, which also forms the basis for the type and level of service they receive. 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.⁴ With this procedure, 55.8% of children 6 to 17 years old were estimated as having an elevated risk for cognitive or behavioral problems: 9.6% had a risk of cognitive delays or low academic achievement, 35.6% had a risk of behavioral or emotional problems, and 10.7% 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, 64.4% 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, 73.4% 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 (64.5%). Estimates here of “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, using criteria similar to the approach taken here, most states use clinically significant scores on quantitative measures to determine eligibility for IEP receipt.

For More Information

This NSCAW II Wave 2 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 Wave 2 Report: Children’s Well-Being* (OPRE Report 2012-38). Information on caregivers, including services needed and received, may be found in the *NSCAW II Wave 2 Report: Caregiver Health and Services* (OPRE Report 2012-58). Other reports from NSCAW II can be found at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html.

⁴ 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).

EXHIBITS

Exhibit 1. Child Characteristics at Wave 2

	<i>N</i>	Total <i>N</i> = 5,261	
		%	<i>SE</i>
Total	5,261	100.0	
Gender			
Male	2,703	50.9	1.5
Female	2,558	49.1	1.5
Age (years)			
1–2	2,385	12.8	0.8
3–5	816	23.1	1.3
6–10	1,001	30.0	1.0
11–17	1,058	34.2	1.2
Race/ethnicity			
Black	1,657	22.5	2.7
White	1,767	41.2	4.1
Hispanic	1,460	29.0	3.8
Other	356	7.3	1.1
Setting			
In-home	3,592	85.5	1.1
Formal kin care	414	2.4	0.4
Informal kin care	486	8.3	0.9
Foster care	690	2.9	0.3
Group home or residential program	50	0.5	0.1
Other out-of-home	24	0.4	0.2
Insurance status			
Private ^a	505	15.0	1.1
Public	4,141	75.0	1.5
Other	73	2.3	0.5
Uninsured	233	7.7	0.8

Note: All analyses were on weighted NSCAW II Wave 2 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 “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.

Exhibit 2. Current Child Insurance Status by Caregiver Report at Wave 2

	<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	4,956	15.0	1.1	72.1	1.6	2.9	0.7	2.3	0.5	7.7	0.8
Gender											
Male	2,539	14.5	1.4	72.7	2.2	3.1	0.9	1.6	0.5	8.1	1.4
Female	2,417	15.5	1.7	71.5	2.0	2.6	0.6	3.1	0.8	7.2	1.2
Age (years) ***											
1–2	2,222	6.3	1.7	79.8	3.5	3.0	1.1	2.5	0.8	8.4	2.8
3–5	765	9.2	1.9	80.4	2.5	3.0	1.9	1.5	0.6	6.0	1.6
6–10	954	15.6	2.0	72.7 ^b	2.7	2.4	0.7	2.4	0.8	6.8	1.6
11–17	1,013	21.6	2.0	63.2 ^c	2.4	3.1	0.8	2.8	1.0	9.3	1.5
Race/ethnicity**											
Black	1,563	9.5	1.6	82.1 ^d	2.6	2.1	0.9	1.1	0.6	5.2	1.5
White	1,674	19.4	2.3	69.1 ^e	2.6	2.3	0.7	2.7	0.8	6.5	1.0
Hispanic	1,376	11.4	2.0	70.6 ^f	2.2	4.7	2.0	2.7	0.9	10.7	1.9
Other	324	21.8	3.7	66.2	5.8	0.9	0.8	0.4 ^g	0.3	10.7	5.2
Setting***											
In-home	3,410	16.4	1.3	70.9 ^h	1.8	2.8	0.7	2.7	0.6	7.3	0.9
Formal kin care	414	2.0	0.8	96.5	1.2	0.8	0.4	0.1	0.1	0.6	0.4
Informal kin care	414	8.6	2.8	70.7 ⁱ	4.8	3.8	1.8	0.2	0.2	16.7 ^j	4.3
Foster care	651	0.7	0.4	94.3	3.2	4.0	3.1	0.5	0.3	0.4	0.2
Group home or residential program	46	0.0 ^k	0.0	98.6	1.0	0.0	0.0	0.5	0.5	0.9	0.9

Note: All analyses were on weighted NSCAW II Wave 2 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 6 to 10 years old were more likely to have private insurance than Medicaid when compared to children 1 to 2 years old ($p < .01$) and children 3 to 5 years old ($p < .05$).
- ^c Children 11 to 17 years old were significantly more likely to have private insurance than Medicaid when compared to children 1 to 2 years old ($p < .001$), children 3 to 5 years old ($p < .001$), and children 6 to 10 years old ($p < .01$). Children 11 to 17 years old were more likely to be uninsured than to have Medicaid, when compared to children 3 to 5 years old ($p < .05$).
- ^d Black children were significantly more likely to have Medicaid than private insurance when compared with White children ($p < .01$) and children of other race ($p < .01$). Black children were also significantly more likely to have Medicaid than other types of insurance, when compared to White children ($p < .05$).
- ^e White children were significantly more likely to have private insurance than Medicaid when compared to Hispanic children ($p < .05$). White children were significantly more likely to have private insurance than to be uninsured, compared to Hispanic children ($p < .01$).
- ^f Hispanic children were more likely to have Medicaid than private insurance when compared to children of other races ($p < .05$). Hispanic children were more likely to be uninsured than to have Medicaid, compared to Black children ($p < .05$).
- ^g Children of other race were less likely to have other types of insurance than Medicaid, when compared to White children ($p < .05$) and Hispanic children ($p < .05$). Children of other race were also less likely to have other types of insurance than private insurance, when compared to White children ($p < .05$) and Hispanic children ($p < .05$).
- ^h Children living in-home with parents were significantly less likely to have Medicaid than private insurance, when compared to children living in formal kin care ($p < .001$), children living in foster care ($p < .001$), and children living in a group home or residential treatment center ($p < .001$). Children living in-home with parents were also significantly less likely to have Medicaid than state health insurance, when compared to children living in formal kin care ($p < .05$) and children living in a group home or residential treatment center ($p < .01$). Children living in-home with parents were also significantly less likely to have Medicaid than other types of insurance, when compared with children living in formal kin care ($p < .001$), children living in foster care ($p < .001$), and children living in a group home or residential treatment center ($p < .05$). Children living in-home with parents were also significantly less likely to have Medicaid than to be uninsured, when compared to children living in formal kin care ($p < .001$), children living in foster care ($p < .001$), and children living in a group home or residential treatment center ($p < .001$).
- ⁱ Children living in informal kin care were significantly less likely to have Medicaid than private insurance, when compared to children living in formal kin care ($p < .05$), children living in foster care ($p < .01$), and children living in a group home or residential treatment center ($p < .05$). Children living in informal kin care were significantly less likely to have Medicaid than to be uninsured, when compared with children living in formal kin care ($p < .01$), children living in foster care ($p < .01$), and children living in a group home or residential treatment center ($p < .01$). Children living in informal kin care were significantly less likely to have Medicaid than other types of insurance, when compared to children living in-home with parents ($p < .001$).
- ^j Children living in informal kin care were significantly more likely to be uninsured than to have private insurance when compared to children living in-home with parents ($p < .05$) and children living in foster care ($p < .05$). Children living in informal kin care were also more likely to be uninsured than to have other types of insurance, when compared to children living in-home with parents ($p < .01$).
- ^k Children living in a group home or residential treatment center were significantly less likely to have private insurance than state health insurance compared with children living in-home with parents ($p < .001$), children living in formal kin care ($p < .05$), and children living in informal kin care ($p < .05$). Children living in a group home or residential treatment center were also significantly less likely to have private insurance than Medicaid when compared to children living in formal kin care ($p < .05$).

Exhibit 3. Child Uninsured in the Past 12 Months by Caregiver Report at Wave 2

	<i>N</i>	Was uninsured at any time during the past 12 months ^a	
		%	<i>SE</i>
Total	4,956	15.7	1.2
Gender			
Male	2,539	15.7	1.5
Female	2,417	15.8	1.7
Age (years)			
1–2	2,222	16.6	3.1
3–5	765	15.4	2.4
6–10	954	14.9	1.9
11–17	1,013	16.4	1.9
Race/ethnicity			
Black	1,563	11.4	1.9
White	1,674	14.4	1.6
Hispanic	1,376	20.4	2.8
Other	324	17.2	5.6
Setting		***	
In-home	3,410	16.2 ^b	1.4
Formal kin care	414	1.1 ^c	0.5
Informal kin care	414	20.3 ^d	4.4
Foster care	651	1.7	0.6
Group home or residential program	46	0.9	0.9
Current insurance status			
Private ^e	506	10.1	3.1
Public	4,144	8.5	1.0
Other	73	7.8	4.9

Note: All analyses were on weighted NSCAW II Wave 2 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 (***) 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 ($p < .001$), children living in 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 less likely to have been uninsured in the past 12 months when compared to children living in informal kin care ($p < .001$).

^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 foster care ($p < .001$) and children living in a group home or residential program ($p < .001$).

^e “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.

Exhibit 4. Children’s Usual Place of Health Care by Caregiver Report at Wave 2

	Location of usual place of health care												
	Has usual place of health care			Clinic		Doctor’s office		Emergency room		Hospital outpatient		Some other place	
	<i>N</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>	%	<i>SE</i>
Total	4,951	97.2	0.7	26.7	2.2	68.4	2.3	2.6	0.5	0.5	0.2	1.7	0.4
Gender													
Male	2,538	97.6	0.8	24.0	2.1	70.0	2.1	3.3	0.8	0.6	0.2	2.1	0.6
Female	2,413	96.8	0.9	29.5	3.3	66.8	3.4	2.0	0.6	0.4	0.2	1.3	0.5
Age (years)													
1–2	2,222	97.8	0.7	27.9	3.6	68.0	3.5	1.1	0.5	0.9	0.6	2.1	0.8
3–5	765	97.7	1.1	26.7	3.8	68.6	3.8	1.9	1.0	0.4	0.3	2.4	1.0
6–10	953	97.5	1.1	23.6	3.3	72.3	3.5	3.4	1.1	0.1	0.1	0.6	0.3
11–17	1,009	96.4	1.1	29.1	3.5	65.0	3.3	3.1	1.0	0.7	0.4	2.1	0.7
Race/ethnicity				***		***		***		***		***	
Black	1,563	96.2	1.4	28.9	3.5	64.3	3.8	2.9	1.0	0.7	0.4	3.1	1.1
White	1,673	98.3	0.6	17.3 ^a	2.4	78.6 ^b	2.6	2.1 ^c	0.6	0.3 ^d	0.2	1.7 ^e	0.6
Hispanic	1,375	96.0	1.4	36.5	4.0	59.4	4.1	3.1	1.2	0.4	0.3	0.7	0.3
Other	321	98.6	0.7	32.2	6.4	61.4	6.2	3.6	2.3	1.2	1.0	1.5	1.1
Setting													
In-home	3,408	97.1	0.8	27.2	2.2	67.8	2.3	2.7	0.5	0.5	0.2	1.8	0.4
Formal kin care	414	99.6	0.3	24.2	5.5	74.7	5.5	1.0	0.9	0.1	0.0	0.1	0.1
Informal kin care	413	97.4	1.3	24.7	4.6	70.4	4.6	3.7	2.1	0.3	0.2	0.8	0.7
Foster care	651	98.9	0.5	18.9	2.8	76.3	3.3	1.0	0.4	1.1	0.5	2.7	1.8
Group home or residential program	45	99.9	0.1	19.2	7.9	68.5	9.3	0.5	0.5	3.4	2.5	8.3	3.0
Current insurance status		*		**		**		**		**		**	
Private	506	99.4 ^f	0.5	15.6 ^g	3.1	82.2 ^h	3.0	1.4	1.0	0.0	0.0	0.8	0.6
Public ⁱ	4,142	97.7 ^j	0.7	26.9	2.4	68.1	2.5	2.8 ^k	0.6	0.6 ^l	0.2	1.6 ^m	0.4
Other	73	100.0	0.0	29.9	11.4	66.8	11.1	0.1	0.1	0.7	0.6	2.5	2.1
None	229	87.1 ⁿ	5.0	49.5 ^o	6.8	43.0 ^p	7.2	2.9 ^q	1.4	0.0 ^r	0.0	4.5 ^s	1.9

Note: All analyses were on weighted NSCAW II Wave 2 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 White children were significantly less likely to have a clinic as a usual place of care than Black children ($p < .01$), Hispanic children ($p < .001$), and children of other race ($p < .05$).
- ^b White children were significantly more likely to have a doctor’s office as a usual place of care than Black children ($p < .001$), Hispanic children ($p < .01$), and children of other race ($p < .05$).
- ^c White children were significantly less likely to have the emergency room as a usual place of care than Black children ($p < .01$).
- ^d White children were significantly less likely to have a hospital as a usual place of care than Black children ($p < .01$), Hispanic children ($p < .001$), and children of other race ($p < .05$).
- ^e White children were significantly less likely to have another place of usual care than Black children ($p < .01$). White children were significantly more likely to have another place of usual care than Hispanic children ($p < .001$) and children of other race ($p < .05$).
- ^f Children with private insurance were significantly more likely to have a usual place of care than children with public insurance ($p < .05$).
- ^g Children with private insurance were significantly less likely to have a clinic as a usual place of care than children with public insurance ($p < .01$).
- ^h Children with private insurance were significantly more likely to have a doctor’s office as a usual place of care 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 Children with public insurance were significantly less likely to have a usual place of care than children with other insurance ($p < .05$).
- ^k Children with public insurance were significantly more likely to have the emergency room as a usual place of care than children with private insurance ($p < .01$).
- ^l Children with public insurance were significantly more likely than children with private insurance to have a hospital as a usual place of care ($p < .01$).
- ^m Children with public insurance were significantly more likely to have another place of usual care than children with private insurance ($p < .01$).
- ⁿ Children with no insurance were significantly less likely to have a usual place of care than children with private insurance ($p < .05$), children with public insurance ($p < .05$), and children with other insurance ($p < .05$).
- ^o Children with no insurance were significantly more likely to have a clinic as a usual place of care than children with private insurance ($p < .001$) and children with public insurance ($p < .01$).
- ^p Children with no insurance were significantly less likely to have a doctor’s office as a usual place of care than children with private insurance ($p < .001$) and children with public insurance ($p < .01$).
- ^q Children with no insurance were significantly more likely to have the emergency room as a usual place of care than children with private insurance ($p < .001$) and children with public insurance ($p < .01$).
- ^r Children with no insurance were significantly less likely to have a hospital as a usual place of care than children with public insurance ($p < .01$). Children with no insurance were significantly less likely to have a hospital as a usual place of care than children with private insurance ($p < .001$).
- ^s Children with no insurance were significantly more likely to have another place of usual care than children with private insurance ($p < .001$) and children with public insurance ($p < .01$).

Exhibit 5. Children’s Preventive Health Services by Caregiver Report at Wave 2

	Up-to-date with immunizations			Well-child checkup past 12 months		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	4,946	96.9	0.6	4,906	82.6	1.3
Gender						
Male	2,534	96.3	1.2	2,520	81.9	1.9
Female	2,412	97.6	0.5	2,386	83.3	1.7
Age (years)					***	
1–2	2,220	92.2	2.8	2,208	91.2 ^a	1.9
3–5	763	97.2	0.8	764	89.3 ^b	2.2
6–10	951	97.6	1.3	938	80.5	2.5
11–17	1,010	97.9	0.8	994	76.7	2.3
Race/ethnicity					**	
Black	1,561	97.5	0.8	1,555	89.4 ^c	1.7
White	1,669	97.3	0.7	1,651	81.7	1.8
Hispanic	1,375	97.4	1.4	1,363	78.1	2.5
Other	322	90.9	5.1	318	83.3	4.6
Setting		*			***	
In-home	3,405	96.6 ^d	0.7	3,385	82.0 ^e	1.4
Formal kin care	413	99.3	0.4	413	97.2	1.0
Informal kin care	415	99.0 ^f	0.5	407	80.6 ^g	4.4
Foster care	650	98.9	0.5	639	91.3	3.3
Group home or residential program	44	100.0	0.0	44	93.1	3.2
Current insurance status					***	
Private	506	97.1	1.4	500	85.2	2.5
Public ^h	4,134	97.4	0.6	4,106	85.3	1.4
Other	73	97.8	2.0	72	69.5	9.9
None	232	91.1	5.1	228	54.7 ⁱ	6.0

Note: All analyses were on weighted NSCAW II Wave 2 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 (** $p < .01$, *** $p < .001$). Asterisks in a column apply to the subsequent results for the covariate.

^a Children 1 to 2 years old were significantly more likely to have attended a well-child checkup in the past 12 months than children 6 to 10 years old ($p < .001$) and children 11 to 17 years old ($p < .01$).

- ^b Children 3 to 5 years old were significantly more likely to have attended a well-child checkup in the past 12 months than children 6 to 10 years old ($p < .05$) and children 11 to 17 years old ($p < .01$).
- ^c Black children were significantly more likely to have attended a well-child checkup in the past 12 months than White children ($p < .01$) and Hispanic children ($p < .001$).
- ^d Children living in-home with parents were significantly less likely to be up to date with immunizations than children living in formal kin care ($p < .01$), children living in informal kin care ($p < .05$), children living in foster care ($p < .05$), and children living in a group home or residential treatment center ($p < .01$).
- ^e Children living in-home with parents were significantly less likely to have attended a well-child checkup in the past 12 months than children living in formal kin care ($p < .001$), children living in foster care ($p < .05$), and children living in a group home or residential treatment center ($p < .01$).
- ^f Children living in informal kin care were significantly less likely to be up to date with immunizations than children living in a group home or residential treatment center ($p < .05$).
- ^g Children living in formal kin care were significantly less likely to have attended a well-child checkup in the past 12 months than children living in formal kin care ($p < .01$) and children living in a group home or residential treatment center ($p < .05$).
- ^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).
- ⁱ Children with no insurance were significantly less likely to have attended a well-child checkup in the past 12 months than children with private insurance ($p < .001$) and children with public insurance ($p < .001$).

Exhibit 6. Delayed Child Medical Care Due to Cost by Caregiver Report at Wave 2

	<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	4,958	9.7	1.1	2.9	0.5	2.5	0.4	4.7	0.7	3.2	0.7
Gender											
Male	2,541	9.4	1.4	3.3	0.9	2.0	0.4	4.5	0.9	2.8	0.7
Female	2,417	10.0	1.5	2.5	0.6	2.9	0.7	4.8	1.0	3.6	1.2
Age (years)		***				***		**		***	
1–2	2,222	3.4 ^b	1.0	2.1	0.9	0.1	0.1	1.7	0.7	0.1	0.1
3–5	765	4.8 ^c	1.2	2.9	1.0	0.5	0.4	2.3	1.0	0.8	0.4
6–10	954	10.6	2.2	3.3	1.2	2.1 ^d	0.7	3.6	1.1	4.4 ^e	1.6
11–17	1,015	14.5	1.9	2.8	0.8	5.0 ^f	0.9	8.2 ^g	1.6	4.8 ^h	1.4
Race/ethnicity						*		***		*	
Black	1,564	6.0	1.2	2.0	0.5	3.0	1.0	1.0 ⁱ	0.4	0.9 ^j	0.5
White	1,675	9.6	1.7	3.7	1.2	2.2	0.6	4.7	0.8	2.8	0.8
Hispanic	1,376	12.7	2.6	2.8	0.9	3.0	1.0	6.9	1.8	5.9	2.0
Other	324	10.4	2.8	1.9	1.1	0.4 ^k	0.3	7.4	2.6	1.6	0.7
Setting		***		***		**		**		**	
In-home	3,410	10.1 ^l	1.2	3.0 ^m	0.6	2.7 ⁿ	0.4	5.0 ^o	0.8	3.2 ^p	0.7
Formal kin care	414	2.6	1.0	0.2	0.1	1.5	0.9	1.0	0.6	0.2	0.2
Informal kin care	416	10.5	5.1	4.1	2.5	0.8	0.8	4.0	2.6	5.4	4.1
Foster care	651	3.2	2.0	1.0	0.6	2.5	1.9	0.5	0.4	0.8	0.6
Group home or residential program	46	1.1	1.1	0.0	0.0	0.0	0.0	1.1	1.1	0.0	0.0
Current insurance status		**						*			
Private	506	15.6	3.3	5.2	2.7	4.4	1.2	6.0	1.8	3.4	1.1
Public ^q	4,144	6.5 ^r	0.8	1.7	0.4	1.4	0.4	3.3	0.7	2.7	0.7
Other	73	29.6	10.2	2.6	2.6	17.0	10.0	9.8	5.7	4.9	3.4
None	233	23.7	5.9	9.9	3.6	4.6	2.2	14.1 ^s	4.2	6.2	4.4

Note: All analyses were on weighted NSCAW II Wave 2 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 1 to 2 years old were significantly less likely to have delayed medical care due to cost than children 6 to 10 years old ($p < .01$) and children 11 to 17 years old ($p < .001$).
- ^c Children 3 to 5 years old were significantly less likely to have delayed medical care due to cost than children 6 to 10 years old ($p < .05$) and children 11 to 17 years old ($p < .001$).
- ^d Children 6 to 10 years old were significantly more likely to have delayed mental health care or counseling due to cost than children 1 to 2 years old ($p < .01$).
- ^e Children 6 to 10 years old were significantly more likely to have delayed eyeglasses due to cost than children 1 to 2 years old ($p < .05$) and children 3 to 5 years old ($p < .05$).
- ^f Children 11 to 17 years old were significantly more likely to have delayed mental health care or counseling due to cost than children 1 to 2 years old ($p < .001$), children 3 to 5 years old ($p < .01$), and children 6 to 10 years old ($p < .05$).
- ^g Children age 11 to 17 were significantly more likely to have delayed dental care due to cost than children 0 to 2 years old ($p < .001$), children 3 to 5 years old ($p < .01$), and children 6 to 10 years old ($p < .05$).
- ^h Children 11 to 17 years old were significantly more likely to have delayed eyeglasses due to cost than children 1 to 2 years old ($p < .01$) and children 3 to 5 years old ($p < .01$).
- ⁱ Black children were significantly less likely to have delayed dental care due to cost than White children ($p < .001$), Hispanic children ($p < .01$), and children of other races ($p < .05$).
- ^j Black children were significantly less likely to have delayed eyeglasses due to cost than White children ($p < .05$) and Hispanic children ($p < .05$).
- ^k Children of other race were significantly less likely to have delayed mental health care or counseling due to cost than Black children ($p < .05$), White children ($p < .05$), and Hispanic children ($p < .05$).
- ^l 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 ($p < .001$), foster care ($p < .01$), and in a group home or residential treatment center ($p < .01$).
- ^m Children living in-home with parents were more likely to have delayed prescription medication due to cost than children living in formal kin care ($p < .001$), children living in foster care ($p < .01$), and children living in a group home or residential treatment center ($p < .001$).
- ⁿ Children living in-home with parents were significantly more likely to have delayed mental health care or counseling due to cost than children living in a group home or residential treatment center ($p < .001$).
- ^o Children living in-home with parents were more likely to have delayed dental care due to cost than children living in formal kin care ($p < .01$), children living in foster care ($p < .001$), and children living in a group home or residential treatment center ($p < .05$).
- ^p Children living in-home with parents were more likely to have delayed eyeglasses due to cost than children living in formal kin care ($p < .001$), children living in foster care ($p < .05$), and children living in a group home or residential treatment center ($p < .001$).
- ^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 insurance were significantly less likely to have delayed medical care due to cost than children with private insurance ($p < .05$) and children with no insurance ($p < .01$).
- ^s Children with no insurance were significantly more likely to have delayed dental care due to cost than children with public insurance ($p < .05$).

Exhibit 7. Dental Care for Children 2 to 17 Years Old by Caregiver Report at Wave 2

	<i>N</i>	Dental care in the past year ^a	
		%	<i>SE</i>
Total	3,576	72.4	1.5
Gender			
Male	1,851	72.6	2.0
Female	1,725	72.2	1.8
Age (years)		***	
2–5	1,626	60.0	3.3
6–10	948	81.5 ^b	1.9
11–17	1,000	75.6 ^c	1.9
Race/ethnicity			
Black	1,058	68.0	3.2
White	1,292	75.3	2.5
Hispanic	965	69.8	3.3
Other	253	77.8	4.0
Setting			
In-home	2,594	72.4	1.7
Formal kin care	255	71.4	7.0
Informal kin care	298	68.3	5.3
Foster care	378	85.7	4.4
Group home or residential program	34	76.2	13.1
Current insurance status			
Private	416	77.5	2.7
Public ^d	2,911	72.5	1.8
Other	55	75.5	10.3
None	192	59.5	6.1

Note: All analyses were on weighted NSCAW II Wave 2 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. 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 Children 6 to 10 years old were significantly more likely to receive dental care in the past year than children 2 to 5 years old ($p < .001$) and children 11 to 17 years old ($p < .05$).

^c Children 11 to 17 years old were significantly more likely to receive dental care in the past year than children 2 to 5 years old ($p < .001$).

^d “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.

Exhibit 8. Children’s Urgent Medical Care in the Past Year by Caregiver Report at Wave 2

	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>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	4,922	31.0	1.9	4,930	4.6	0.6	4,927	8.7	1.1
Gender									
Male	2,522	31.5	2.4	2,526	4.5	1.0	2,524	9.7	1.5
Female	2,400	30.5	2.3	2,404	4.8	0.8	2,403	7.7	1.2
Age (years)		*			***				
1–2	2,212	42.6 ^a	4.1	2,212	8.6 ^b	1.6	2,211	8.7	2.4
3–5	763	32.7	3.8	763	2.4	0.7	762	7.7	2.0
6–10	949	25.8	2.3	947	3.1	1.2	949	5.3	0.9
11–17	996	30.0	2.9	1,006	6.0 ^c	1.2	1,003	12.4	2.1
Race/ethnicity		**						*	
Black	1,553	25.7 ^d	3.0	1,558	4.3	0.8	1,557	5.5 ^e	1.5
White	1,664	37.7 ^f	2.4	1,665	4.0	0.9	1,663	11.3	1.6
Hispanic	1,368	24.2	3.1	1,367	5.6	1.4	1,368	6.8	1.8
Other	318	37.9	6.1	321	5.6	2.6	320	12.6	3.5
Setting					*			*	
In-home	3,402	31.4	2.1	3,405	4.8 ^g	0.7	3,404	9.1 ^h	1.2
Formal kin care	412	17.2	4.2	412	2.3	1.0	412	4.1	1.1
Informal kin care	415	32.4	5.1	416	1.9	1.0	416	6.2	2.0
Foster care	636	26.8	4.7	637	7.1 ⁱ	1.7	636	8.8	3.7
Group home or residential program	37	33.4	13.8	40	19.2	14.4	39	6.6	3.8
Current insurance status									
Private	37	33.4	13.8	40	19.2	14.4	39	6.6	3.8
Public ^j	503	32.2	3.8	506	3.5	1.2	504	11.8	2.7
Other	4,116	31.2	2.3	4,120	5.1	0.7	4,119	8.1	1.1
None	73	28.4	9.4	73	2.5	2.0	73	14.0	8.1

Note: All analyses were on weighted NSCAW II Wave 2 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.

- ^a Children 1 to 2 years old were significantly more likely to visit an ER or urgent care for illness or injury than children 6 to 10 years old ($p < .01$) and children 11 to 17 years old ($p < .01$).
- ^b Children age 1 to 2 years old were significantly more likely to have an overnight hospital admission for illness or injury than children 3 to 5 years old ($p < .001$) and children 6 to 10 years old ($p < .05$).
- ^c Children 11 to 17 years old were significantly more likely to have an overnight hospital admission for illness or injury than children 3 to 5 years old ($p < .01$).
- ^d Black children were significantly less likely to visit an ER or urgent care for illness or injury than White children ($p < .01$) and children of other race ($p < .05$).
- ^e Black children were significantly less likely to have an injury, accident, or poisoning that needed care from a doctor or nurse than White children ($p < .01$).
- ^f White children were significantly more likely to visit an ER or urgent care for illness or injury than Hispanic children ($p < .01$).
- ^g Children living in-home with parents were significantly less likely to have an overnight hospital admission for illness or injury than children living in informal kin care ($p < .05$).
- ^h Children living in-home with parents were significantly more likely to have an injury, accident, or poisoning that needed care from a doctor or nurse than children living in formal kin care ($p < .01$).
- ⁱ Children living in foster care were more likely to have an overnight hospital admission for illness or injury than children living in formal kin care ($p < .01$) and children living in informal kin care ($p < .05$).
- ^j “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.

Exhibit 9. Risk of a Behavioral/Emotional Problem Among Children 1.5 to 17 Years Old at Wave 2

	<i>N</i>	Risk of a behavioral/emotional problem ^a	
		%	<i>SE</i>
Total	4,801	37.1	1.3
Gender			
Male	2,464	36.8	2.0
Female	2,337	37.4	1.8
Age (years)		***	
1.5–5	2,844	16.5	1.9
6–10	937	44.3 ^b	2.7
11–17	1,020	52.0 ^c	2.4
Race/ethnicity			
Black	1,499	34.3	3.1
White	1,646	39.4	1.9
Hispanic	1,319	35.4	2.7
Other	321	40.1	5.6
Setting			
In-home	3,324	36.7	1.3
Formal kin care	397	34.3	7.1
Informal kin care	403	35.4	4.8
Foster care	612	45.8	4.7
Group home or residential program	46	70.4	15.2
Insurance status			
Private	492	40.1	4.5
Public ^d	3,996	36.8	1.6
Other	72	37.3	9.7
Uninsured	230	32.0	5.2

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 to test statistical significance. Statistical significance is noted by asterisks in the column above the statistically significant result (*** $p < .001$).

^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 6 to 10 years old were significantly more likely to be identified as having a behavioral/emotional problem than children 1.5 to 5 years old ($p < .001$).

^c Children 11 to 17 years old were significantly more likely to be identified as having a behavioral/emotional problem than children 1.5 to 5 years old ($p < .001$) and children 6 to 10 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 SCHIP.

Exhibit 10. Risk of a Behavioral/Emotional Problem and Substance Abuse Problem Among Children 11 to 17 Years Old At Wave 2

	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	1,021	52.0	2.4	931	14.6	1.4	1,021	55.5	2.4
Gender									
Male	468	49.9	3.5	417	14.1	2.7	468	54.9	3.0
Female	553	53.5	3.2	514	14.9	2.1	553	56.0	3.2
Age (years)		*			***			**	
11–12	327	43.5 ^c	3.9	283	3.8	1.9	327	43.9 ^d	3.9
13–14	284	56.8	4.3	267	9.3	2.5	284	60.0	4.6
15–17	410	55.3	4.6	381	27.1 ^e	2.9	410	61.9	4.8
Race/ethnicity									
Black	279	53.7	5.2	253	9.9	3.2	279	55.0	5.3
White	386	49.9	3.7	345	16.4	2.3	386	54.4	3.9
Hispanic	248	56.8	5.1	231	17.3	3.6	248	61.3	4.9
Other	105	46.0	8.3	99	8.7	4.2	105	47.2	8.5
Setting					**			***	
In-home	725	51.0	2.6	670	12.6	1.5	725	54.0	2.5
Formal kin care	52	62.9	12.1	46	4.3 ^f	2.4	52	64.0	12.1
Informal kin care	92	54.6	9.3	80	34.5 ^g	8.5	92	61.3	9.1
Foster care	107	56.2	8.4	93	18.7	5.6	107	63.2	8.5
Group home or residential program	34	71.5	17.4	31	46.1	17.0	34	96.7 ^h	2.0
Insurance status									
Private	164	48.9	5.7	149	12.2	2.8	164	53.5	5.7
Public ⁱ	757	54.1	2.9	688	15.2	2.0	757	57.5	2.9
Other	14	54.5	19.4	14	7.5	5.6	14	55.9	19.3
Uninsured	77	43.0	9.1	71	19.3	5.5	77	46.0	7.7

Note: All analyses were on weighted NSCAW II Wave 2 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 (* $p < .05$, ** $p < .01$, *** $p < .001$). An asterisk in a column applies to the subsequent results for the covariate. The table originally posted displayed the *N* of children in the clinical range instead of the total number of children. The table was updated to display total *Ns*.

^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 CBCL, YSR, TRF, 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 behavioral/emotional problem than children 13 to 14 years old ($p < .05$) and 15 to 17 years old ($p < .05$).

^d Children 11 to 12 years old were significantly less likely to be at risk for a behavioral/emotional or substance abuse problem than children 13 to 14 years old ($p < .05$) and 15 to 17 years old ($p < .01$).

^e Children 15 to 17 years old were significantly more likely to be at risk of a substance abuse problem than children 11 to 12 years old ($p < .001$) and 13 to 14 years old ($p < .001$).

^f Children living in formal kin care were significantly less likely to be at risk for substance abuse problem than children living in informal kin care ($p < .05$), children living in foster care ($p < .05$) and children living in a group home or residential treatment program ($p < .05$).

^g Children living in informal kin care were significantly more likely to be at risk for substance abuse problem than children living in-home ($p < .05$).

^h Children living in a group home or residential treatment program were significantly more likely to be at risk for a behavioral/emotional or substance abuse problem than children living in-home ($p < .001$), children living in formal kin care ($p < .01$), children living in informal kin care ($p < .05$), and children living in foster care ($p < .01$).

ⁱ “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.

Exhibit 11. Specialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2

	Outpatient services ^a in the past year ^b			Inpatient services ^c in the past year		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	4,949	17.9	1.2	4,948	3.5	0.6
Gender						
Male	2,534	20.0	1.7	2,534	4.1	1.0
Female	2,415	15.7	1.5	2,414	2.9	0.7
Age (years)		***			***	
1.5–5	2,982	7.2 ^d	1.5	2,983	0.1 ^e	0.0
6–10	953	21.7	2.5	952	3.2 ^f	1.2
11–17	1,012	25.6	2.8	1,011	7.3	1.1
Race/ethnicity		***				
Black	1,562	12.3	1.9	1,562	3.7	1.0
White	1,672	25.5 ^g	2.2	1,671	3.9	1.2
Hispanic	1,372	11.3	1.5	1,372	2.4	0.6
Other	324	18.5	3.6	324	5.3	2.4
Setting		***			*	
In-home	3,410	16.6	1.3	3,409	3.2	0.6
Formal kin care	413	15.2	4.5	413	4.0	3.3
Informal kin care	415	18.9	3.8	415	2.4	1.2
Foster care	645	45.6 ^h	4.9	646	4.4	1.3
Group home or residential program	45	78.9 ⁱ	6.5	44	53.8 ^j	11.5
Insurance						
Private	506	19.5	4.0	506	3.0	1.0
Public ^k	4,138	17.8	1.4	4,137	3.7	0.7
Other	73	20.4	7.3	73	2.2	2.2
None	231	15.3	3.6	231	3.3	1.8
Risk of a behavioral/ emotional problem (1.5- to 10-year-olds only)^l		***			*	
Yes	925	29.5	2.8	925	4.6	1.9
No	2,847	7.6	1.4	2,847	0.2	0.2
Risk of a behavioral/ emotional problem or substance use problem (11- to 17-year-olds only)^m		***			***	
Yes	593	35.0	3.7	592	11.6	1.9
No	419	14.0	3.1	419	2.0	0.8

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 Wave 2 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. The table originally posted did not include children under 2 years old. The problem has been resolved and all estimates were updated for this version.

- ^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 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 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 ($p < .001$).
- ^e Children 1.5 to 5 years old were significantly less likely to have received inpatient services in the past 12 months than children 6 to 10 years old ($p < .05$) and 11 to 17 years old ($p < .001$).
- ^f Children 6 to 10 years old were significantly less likely to have received inpatient services in the past 12 months than children 11 to 17 years old ($p < .01$).
- ^g White children were significantly more likely to have received outpatient behavioral health services in the past 12 months than Black and Hispanic children ($p < .001$).
- ^h Children living in foster care were significantly more likely to have used outpatient behavioral services in the past 12 months than children living in-home with parents ($p < .001$), formal kin care ($p < .001$), and informal kin care ($p < .001$).
- ⁱ Children living in a group home or residential treatment program were significantly more likely to have used outpatient behavioral services in the past 12 months than children living in-home with parents ($p < .001$), formal kin care ($p < .001$), informal kin care ($p < .001$), and foster care ($p < .01$).
- ^j Children living in a group home or residential treatment program were significantly more likely to have used inpatient services in the past 12 months than children living in-home with parents ($p < .01$), formal kin care ($p < .01$), informal kin care ($p < .01$), and foster care ($p < .01$).
- ^k “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.
- ^l Risk 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 CBCL (administered for children 1.5 to 18 years old), YSR (administered to children 11 years old and older), the TRF (administered for children 6 to 18 years old); the 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).
- ^m 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 12. Nonspecialty Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2

	Family doctor ^a in the past year ^b			School-based services ^c in the past year		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	4,944	8.0	0.7	4,928	11.9	1.0
Gender		*			***	
Male	2,531	10.0	1.4	2,524	15.1	1.5
Female	2,413	6.0	0.8	2,404	8.6	0.9
Age (years)		***			***	
1.5–5	2,983	2.4 ^d	0.8	2,980	2.9 ^e	1.0
6–10	951	13.2	2.0	949	16.5	2.1
11–17	1,008	9.3	1.4	997	17.3	2.1
Race/ethnicity		***			***	
Black	1,561	5.7	1.1	1,558	11.4	1.7
White	1,668	12.7 ^f	1.6	1,662	15.4	1.8
Hispanic	1,373	3.7	0.6	1,367	7.2 ^g	1.2
Other	323	6.1	2.3	322	12.5	4.4
Setting		*				
In-home	3,408	8.4	0.8	3,396	11.5	1.1
Formal kin care	413	5.4	2.8	412	10.6	4.3
Informal kin care	415	3.2 ^h	1.6	415	11.2	2.2
Foster care	645	9.6	2.0	642	21.1	4.0
Group home or residential program	42	9.4	4.1	42	29.0	14.2
Insurance						
Private	504	8.4	2.1	505	15.5	3.4
Public ⁱ	4,135	8.1	0.8	4,118	11.4	1.0
Other	73	7.6	4.4	73	10.8	5.3
None	231	6.2	3.1	231	9.5	3.2
Risk of a behavioral/ emotional problem (1.5- to 10-year-olds only)^j		***			***	
Yes	925	16.5	2.3	922	21.0	2.5
No	2,847	3.6	1.1	2,844	4.3	1.1
Risk of a behavioral/ emotional problem or substance use problem (11- to 17-year-olds only)^k					***	
Yes	589	12.1	2.0	581	23.5	2.5
No	419	5.9	2.1	416	9.6	2.4

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 Wave 2 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. The table originally posted did not include children under 2 years old. The problem has been resolved and all estimates were updated for this version.

- ^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 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 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 ($p < .001$) and 11 to 17 years old ($p < .001$).
- ^e 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 ($p < .001$).
- ^f White children were significantly more likely to have received behavioral health services from a family doctor in the past 12 months than Black ($p < .01$) and Hispanic children ($p < .001$).
- ^g Hispanic children were significantly less likely to have received school-based behavioral health services in the past 12 months than Black ($p < .05$) and White children ($p < .001$).
- ^h Children living in informal kin care were significantly less likely to have received behavioral health services from a family doctor in the past 12 months than children living in-home with parents ($p < .05$), and in foster care ($p < .05$).
- ⁱ “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.
- ^j Risk 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 CBCL (administered for children 1.5 to 18 years old), YSR (administered to children 11 years old and older), the TRF (administered for children 6 to 18 years old), the 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).
- ^k 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 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 13. Any Behavioral Health Service Use for Children 1.5 to 17 Years Old by Caregiver Report at Wave 2

	<i>N</i>	Any behavioral health service ^a in the past year ^b	
		%	<i>SE</i>
Total	4,951	24.4	1.4
Gender		*	
Male	2,536	27.6	2.0
Female	2,415	21.1	1.7
Age (years)		***	
1.5–5	2,983	9.2 ^c	1.6
6–10	954	33.5	2.5
11–17	1,012	32.2	3.1
Race/ethnicity		***	
Black	1,562	19.2	2.2
White	1,673	34.1 ^d	2.1
Hispanic	1,373	15.3	1.9
Other	324	21.9	4.3
Setting		***	
In-home	3,410	23.4	1.5
Formal kin care	413	18.7	5.0
Informal kin care	415	23.8	3.7
Foster care	647	48.7 ^e	4.8
Group home or residential program	45	81.9 ^f	6.3
Insurance			
Private	506	26.3	4.1
Public ^g	4,140	24.7	1.6
Other	73	25.3	8.5
None	231	17.4	3.9
Risk of a behavioral/ emotional problem (1.5- to 10-year-olds only)^h		***	
Yes	927	43.0	2.5
No	2,847	11.1	1.7
Risk of a behavioral/ emotional problem or substance use problem (11- to-17-year-olds only)ⁱ		***	
Yes	593	42.3	3.9
No	419	19.6	3.4

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 Wave 2 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. The table originally posted did not include children under 2 years old. The problem has been resolved and all estimates were updated for this version.

^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 for the past 12 months.
- ^c 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 ($p < .001$).
- ^d White children were significantly more likely to have used any behavioral health service in the past 12 months than Black ($p < .001$), Hispanic children ($p < .001$), and Other ($p < .05$).
- ^e Children living in foster care were significantly more likely to have used any behavioral health service in the past 12 months than children living in-home with parents ($p < .001$), formal kin care ($p < .001$), and informal kin care ($p < .001$).
- ^f Children living in a group home or residential treatment program were significantly more likely to have used any behavioral health service in the past 12 months than children living in-home with parents ($p < .001$), formal kin care ($p < .001$), informal kin care ($p < .001$), and foster care ($p < .01$).
- ^g “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.
- ^h Risk 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 CBCL (administered for children 1.5 to 18 years old), YSR (administered to children 11 years old and older), the TRF (administered for children 6 to 18 years old), the 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).
- ⁱ 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 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 14. Current Use of Psychotropic Medications Among Children 1.5 to 17 Years Old by Caregiver Report at Wave 2

	<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	4,802	11.7	1.2	3.1	0.8	3.1	0.5
Gender		*		*			
Male	2,454	14.9	2.0	4.4	1.1	3.7	0.8
Female	2,348	8.5	1.2	1.9	0.5	2.5	0.6
Age (years)		***		**		***	
1.5–5	2,976	1.6 ^a	0.5	0.5 ^b	0.3	0.2 ^c	0.2
6–10	926	20.1	2.8	4.6	1.6	4.8	1.3
11–17	900	15.4	2.3	4.8	1.3	4.8	1.1
Race/ethnicity		*				***	
Black	1,531	8.8	1.7	2.9	1.5	1.1	0.5
White	1,592	18.2 ^d	2.8	4.7	1.6	5.0 ^e	0.9
Hispanic	1,350	6.2	1.3	1.8	0.6	1.8	0.7
Other	310	8.1	2.8	0.7	0.4	4.2	2.1
Setting		***				***	
In-home	3,301	10.9	1.2	2.8	0.7	2.9 ^f	0.6
Formal kin care	409	15.9	5.8	10.0	6.1	0.6	0.4
Informal kin care	403	11.9	3.2	2.0	1.1	2.5	1.3
Foster care	628	23.8 ^g	4.6	5.3	1.2	9.3 ^h	3.1
Group home or residential program	42	67.4 ⁱ	9.6	8.4	4.4	40.2 ^j	13.6
Insurance status						**	
Private	494	8.8	1.4	2.3	0.9	1.6	0.8
Public ^k	4,014	12.9	1.5	3.5	0.9	3.7 ^l	0.7
Other	72	9.3	5.1	1.0	0.7	0.0	0.0
None	221	6.4	2.6	2.4	2.1	1.7	1.6

Note: All analyses were on weighted NSCAW II Wave 2 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. The table originally posted did not include children under 2 years old. The problem has been resolved and all estimates were updated for this version.

- ^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 medication than children 6 to 10 years old ($p < .05$) and 11 to 17 years old ($p < .01$).
- ^c Children 1.5 to 5 years old were significantly less likely to be currently using three or more psychotropic medication than children 6 to 10 years old ($p < .01$) and 11 to 17 years old ($p < .001$).
- ^d White children were significantly more likely to be currently using any psychotropic medication than Black ($p < .01$), and Hispanic children ($p < .01$).
- ^e White children were significantly more likely to be currently using three or more psychotropic medication than Black ($p < .001$), and Hispanic children ($p < .05$).
- ^f Children living in in-home with parents were significantly more likely to be currently using three or more psychotropic medication than children living in formal kin care ($p < .05$).
- ^g Children living in foster care were significantly more likely to be currently using any psychotropic medication than children living in-home with parents ($p < .05$).
- ^h Children living in foster care were significantly more likely to be currently using three or more psychotropic medication than children living in formal kin care ($p < .01$).
- ⁱ 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 parents ($p < .01$), formal kin care ($p < .01$), informal kin care ($p < .01$), and foster care ($p < .01$).
- ^j Children living in a group home or residential treatment program were significantly more likely to be currently using three or more psychotropic medication than children living in-home with parents ($p < .05$), formal kin care ($p < .05$), and informal kin care ($p < .05$).
- ^k “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.
- ^l Children with public insurance were significantly more likely to be currently using three or more psychotropic medication than children with “Other insurance, including military health plan” insurance ($p < .001$).

Exhibit 15. Participation in Child Care, Head Start, and Early Intervention Services Among Children 1 to 5 Years Old At Wave 2

	Any type of day care program ^a			Head Start ^b			IFSP/IEP ^c		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	3,395	27.2	2.1	976	28.2	5.3	2,975	8.5	1.3
Gender								***	
Male	1,776	28.2	2.8	530	22.9	6.0	1,545	13.0	2.3
Female	1,619	26.0	2.7	446	35.0	7.0	1,430	3.4	0.6
Age (years)		***			**				
1–2	2,210	20.2	2.9	585	10.3	5.2	2,212	9.5	1.8
3–5	762	41.0	2.9	339	36.8	7.0	763	7.9	1.6
Race/ethnicity									
Black	1,140	31.8	3.2	399	36.6	6.4	1,011	4.6	1.1
White	1,086	28.4	3.4	310	23.1	8.4	915	11.2	2.4
Hispanic	974	22.7	4.7	224	30.4	11.0	873	8.9	2.2
Other	179	22.6	6.9	40	12.3	8.6	162	5.3	2.3
Setting								*	
In-home	2,289	25.9	2.2	564	29.0	5.6	1,954	7.9	1.3
Formal kin care	321	42.7	9.9	136	25.9	11.4	296	10.0 ^d	2.5
Informal kin care	288	29.6	8.5	68	16.8	9.2	258	3.7	1.3
Foster care	497	44.0	6.8	208	36.3	13.5	454	33.7 ^e	7.6
Insurance status								*	
Private	278	32.4	7.3	83	14.4	6.8	218	8.7	3.4
Public ^f	2,940	26.6	2.1	849	30.8	6.0	2,602	9.2	1.6
Other	48	25.8	7.9	14	12.0	8.9	43	3.2	2.4
Uninsured	129	26.6	7.5	30	29.1	12.3	108	1.2 ^g	0.6
Developmental Problems^h								***	
Yes	793	22.9	4.1	236	21.8	7.0	1,339	17.7	2.8
No	2,602	28.4	2.5	740	29.6	6.0	1,634	1.7	0.4

Note: All analyses were on weighted NSCAW II Wave 2 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 (* $p < .05$, ** $p < .01$, *** $p < .001$). An asterisk in a column applies to the subsequent results for the covariate. IFSP = Individualized Family Service Plan; IEP = Individualized Education Program.

^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 living in formal kin care were significantly more likely to have an IFSP/IEP than children living in informal kin care ($p < .05$)

^e Children living foster care were significantly more likely to have an IFSP/IEP than children living in-home ($p < .01$), children living in formal kin care ($p < .05$), and children living in informal kin care ($p < .01$)

^f “Public” includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.

^g Uninsured children were significantly less likely to have an IFSP/IEP than children with private insurance ($p < .05$), and children with public insurance ($p < .01$).

^h Developmental problem 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 BDI or K-BIT, communication development based on the PLS-3, and adaptive development based on the Vineland Daily Living Skills.

Exhibit 16. Developmental Problems Among Children 1 to 5 Years Old at Wave 2

	<i>N</i>	Developmental Problems ^a	
		%	<i>SE</i>
Total	2,992	42.6	2.6
Gender		***	
Male	1,560	50.6	3.4
Female	1,432	33.5	3.6
Age (years)			
1–2	2,225	50.4	5.0
3–5	767	38.3	3.1
Race/ethnicity			
Black	1,015	37.8	5.9
White	922	42.9	4.2
Hispanic	877	46.0	4.4
Other	164	43.0	13.0
Setting		**	
In-home	1,962	44.3 ^b	2.7
Formal kin care	297	20.2	4.7
Informal kin care	258	24.4	5.9
Foster care	461	52.8 ^c	7.1
Insurance status			
Private	219	42.4	7.9
Public ^d	2,616	42.5	3.0
Other	43	26.3	10.2
Uninsured	109	47.5	11.6

Note: All analyses were on weighted NSCAW II Wave 2 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 (** $p < .01$, *** $p < .001$). An asterisk in a column applies to the subsequent results for the covariate. This table has been revised since its original posting on December 18, 2012. A problem was identified in the basal score calculation for a subset of children receiving the KBIT, and/or BDI-2. 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 Developmental problem 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 BDI or K-BIT, communication development based on the PLS-3, and adaptive development based on the Vineland Daily Living Skills.

^b Children living in-home were significantly more likely to be identified as having developmental problem than children living in formal kin care ($p < .05$) and children living in informal kin care ($p < .05$).

^c Children living in foster care were significantly more likely to be identified as having developmental problem than children living in formal kin care ($p < .01$) and children living in informal kin 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 SCHIP.

Exhibit 17. Special Education Service Use and Risk of Behavioral/Emotional and/or Cognitive Problems Among Children 6 to 17 Years Old At Wave 2

	Risk of any behavioral/emotional and/or cognitive problems			Children with IEP ^a		
	<i>N</i>	%	<i>SE</i>	<i>N</i>	%	<i>SE</i>
Total	1,908	55.8	2.2	1,960	24.8	1.8
Gender					***	
Male	963	56.9	3.2	977	32.3	2.6
Female	945	54.8	2.9	983	17.4	2.0
Age (years)						
6–10	894	52.0	3.7	947	21.7	2.1
11–17	1,014	58.9	2.4	1,013	27.4	2.5
Race/ethnicity					*	
Black	538	55.2	4.5	547	22.6	3.2
White	732	60.4	3.3	752	30.3 ^b	2.1
Hispanic	475	53.1	3.5	496	19.2	3.4
Other	160	43.9	5.4	160	22.3	5.4
Setting					*	
In-home	1,405	55.1	2.5	1,446	24.4	1.9
Formal kin care	110	55.4	9.5	116	24.8	8.2
Informal kin care	157	57.3	5.5	157	18.9	6.2
Foster care	183	69.1	6.3	191	44.8 ^c	6.0
Group home or residential program	40	72.7	15.7	37	55.3 ^d	14.5
Insurance status						
Private	279	50.9	5.5	283	20.8	3.5
Public ^e	1,471	59.0	2.4	1,518	27.0	2.0
Other	28	47.5	13.2	30	17.3	8.9
Uninsured	121	42.7	6.8	121	18.2	5.0
Risk of behavioral/emotional or cognitive problems^f					***	
Cognitive only	—	—	—	148	35.6	6.4
Behavioral/emotional only	—	—	—	710	26.6	2.6
Both cognitive and behavioral/emotional	—	—	—	225	64.5 ^g	4.4
Neither cognitive or behavioral	—	—	—	809	11.6 ^h	2.0

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 December 18, 2012. A problem was identified in the basal score calculation for a subset of children receiving the KBIT and 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 White children were significantly more likely to have an IEP than Black ($p < .05$) and Hispanic children ($p < .01$).
- ^c Children living foster care were significantly more likely to have an IEP than children living in-home ($p < .01$), and children living in informal kin care ($p < .05$)
- ^d Children living in group home/residential treatment were significantly more likely to have an IEP than children living in informal kin care ($p < .05$).
- ^e "Public" includes children who did not have private coverage at the time of interview, but who had Medicaid and/or a SCHIP.
- ^f 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 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).
- ^g Children with both cognitive and behavioral problems were significantly more likely to have an IEP than children with only cognitive problems ($p < .001$) and children with only behavioral problems ($p < .001$)
- ^h Children with neither cognitive or behavioral problems were significantly less likely to have an IEP than children with only cognitive problems ($p < .001$), children with only behavioral problems ($p < .001$) and children with both cognitive and behavioral problems ($p < .001$).

REFERENCES

- Achenbach, T. M. (1991a). *Integrative guide for the 1991 CBCL/4-18, YSR, and TRF profiles*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Achenbach, T. M. (1991b). *Manual for the Child Behavior Checklist/4-18 and 1991 profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Achenbach, T. M. (1991c). *Manual of the Teacher's Report Form and 1991 Profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the ASEBA School-Age Forms and Profiles*. Burlington, VT: University of Vermont, Research Center for Children, Youth & Families.
- Ascher, B. H., Farmer, E. M. Z., Burns, B. J., & Angold, A. (1996). The Child and Adolescent Services Assessment (CASA): Description and psychometrics. *Journal of Emotional and Behavioral Disorders*, 4(1), 12–20.
- Bloom, B., Cohen, R. A., & Freeman, G. (2011). Summary health statistics for U.S. children: National Health Interview Survey, 2010. National Center for Health Statistics. *Vital Health Statistics*, 10(250).
- Briere, J. (1996). *Trauma Symptom Checklist for Children: Professional manual*. Lutz, FL: Psychological Assessment Resources.
- Burns, B. J., Angold, A., Magruder-Habib, K., Costello, E. J., & Patrick, M. K. S. (1994). *The Child and Adolescent Services Assessment (CASA), parent interview and child interview*. Durham, NC: Developmental Epidemiology Program, Department of Psychiatry, Duke University Medical Center.
- Burns, B. J., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M. Z., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14(3), 147–159.
- Cohen, R. A., Ward, B. W., & Schiller, J. S. (2011, June). *Health insurance coverage: early release of estimates from the National Health Interview Survey, 2010*. National Center for Health Statistics. Retrieved May 31, 2012, from <http://www.cdc.gov/nchs/nhis.htm>
- Danaher, J. (2005). Eligibility policies and practices for young children under Part B of IDEA. *NECTAC Notes*, 15, 1–17.
- Farmer, E. M. Z., Angold, A., Burns, B. J., & Costello, E. J. (1994). Reliability of self-reported service use: Test-retest consistency of children's responses to the Child and Adolescent Services Assessment (CASA): Description and psychometrics. *Journal of Child and Family Studies*, 3, 307–325.

- Hassan, A., Harris, S. K., Sherritt, L., Van Hook, S., Brooks, T., Carey, P., Kossack, R., Kulig, J., & Knight, J. R. (2009). Primary care follow-up plans for adolescents with substance use problems. *Pediatrics*, *124*(1), 144-150.
- Hebbeler, K. M., Spiker, D., Bailey, D., Scarborough, A., Mallik, S., Simeonsson, R., Singer, M., & Nelson, L. (2007). *Early intervention for infants and toddlers with disabilities and their families: Participants, services and outcomes. Final report of the National Intervention Longitudinal Study*. Retrieved December 10, 2007, from <http://www.sri.com/neils/reports.html>
- Hodapp, R. M., & Fidler, D. J. (1999). Special education and genetics: Connections for the 21st century *Journal of Special Education*, *33*(3), 130–137.
- Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*(9), 1548–1555.
- Kaufman, A., & Kaufman, N. (1990). *Kaufman Brief Intelligence Test (K-BIT)*. Circle Pines, MN: American Guidance Service.
- Kaufman, A. S., & Kaufman, N. L. (2004). *Kaufman Assessment Battery for Children manual* (2nd ed.). Circle Pines, MN: American Guidance Service.
- Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K., & Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent Medicine*, *156*(6), 607–614.
- Kovacs, M. (1992a). *Children's Depression Inventory*. North Tonawanda, NY: Multi-Health Systems.
- Kovacs, M. (1992b). *The Children's Depression Inventory (CDI) manual*. Toronto: Multi-Health Systems.
- Merikangas, K. R., He, J. P., Brody, D., Fisher, P. W., Bourdon, K., & Koretz, D. S. (2010). Prevalence and treatment of mental disorders among US children in the 2001–2004 NHANES. *Pediatrics*, *125*(1), 75–81.
- National Survey of Children's Health (NSCH) (2007). *Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website*. Retrieved May 31, 2012, from www.childhealthdata.org
- Newborg, J. (2005). *Battelle Developmental Inventory, Second Edition: Examiner's manual*. Itasca, IL: Riverside.
- Olfson, M., Marcus, S., Weissman, M., & Jensen, P. S. (2002). National trends in the use of psychotropic medications by children. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*(5), 514–521.

- Pastor, P. N., Reuben, C. A., & Duran, C. R. (2012). Identifying emotional and behavioral problems in children aged 4–17 years: United States, 2001–2007. *National Health Statistics Report*, 48, 1-17. Retrieved from <http://www.cdc.gov/nchs/data/nhsr/nhsr048.pdf>
- Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Simpson, G. A., Cohen, R. A., Pastor, P. N., & Reuben, C. A. (2008). *Use of mental health services in the past 12 months by children aged 4–17 years: United States 2005–2006. NCHS data brief, N. 8*. Retrieved January 15, 2009, from <http://www.cdc.gov/nchs/data/databriefs/db08.pdf>.
- Sparrow, S. S., Carter, A. S., & Cicchetti, D. V. (1993). *Vineland screener: overview reliability, validity, administration and scoring*. New Haven, CT: Yale University Child Study Center.
- Substance Abuse and Mental Health Services Administration (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings* (NSDUH Series H-41, HHS Publication No. (SMA) 11-4658). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs (2011). *30th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2008* (<http://www2.ed.gov/about/reports/annual/osep/2008/parts-b-c/30th-idea-arc.pdf>). Washington, DC: Author.
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2009a). *The National Survey of Children's Health 2007: Preventive Dental Care*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved May 31, 2012, from <http://mchb.hrsa.gov/nsch/07main/national/1child/2healthcare/pages/05pdc.html>
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2009b). *The National Survey of Children's Health 2007: Preventive Health Care Visits*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved May 31, 2012, from <http://mchb.hrsa.gov/nsch/07main/national/1child/2healthcare/pages/04phcv.html>
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (2010). *The National Survey of Children's Health 2007: Mental Health Status*. Rockville, MD: U.S. Department of Health and Human Services. Retrieved May 31, 2012, from <http://www.mchb.hrsa.gov/nsch/07emohealth/national/mhs/pages/2mhs.html>

U.S. Government Accountability Office (2011). *Foster children: HHS guidance could help states improve oversight of psychotropic prescriptions* (Publication No. GAO-12-201). Washington, DC: Author.

Woodcock, R. W., McGrew, K. S., & Mather, N. (2001). *Examiner's manual: Woodcock-Johnson III Tests of Cognitive Abilities*. Itasca, IL: Riverside.

Zimmerman, I. L., Steiner, V. G., & Pond, R. E. (1992). *PLS-3: Preschool Language Scale-3*. San Antonio, TX: The Psychological Corporation.

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). The 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 the 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). 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 (W-J) 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=6).
- *Developmental Need*. Developmental problems was defined based on children 1 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 the W-J 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 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.