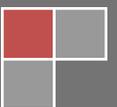


2011

CONNECTICUT'S SCHOOL BASED DIVERSION INITIATIVE

Evaluation Report

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EXECUTIVE SUMMARY

The following report contains findings from an evaluation of Connecticut's School Based Diversion Initiative (SBDI) pilot project. The Connecticut School-Based Diversion Initiative (SBDI) is a component of the John D. and Catherine T. MacArthur Foundation Models for Change Mental Health/Juvenile Justice Action Network. This initiative began in January of 2009 as a collaborative effort of the Judicial Branch's Court Support Services Division (CSSD) and the Connecticut Department of Children and Families (DCF). The Connecticut Center for Effective Practice (CCEP) coordinated the SBDI initiative which involved education and training of school personnel on recognizing mental health symptoms, accessing available community supports, cultural competency, and managing crises in the school environment; relationship building between schools and existing mental health infrastructure in the communities (in particular, the Emergency Mobile Psychiatric Services providers); and linking to local Community Collaboratives which oversee implementation of the System of Care model in Connecticut. Beginning in September 2009, the SBDI initiative was implemented in two schools/districts: 1) Luis Munoz Marin School, a Kindergarten through 8th Grade school in Bridgeport, Connecticut (urban SBDI); and 2) Joseph A. DePaolo and John F. Kennedy Middle Schools in Southington, Connecticut (suburban SBDI). Two Connecticut communities were selected as comparison sites due to comparable sociodemographic characteristics as the SBDI communities, but schools in these communities did not participate in the SBDI intervention. The comparison communities are New Haven (urban non-SBDI) and Middletown (suburban non-SBDI).

This project had three primary goals:

- 1) To build knowledge and skills of teachers and other school staff to recognize and manage behavioral health crises in school.**
- 2) To link youth with mental health needs who are at risk for juvenile justice involvement to appropriate, alternative community-based services and supports.**
- 3) To reduce the number of youth that are arrested or come into contact with law enforcement and juvenile justice systems.**

SOURCES OF DATA AND SAMPLE

The present evaluation is based on: a) individual-level data from DCF's Emergency Mobile Psychiatric Services (EMPS), which provides first response services to individuals in need of psychiatric care throughout Connecticut; b) individual-level Connecticut Judicial Branch, Court Support Services Division (CSSD) juvenile court referral data; and c) CSSD community-level juvenile court referral data. The time frame for the data extraction was 9/1/2008-8/31/2010 for the CSSD data and 9/1/2009-8/31/2010 for the EMPS data (the electronic record system was put into place in July 2009).

- From September 1, 2008 through August 31, 2009, 2471 charges were reported for 1576 youth in the four communities.
- From September 1, 2009 through August 31, 2010, 2348 youth had at least one referral to Emergency Mobile Psychiatric Services (EMPS; N = 866) or Court Support Services Division (CSSD; N = 1643) across the four communities.

GOAL 1: TO BUILD KNOWLEDGE AND SKILLS OF TEACHERS AND OTHER SCHOOL STAFF TO RECOGNIZE AND MANAGE BEHAVIORAL HEALTH CRISES IN SCHOOL.

In addition to linkages to local EMPS services and Community Collaboratives, staff at the SBDI schools received training in nine areas: Recognizing Mental Health Systems in Children, Effective Collaboration with EMPS, Parent Involvement in School Interventions, Changes in Juvenile Law, Overview of the CT Behavioral Health System, Uniform Crisis Prevention Planning, Effective Collaboration with Police and Law Enforcement, Classroom Behavior Management and Crisis De-Escalation, and Multicultural Competence and School-Based Mental Health. According to CHDI, **the SBDI was more integrated into routine practice in the suburban community** than in the urban community. The suburban district had early and strong buy-in and support from administration and staff participated in required training activities. As such, a larger number of school personnel regularly attended the training than in the urban SBDI community where logistical issues prevented the same degree of integration in the urban district.

An examination of the EMPS referral data from September 1, 2009 through August 31, 2010, shows that in comparison to the non-SBDI communities, **EMPS referrals in the SBDI communities** were not only **higher and more likely to be initiated by schools**, but referrals were for **more racially diverse youth** than what was expected based on community demographics.

- EMPS received referrals for a greater proportion of youth in the SBDI communities compared to the non-SBDI communities (1.7% vs. 1.3% of total youth population in communities).
- **Youth in the suburban SBDI community were more often referred by schools (34%) and less likely to be referred by emergency departments (7%)** than youth in the suburban non-SBDI comparison community (19% and 16%, respectively).
- Although white/Caucasian youth were disproportionately referred to EMPS and youth of color were disproportionately referred to CSSD across the four communities, **the suburban SBDI community referred fewer Caucasian individuals to EMPS than expected based on the demographic makeup of the community (81% actual vs. 96% expected) and youth of color were referred to EMPS at a higher rate than expected (6% actual vs. .8% expected)**. *The suburban comparison community had the opposite finding*, with more Caucasian youth and fewer youth of color being referred to EMPS than expected based on the community demographics.
- In the Urban non-SBDI community, fewer Caucasian youth and more youth of color were referred to EMPS than expected based on population demographics. **In the Urban SBDI community, the referrals were much more proportionate to the population demographics.**

Findings suggest that the SBDI trainings in both the suburban and urban communities may have been effective in educating school personnel on the identification of youth who are experiencing typically less outwardly disruptive psychological problems, such as depression and anxiety, as well as the identification of youth who have experienced trauma in their lives.

- Across the four communities, youth were most commonly referred to EMPS for disruptive behavior (29%), followed by harm or risk of harm to self (24%), or depression (15%). Thirteen percent of the sample presented with problems at school.

- In the suburban SBDI community, **youth were twice as likely to present with a risk of harm to self** (49% vs. 24%) **and depression** (40% vs. 22%), **significantly less likely to present with disruptive behavior problems** (28% vs. 50%), and **more likely to have a trauma history** than youth referred to EMPS in the suburban non-SBDI community (49% vs. 33%).
- **In both SBDI regions, the SBDI schools referred a greater proportion of youth with trauma histories (63% vs. 42%) and who were Seriously Emotionally Disturbed (50% vs. 28%) than the non-SBDI schools.**
 - In the suburban SBDI community, 74% of youth referred to EMPS met the criteria for Serious Emotional Disturbance (SED) vs. 32% in the Non-SBDI community.

GOAL 2: TO LINK YOUTH WITH MENTAL HEALTH NEEDS WHO ARE AT RISK FOR JUVENILE JUSTICE INVOLVEMENT TO APPROPRIATE, ALTERNATIVE COMMUNITY-BASED SERVICES AND SUPPORTS.

An examination of EMPS data suggests that youth referred to EMPS in the SBDI communities may have had greater success in connecting with EMPS and that the combination of EMPS and SBDI may help youth address key issues that can negatively impact functioning at school.

- Youth referred to EMPS in the urban SBDI community were more likely to have a mobile response to the referral (74%) than the urban comparison community (48%)
- **A greater percentage of referred youth from the suburban SBDI community had their first contact in the schools (36% vs. 26%) and were more likely to have a stabilization follow-up** after the initial crisis response from the EMPS service provider in that community (60% vs. 20%) than youth referred to EMPS in the suburban comparison community.
- A significantly greater proportion of referrals from urban SBDI schools resulted in an initial contact taking place in the home (62% vs. 26%) than urban non-SBDI schools, while a greater percentage of referrals from non-SBDI schools resulted in initial contacts taking place in the school (73% vs. 39%)
- **Youth referred to EMPS in the SBDI communities had significantly longer courses of EMPS** coordinated care than youth referred to EMPS in the non-SBDI communities (average of 19 days vs. 12 days).
 - In the suburban SBDI community, the average length of EMPS treatment was 25 days, compared to an average of 3 days in the suburban non-SBDI community
- **Parents and guardians of youth referred to EMPS in the urban SBDI community reported higher levels of satisfaction and participation in treatment planning** than parents and guardians of youth in the other communities
- Eighty-eight percent of all EMPS referred youth across all communities were referred to some type of behavioral health aftercare services.
- Youth in all the communities improved over time on the school performance issues. However, at discharge in the suburban SBDI community, **fewer SBDI school-referred youth were rated as having a behavioral issue that negatively impacted functioning at school (19% vs. 63% in non-SBDI schools).**

GOAL 3: TO REDUCE THE NUMBER OF YOUTH THAT ARE ARRESTED OR COME INTO CONTACT WITH LAW ENFORCEMENT AND JUVENILE JUSTICE SYSTEMS.

Of the 2348 youth who were referred to EMPS and/or CSSD in the four communities from September 1, 2009 through August 31, 2010, 35% ($n = 816$) were initially referred to EMPS and 1532 (65%) were initially referred to CSSD.

- The SBDI communities had significantly more initial referrals to EMPS than the non-SBDI communities (54% vs. 31%). The suburban SBDI community had the largest percentage of youth with initial EMPS contact at 73%.

Of the 2348 youth, 22% ($n = 513$) had previous involvement with CSSD in the preceding year (September 1, 2008 through August 31, 2009). These youth were significantly more likely to have initial contact with CSSD than EMPS (93% vs. 7%) than youth with no prior CSSD involvement.

- Youth that were referred to EMPS first, across the four communities, were more likely to be female (43% vs. 37%), younger (12 years vs. 15 years), Caucasian (58% vs. 39%), and of Hispanic or Latino ethnicity (43% vs. 37%). Whereas youth referred to CSSD first were more likely to be male (63% vs. 57%), older, and youth of color (59% vs. 35%).

Of the 2348 youth, 604 (25.7%) had subsequent involvement with CSSD after the initial referral to either system in the index period.

- **Youth in the SBDI communities had less risk of subsequent CSSD involvement than youth in the non-SBDI communities even after controlling for prior CSSD involvement, race, age, and gender** (43% vs. 31%).
- 34% of those with an initial CSSD contact ($n = 522$) and 10% of those with an initial EMPS contact ($n = 82$) had subsequent involvement with CSSD.
- For youth with previous involvement with CSSD, rates of re-offense were significantly less in the SBDI communities than the non-SBDI communities (57% vs. 45%).
- The median time to subsequent CSSD involvement for youth with prior CSSD contact was 258 days in the non-SBDI communities vs. 398 days in the SBDI communities.
- **The greatest risk of subsequent CSSD involvement was within the first 30 days of initial contact** with either system.

In terms of juvenile court referrals, in contrast to what was expected to occur following the state law change giving juvenile courts jurisdiction over delinquent 16 year olds, the communities offering the SBDI initiative **showed a decrease in delinquency referrals in the year 2009/2010, while non-SBDI communities had an increase.**

- **Delinquency referrals decreased in the urban SBDI community by 1.1% from the pre-SBDI to SBDI year, while the urban comparison community had a 9% increase in delinquency referrals.** The suburban SBDI community experienced a 6.4% increase in delinquency referrals from the pre-SBDI year to the SBDI year, as compared to a 9% increase in the suburban comparison community.
- In terms of youth served by EMPS and juvenile courts, greater percentages of youth in SBDI communities utilized EMPS services (close to 1.5% in each community). In the suburban SBDI community, more youth were referred to EMPS than to courts during the index year. As noted previously, although court referrals increased slightly overall in the urban SBDI community, there was a decrease in delinquency referrals to courts from that region.

CONCLUSION

Results indicate that the School Based Diversion Initiative may be effective in helping to maximize the most appropriate placement of youth in distress or at high risk for juvenile justice involvement. SBDI trainings in both the suburban and urban communities may have been effective in educating school personnel on the identification of youth who are experiencing typically less outwardly disruptive psychological problems, such as depression and

anxiety, as well as the identification of youth who have experienced trauma in their lives. Although we cannot determine from the current data the extent to which individuals may have been diverted entirely from the court system, results indicate that rates of subsequent contact with juvenile courts were significantly reduced in youth who were referred to Emergency Mobile Psychiatric Services (EMPS) and for youth who resided in communities in which the SBDI was implemented. Data from the December 2010 progress report completed by CHDI substantiate the findings presented in this report and speak to the success and sustainability of the SBDI initiative-- not only are the original schools continuing to refer students to EMPS services after completion of the program, but Connecticut's SBDI project has been expanded over the 2010/2011 school year to include two schools in two additional communities (East Hartford and Meriden) , with plans for further expansion underway.

INTRODUCTION

The following report contains findings from an evaluation of Connecticut's School Based Diversion Initiative (SBDI) pilot project. The Connecticut School-Based Diversion Initiative (SBDI) is a component of the John D. and Catherine T. MacArthur Foundation Models for Change Mental Health/Juvenile Justice Action Network. This initiative began in January of 2009 as a collaborative effort of the Judicial Branch's Court Support Services Division (CSSD) and the Connecticut Department of Children and Families (DCF). The Connecticut Center for Effective Practice (CCEP) coordinates the SBDI initiative which involves education and training of school personnel on recognizing mental health symptoms, accessing available community supports, cultural competency, and managing crises in the school environment; relationship building between schools and existing mental health infrastructure in the communities (in particular, the Emergency Mobile Psychiatric Services providers); and linking to local Community Collaboratives which oversee implementation of the System of Care model in Connecticut.

This project has three primary goals:

- 1) To build knowledge and skills of teachers and other school staff to recognize and manage behavioral health crises in school.
- 2) To link youth with mental health needs who are at risk for juvenile justice involvement to appropriate, alternative community-based services and supports.
- 3) To reduce to number of youth that are arrested or come into contact with law enforcement and juvenile justice systems.

Beginning in September 2009, the SBDI initiative was implemented in the following schools/districts:

Luis Munoz Marin School, a Kindergarten through 8th Grade school in Bridgeport, Connecticut (urban SBDI). Bridgeport is Connecticut's largest city comprised of a racially, ethnically, and sociodemographically diverse population of 136,715 individuals. There are an estimated 25,574 youth aged 5-17 in this community. The median household income is \$37,823 and 19.2% of families are below the poverty level.

Joseph A. DePaolo and John F. Kennedy Middle Schools in Southington, Connecticut (suburban SBDI), a largely suburban community located in Central Connecticut comprised of a primarily Caucasian population of 42,077 individuals, including 6,995 youth ages 5-17. The median household income is \$78,094 with 2.7% of families living below poverty level.

Two Connecticut communities were selected as comparison sites due to comparable sociodemographic characteristics, but schools in these communities did not participate in the SBDI intervention. The comparison communities are:

New Haven (urban non-SBDI)—the comparison site for the Bridgeport community. New Haven is comprised of an ethnically and sociodemographically diverse population of 123,628 individuals, including 20,180 youth ages 5-17. It is Connecticut's third largest city. The median household income is \$37,823 with 19.2% of families living below the poverty level.

Middletown (suburban non-SBDI) was selected as the suburban comparison site Southington. Middletown is comprised of a primarily Caucasian population of 47,702 individuals, including 6,868 youth ages 5-17. The median household income is \$76,423 and 6.9% of families are below the poverty level.

Table 1 in the Appendix contains more detailed sociodemographic data on the four communities.

THE SCHOOL BASED DIVERSION INITIATIVE (SBDI)¹

The first step in the SBDI process involved the development of a manual containing standard tools and procedures for screening and assessment, training and evaluation materials, and descriptions of programs and available resources. Next, CHDI met with school administrators and began facilitating connections between the schools, mental health service providers, legal and law enforcement personnel, and other community stakeholders. The SBDI schools had the advantage of being situated in communities that were also participating in a SAMHSA-funded Wraparound Infrastructure Development project. As a result, the school personnel at the SBDI schools had a link into a developing network of multi-agency stakeholders committed to ensuring that youth with behavioral health issues receive the most appropriate and complete supports necessary for positive growth and development. Memorandums of Agreement were then established between the school districts and Emergency Mobile Psychiatric Service (EMPS) providers in each community (Child Guidance Center of Greater Bridgeport and Wheeler Clinic in Southington). Based on findings from community needs assessments that were conducted in both communities, nine core elements of training were established: Recognizing Mental Health Systems in Children, Effective Collaboration with EMPS, Parent Involvement in School Interventions, Changes in Juvenile Law, Overview of the CT Behavioral Health System, Uniform Crisis Prevention Planning, Effective Collaboration with Police and Law Enforcement, Classroom Behavior Management and Crisis De-Escalation, and Multicultural Competence and School-Based Mental Health. In the suburban SBDI, school administrators were able to integrate the SBDI into the school district's formal professional development curriculum and trainings were regularly attended by 35 school personnel from the two schools. Due to several logistical and implementation issues, the school in the Urban SBDI was not able to make the SBDI training part of its core professional development curriculum; however, seven staff participated regularly. Training participants across both sites included teachers, guidance counselors, administrators, school psychologists and social workers, and School Resource Officers.

SOURCES OF DATA AND ANALYTIC STRATEGY

The current evaluation is based on: a) individual-level data from four communities served by DCF's Emergency Mobile Psychiatric Services (EMPS), which provides first response services to individuals in need of psychiatric care throughout Connecticut; b) individual-level juvenile court referral data from the four communities; and c) Connecticut Judicial Branch, Court Support Services Division (CSSD) community-level juvenile court referral data. The time frame for the data extraction was 9/1/2008-8/31/2010 for the CSSD data and 9/1/2009-8/31/2010 for the EMPS data (the electronic record system was put into place in July 2009).

Individual-level data were linked between systems (EMPS and CSSD) by a unique identifier so that 1) individuals who appeared in both systems could be identified, 2) individuals who only appeared in one system could be identified, and 3) patterns of cross-system services could be examined. Three comparisons were made for each dependent variable: a) suburban SBDI community vs. urban SBDI community; b) suburban SBDI community vs. suburban non-SBDI community; and c) urban SBDI community vs. urban non-SBDI community. Data were also weighed by the population of youth, aged 5-17, in each community². For the EMPS data, additional sub-analyses

¹ Connecticut Health and Development Institute, Connecticut School Based Diversion Program, Evaluation Report, December 2009

² Based on figures from the 2005- 2009 American Community Survey

http://factfinder.census.gov/servlet/DatasetMainPageServlet?_lang=en&_ts=315173857046&_ds_name=ACS_2009_5YR_G00_&_program=

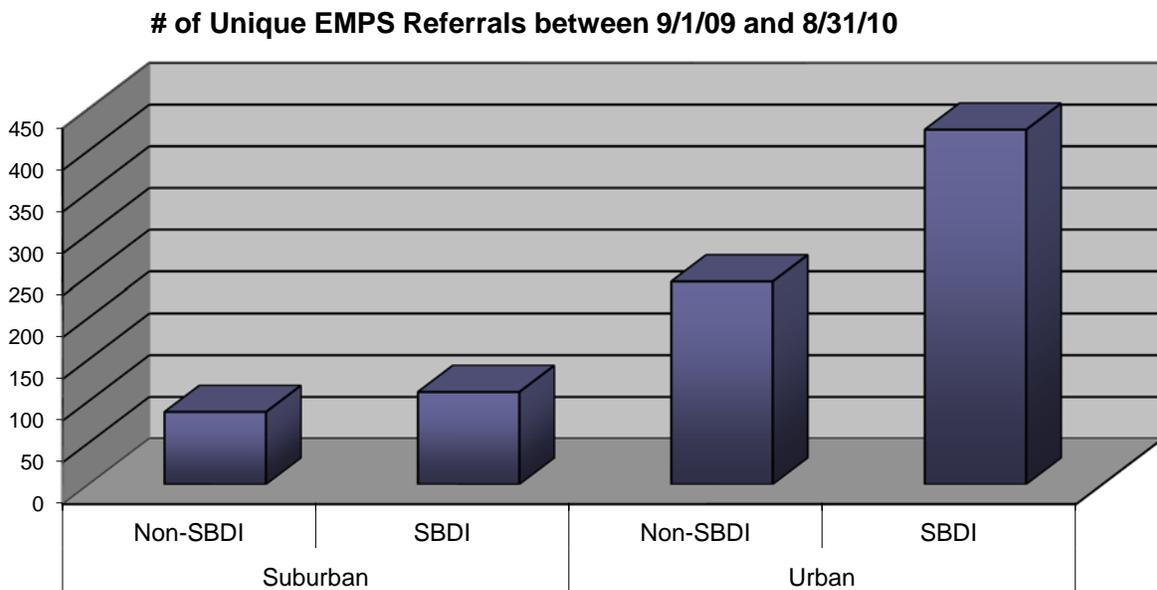
were conducted to compare youth who were referred from SBDI schools versus youth who were referred from non-SBDI schools within and between each community. Statistical comparisons were made, when possible, using non-parametric Chi-Square analyses and univariate Analysis of Variance (ANOVAs). Cox regression was used to determine risk of subsequent referral to juvenile court in the communities, after an initial referral to CSSD or EMPS during index period (September 1, 2009- August 31, 2010). Analyses were conducted controlling for previous CSSD involvement, age, race, and gender.

GOAL 1: EARLY RECOGNITION AND MANAGEMENT OF BEHAVIORAL HEALTH ISSUES

To build knowledge and skills of teachers and other school staff to recognize and manage behavioral health crises in school.

EMERGENCY MOBILE PSYCHIATRIC SERVICE DATA

Data were obtained from the Emergency Mobile Psychiatric Service records on calls received from individuals in the four communities during the index year of September 1, 2009 through August 31, 2010. During this period, EMPS received 1079 calls on 866 unique individuals in these communities.



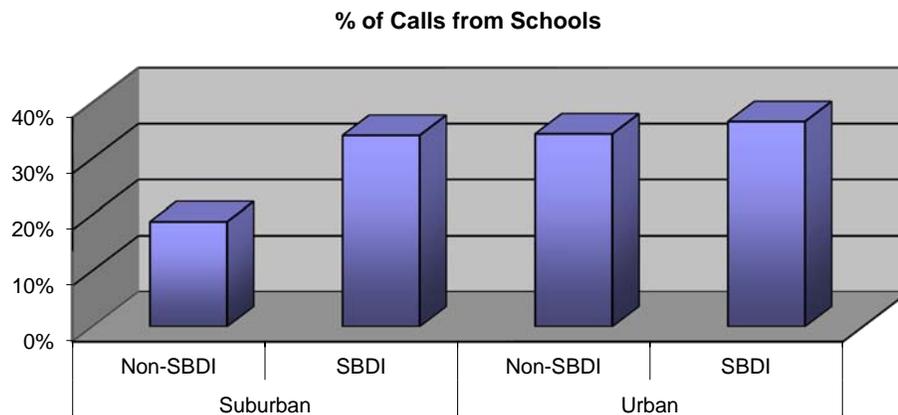
The number of youth connected with EMPS during this time period is equivalent to 1.6% of the youth population in the suburban SBDI community and 1.7% of the youth population in the urban SBDI community during the index year. The comparison communities received calls from 1.3% and 1.2% of the population in the suburban non-SBDI community and urban non-SBDI community, respectively.

SOURCE OF REFERRAL

Table 2 (Appendix A) contains information about the source of EMPS referrals in the four communities during the index period. Self or family referrals made up 41% of all the EMPS calls across the four communities. Thirty-four percent of EMPS referrals were made by schools—the second highest referral source. **Youth in the suburban SBDI**

Goal 1: Early Recognition and Management of Behavioral Health Issues

community were more often referred by schools (34%) and less likely to be referred by emergency departments (7%) than youth in the suburban non-SBDI comparison community (19% and 16%, respectively). Youth in the suburban SBDI community were also more likely to be referred by self or family (45%) than youth in the urban SBDI community (35%). In contrast, youth in the Urban SBDI community were less likely to be referred by self or family than youth in the urban non-SBDI comparison community (35% vs. 43%) and were more likely to be referred to EMPS by an emergency department (13%) than youth in both the urban (7%) and suburban (7%) comparison communities. Almost 60% of the referrals that EMPS received from urban SBDI community emergency departments were categorized as Inpatient Diversion cases. This is significantly higher than percentages of such cases in the urban comparison community (12%).



Personnel in 105 different schools in the four communities made referrals. In the suburban SBDI community, referrals were received from two SBDI schools and eight non-SBDI schools. In the urban SBDI community, referrals were received from one SBDI school and 44 non-SBDI schools. In the suburban SBDI community, 30% of all school referrals came from the SBDI schools in the area. In the urban SBDI community, less than 10% of the school referrals came from the SBDI school.

DEMOGRAPHIC CHARACTERISTICS OF EMPS REFERRALS

During the index period, calls pertained to 454 female (42%) and 625 male (58%) youth, 3 to 19 years of age (average age = 12.56, $sd = 3.52$) across the four communities. Thirty-six percent of the referrals were for youth of color and 43% of the referrals were for Caucasian youth. In terms of ethnicity, 40% of all referrals were made for Hispanic/Latino youth.

As expected, based on the differences in population demographics between the urban and suburban communities, youth referred to EMPS in the urban and suburban SBDI communities differed on several key demographic variables. Youth referred to EMPS in the suburban SBDI community were more likely to be female (49% vs. 39%), Caucasian (89% vs. 31%), English speaking at home (95% vs. 78%), living in US longer than 7 years (88% vs. 71%), and receiving private insurance (50% vs. 14%) than youth referred to EMPS in the urban SBDI community. Youth referred to EMPS in the suburban SBDI community were also less likely to be Hispanic (11% vs. 55%) and less likely to meet eligibility requirements for Temporary Assistance for Needy Families (TANF) criteria (34% vs. 49%).

A comparison between youth referred to EMPS in the suburban SBDI and non-SBDI communities revealed that youth in the suburban SBDI community were more likely to be female (49% vs. 34%), less likely to be youth of Hispanic, Latino, or Spanish origin (11 vs. 19%), less likely to be youth of color (6% vs. 15%), less likely to have

Goal 1: Early Recognition and Management of Behavioral Health Issues

Connecticut’s public health insurance (HUSKY A) (36% vs. 55%), and more likely to have private health insurance (50% vs. 30%) than youth referred to EMPS in the non-SBDI suburban comparison community.

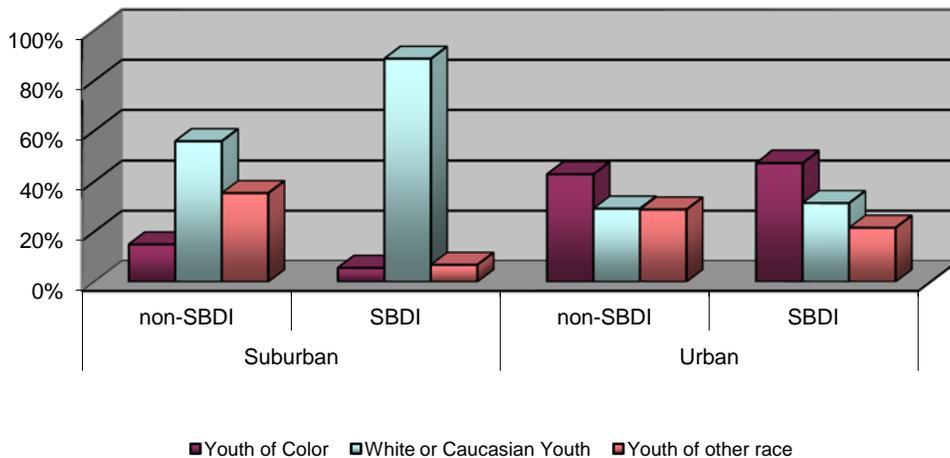
Referrals to EMPS in the Urban SBDI community referrals were more likely to be for male youth (61% versus 53%) and for youth who did not meet the eligibility criteria Temporary Assistance for Needy Families (TANF) (49% vs. 76%) than youth referred to EMPS in the Urban non-SBDI comparison community.

Table 3 (Appendix A) contains details on the demographic variables by community.

Demographic differences between youth referred from SBDI vs. non-SBDI schools in the two SBDI communities.

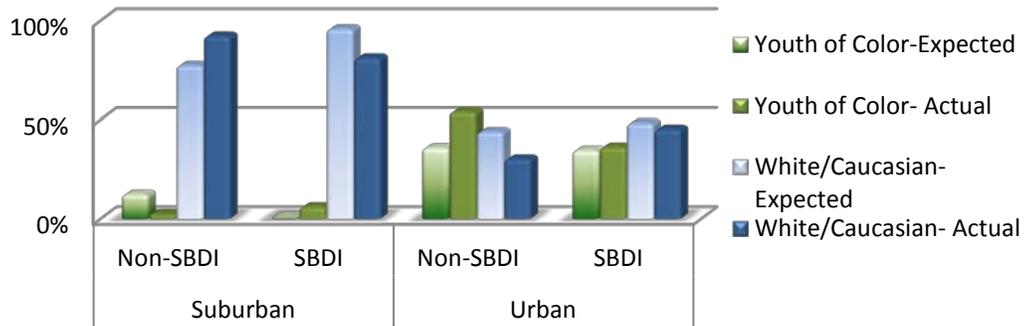
Within the two SBDI communities, a significantly greater proportion of referrals from the SBDI schools were for youth who had lived in the United States for seven years or longer (96.6%) compared to youth referrals from non-SBDI schools (76.6%). In the urban community, the SBDI school referred a significantly greater proportion of male youth to EMPS (93%) than the non-SBDI schools in the urban SBDI community (61%). Across both SBDI communities, youth referred to EMPS from SBDI schools were also less likely to be youth of color (19% vs. 43%) than youth referred to EMPS from non-SBDI schools in these communities. However, an examination of the actual versus expected number of referrals based on the ethnic and racial makeup of the communities shows that the non-SBDI school referrals in the suburban SBDI community referred fewer youth of color and more Caucasian youth than what would be expected based on the population, while the SBDI school referred more youth of color and fewer Caucasian youth than would be expected based on the population. In the urban SBDI community, non-SBDI school referrals were for more youth of color and fewer Caucasian youth than what was expected based on the community demographics, while the SBDI school referred a more representative proportion of youth of color and Caucasian youth.

Race



Goal 1: Early Recognition and Management of Behavioral Health Issues

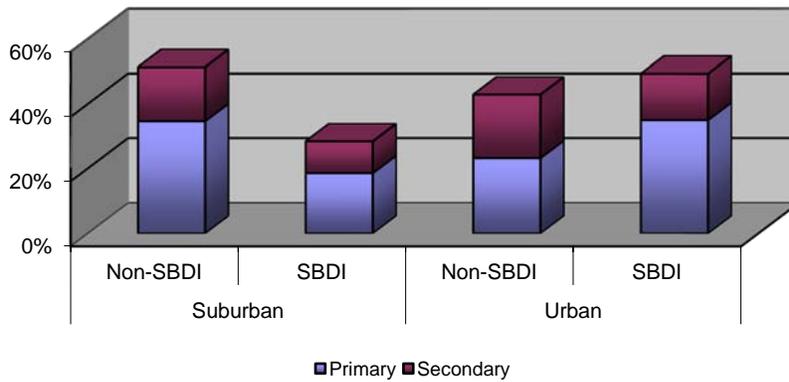
Actual vs. Expected Referrals



PRESENTING PROBLEMS

The most common problem prompting EMPS referrals across the four communities was disruptive behavior (29%), followed by harm or risk of harm to self (24%), and depression (15%). **Tables 4 and 5** contain details about primary and secondary presenting problems.

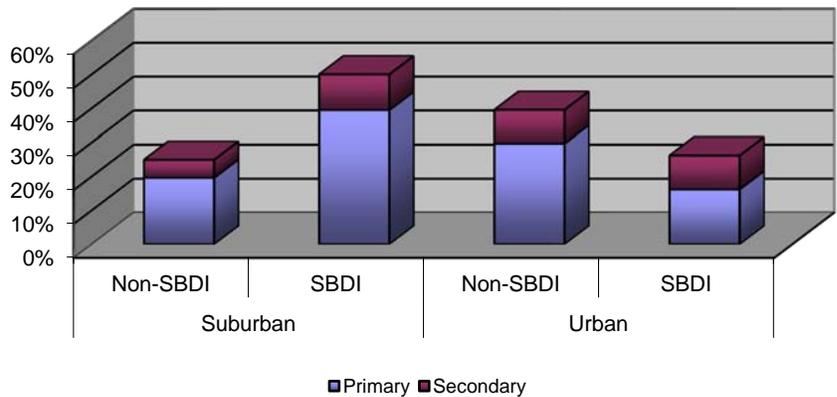
Disruptive Behavior



Youth referred from the urban SBDI community had significantly higher rates of primary disruptive behavior problems (35%) than youth referred from the suburban SBDI (19%) and urban non-SBDI communities (23%), $p < .001$. Youth referred to suburban non-SBDI EMPS had significantly higher rates of primary disruptive behavior problems (35%) than those in suburban SBDI areas, $p < .001$.

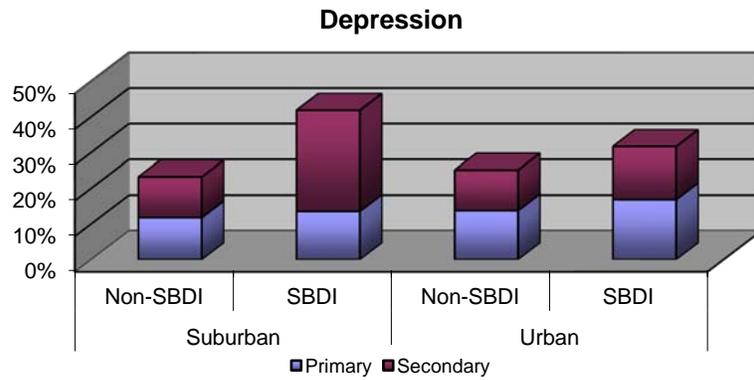
Suburban SBDI community youth were more likely to present with primary harm or risk of harm to self (40%) than urban SBDI community youth (16%) and suburban non-SBDI community youth (20%), $p < .001$. A greater percentage of urban non-SBDI youth presented primarily with harm or risk of harm to self (30%) than urban SBDI youth, $p < .001$.

Harm/Risk of Harm to Self



Goal 1: Early Recognition and Management of Behavioral Health Issues

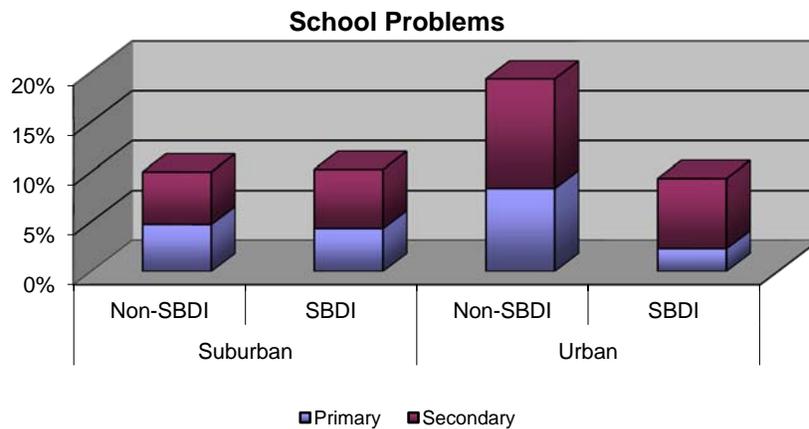
Thirty-one percent of the sample presented with primary or secondary depression. Youth referred in the suburban SBDI community had significantly higher rates of depression (42%) than those in suburban non-SBDI (21%) and urban SBDI communities (33%), $p < .001$. Urban SBDI EMPS clients had significantly higher rates of depression than urban non-SBDI EMPS youth (25%), $p = .02$.



Seventeen percent of the sample presented with primary or secondary risk of harm or harm to others. There were no significant differences between communities. Eighteen percent of the sample presented with primary or secondary issues with family conflict. The suburban non-SBDI community had significantly higher rates of youth presenting with family conflict (25%) than the suburban SBDI community (14%), $p = .02$. Fifteen percent of the sample presented with primary or secondary issues with anxiety, with no significant differences between the communities.

ACADEMIC ISSUES

Thirteen percent of the sample presented with problems in school. The urban non-SBDI community had significantly higher rates of youth presenting with school problems (20%) compared to the urban SBDI-community (10%), $p < .001$. Youth referred from the urban SBDI community were significantly more likely to have been suspended or expelled from school in the 6 months prior to EMPS admission than youth referred from the suburban SBDI community, $p < .001$. **Table 6** (Appendix A) contains detailed information about academic issues.



Differences in academic issues between youth referred from SBDI vs. non-SBDI schools. A greater percentage of youth referred from the suburban SBDI schools were rated as having no academic issues that negatively impacted performance at school (94%) than youth referred from the suburban non-SBDI schools (60%), $p = .01$. In the urban SBDI community, the SBDI school referred more youth with behavioral issues that negatively impacted performance at school (50%), compared to the non-SBDI schools (21%), $p = .01$.

Goal 1: Early Recognition and Management of Behavioral Health Issues

In the urban SBDI community, a significantly greater proportion of SBDI school referrals were for youth who had been suspended or expelled in the 6 months prior to the EMPS contact (54% vs. 26% urban non-SBDI schools, $p = .03$). A greater proportion of these SBDI-referred youth also had a history of a traumatic experiences (64% vs. 38% urban non-SBDI schools, $p = .05$).

ALCOHOL AND DRUG USE

Ninety-four percent of the sample did not have an alcohol or drug problem at the time of the current episode. Youth referred to EMPS in the suburban SBDI community had more alcohol and/or drug use in the current episode than urban SBDI youth ($p = .02$). See **Table 7** in Appendix A for details.

ARRESTS

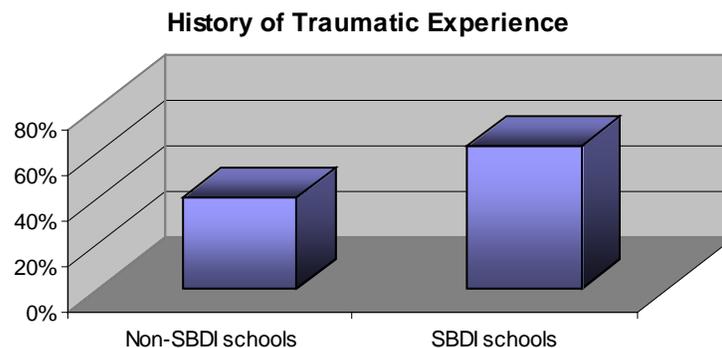
Two percent of the sample was arrested during the current episode of care, with no significant differences between communities. Eight percent had been arrested in the six months prior to contacting EMPS. Suburban SBDI referred youth had significantly fewer arrests than suburban non-SBDI youth in the six months prior to the current episode ($p = .02$). **Table 8** in Appendix A contains arrest data.

TRAUMA HISTORY

Thirty-four percent of the youth referred to EMPS had a trauma history. In the suburban SBDI community, the proportion of youth that had experienced a traumatic event in their lifetime (49%) was significantly higher than the proportion of youth with trauma histories referred from the urban SBDI (34%, $p < .001$) and suburban non-SBDI communities (33%, $p = .004$). **Table 9** in the appendix contains details on trauma history.

In terms of type of trauma, youth referred from the urban SBDI community were significantly more likely to have witnessed a violent act (23%) or have a history of other traumatic experiences (16%) than youth referred from the suburban SBDI community (12%, $p = .002$ and 10%, $p < .05$, respectively). A significantly greater proportion of youth referred from the urban non-SBDI community were victims of traumatic violence (18%) than the proportion of youth referred from the urban SBDI community (9%), $p < .001$.

Differences in trauma history between youth referred from SBDI vs. non-SBDI schools. In both SBDI communities, the SBDI schools referred a greater proportion of youth with trauma histories (63.3%) than the non-SBDI schools (43.1%), $p = .02$. None of the 30 referrals from SBDI schools had a history of disrupted attachments/multiple placements, compared to 19% of referrals from non-SBDI schools, $p = .01$.

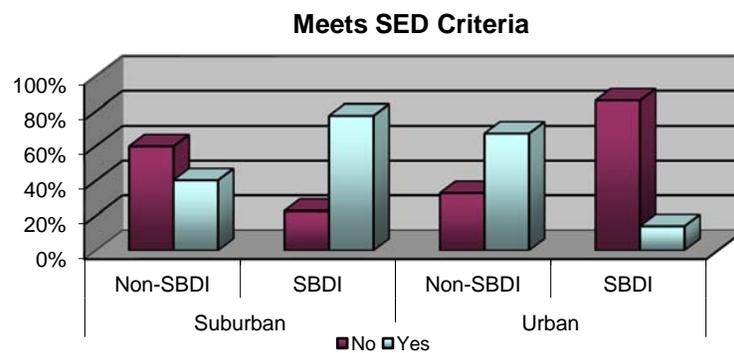


Goal 1: Early Recognition and Management of Behavioral Health Issues

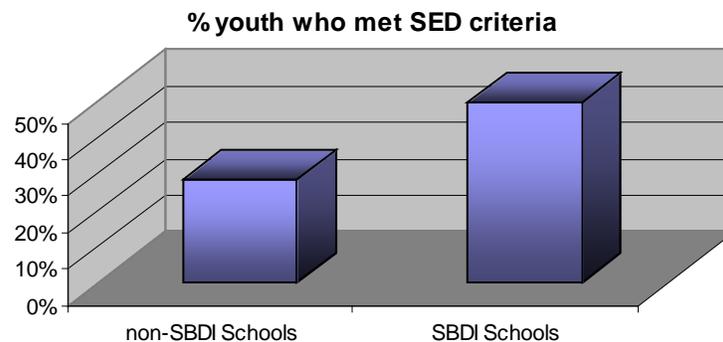
INVOLVEMENT IN DCF SERVICES

At intake, youth referred from the urban SBDI community were significantly more likely to be receiving services from DCF's Voluntary Services Program than youth referred from the urban non-SBDI community (5.3% vs. 1.9%), $p < .05$. A significantly greater percent of youth referred from suburban SBDI were in DCF's Out of Home Child Protective Services (11.3%) compared to youth referred from the urban SBDI community (5.0%) and the suburban non-SBDI community (1.1%), $p < .01$. See **Table 10** in Appendix A for details.

Seventy-seven percent of the youth referred to EMPS in the suburban SBDI community met the criteria for being Seriously Emotionally Disturbed compared to 14% of urban SBDI community referrals ($p < .001$) and 40% of suburban non-SBDI community referrals ($p < .001$). Youth referred from the urban non-SBDI community were also more likely to meet the SED criteria (67%) than youth referred from the urban SBDI community ($p < .001$).



Differences in the percentage of youth who met SED criteria referred from SBDI vs. non-SBDI schools. A significantly greater percent of youth referred from SBDI schools met the criteria for a Serious Emotional Disturbance (50%) than youth referred from non-SBDI schools (28%), $p = .02$.



FUNCTIONING AT INTAKE

Youth functioning was assessed by the parent and worker forms of the Ohio Scales. Youth referred to EMPS from the urban SBDI community had significantly lower ratings by parents of youth functioning ($p < .001$). Youth referred from the suburban SBDI community had significantly higher ratings of youth functioning when assessed by workers at intake ($p < .05$). Youth referred to EMPS in the suburban SBDI-community had significantly lower scores on parent-rated functioning than youth referred to EMPS in the suburban SBDI community ($p = .002$).

GOAL 2: LINK HIGH-RISK YOUTH TO COMMUNITY SUPPORTS

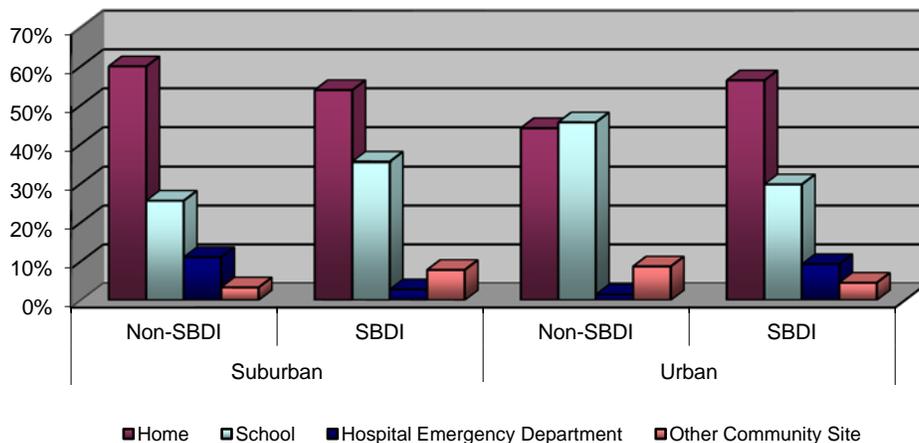
To link youth with mental health needs who are at risk for juvenile justice involvement to appropriate, alternative community-based services and supports

INITIAL CONTACT MODE AND LOCATION

In terms of mode of contact, 64% of the youth referred to EMPS had an initial EMPS contact that was mobile in nature. Youth referred from the urban SBDI community were more likely to have a mobile initial contact (74%) than youth referred from the suburban SBDI community (59%) and the urban non-SBDI community (48%), $p < .001$. Youth referred to EMPS from the suburban SBDI community were more likely to have a “deferred mobile” response (27%) and less likely to have a non-mobile response (14%) than youth referred from the suburban non-SBDI community (7% and 30%, respectively), $p < .001$. Deferred mobile response in three of the four communities was due primarily to family declination of mobile services. In the suburban SBDI community, however, the primary reason for deferred mobile responses was due to the percentage of referrals made after mobile response hours. Ninety percent of non-mobile contacts took place via telephone. **Table 11** (Appendix A) contains detailed information on EMPS contact mode and location.

Across the four communities, over half of the first mobile contacts took place in the home (54%). Schools comprised the next most common location for the initial mobile contact (34%). In comparison to suburban non-SBDI referrals, **a greater percentage of youth referred from the suburban SBDI community had their first contact in schools** (36% vs. 30%) and a smaller percentage of initial contacts took place in emergency departments (9% vs. 3%), $p = .024$. Youth referred from the urban SBDI community had significantly fewer initial contacts in the schools (30%) than youth referred from the suburban SBDI (36%, $p = .002$) and urban non-SBDI communities (46%, $p = .001$).

Location of first mobile contact



Thirty-six percent of the youth referred to EMPS received a stabilization follow-up contact after the initial face-to-face contacts. Youth referred from the suburban SBDI community had a significantly higher rate of stabilization follow-up (60%) than youth referred from either the urban SBDI (35%) or suburban non-SBDI communities (20%), $p < .001$.

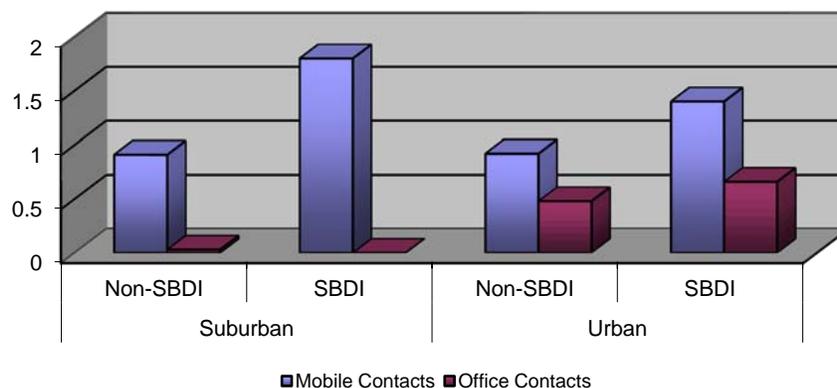
Differences in mode of response between youth referred from SBDI vs. non-SBDI schools. In the urban SBDI community, SBDI school referrals resulted in significantly fewer mobile contacts ($n = 8$, 57%) and more deferred mobile contacts ($n = 5$, 36%) than referrals from non-SBDI schools ($n = 144$, 84% and $n = 20$, 12%, respectively, $p = .03$). **A significantly greater proportion of urban SBDI referrals resulted in an initial contact taking place in the home (62%) compared to 26% of the referrals from urban non-SBDI schools**, while a greater percentage of referrals from non-SBDI schools resulted in initial contacts taking place in the school (73% vs. 39%), $p = .05$.

EMPS SERVICE VARIABLES

Youth referred to EMPS in the suburban SBDI community had significantly longer courses of treatment than youth referred to EMPS in the suburban non-SBDI community ($p < .001$), averaging just under 25 days compared to 3 days. Youth referred to EMPS in the urban non-SBDI area had significantly shorter length of treatment than urban SBDI youth ($p = .003$). See **Table 12** in Appendix A for details.

Youth referred to EMPS in the suburban SBDI community had significantly more mobile contacts during the course of care than those in the suburban non-SBDI community ($p < .001$). Urban SBDI EMPS youth had more office-based visits than suburban SBDI youth ($p < .001$) over the course of care.

Average # of Mobile and Office Contacts



Fifteen percent of the sample was evaluated by an emergency department during the current episode of care with no significant between community differences.

TREATMENT INVOLVEMENT AND SATISFACTION

In general, parents and guardians felt that the treatment plans included their ideas about their child's treatment needs and were satisfied with the mental health services received. Parents and guardians of youth in the urban SBDI community reported significantly higher levels of satisfaction and participation in treatment planning than parents/guardians in the other communities ($p < .001$). See **Table 13** in Appendix A for details.

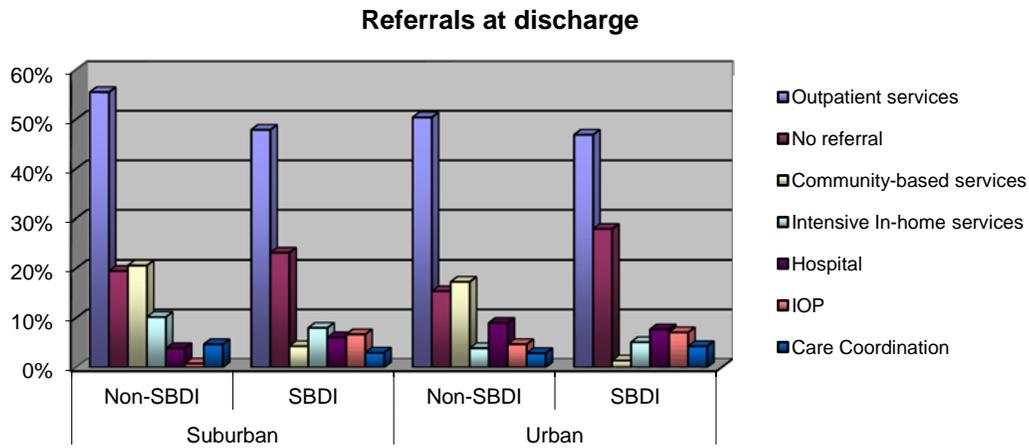
FUNCTIONING AT INTAKE AND DISCHARGE

At intake, youth were most often faced with behavioral issues, social issues, and academic issues as barriers to positive functioning at school. While these issues remained significant at discharge, the percentage of youth facing them decreased. Youth in all the communities improved over time on the school performance issues. However, **at discharge in the suburban SBDI community, fewer SBDI school-referred youth were rated as having a behavioral issue that negatively impacted functioning at school (19% vs. 63% in non-SBDI schools).**

At discharge, youth referred from the urban SBDI community continued to have significantly lower parental ratings of youth functioning than youth referred to EMPS in the urban non-SBDI community ($p < .001$) or suburban SBDI community ($p = .002$). Youth referred to EMPS in the urban SBDI community had significantly higher worker-rated functioning at discharge than youth referred to EMPS in the suburban SBDI community ($p = .002$). See **Table 14** in Appendix A for details.

DISCHARGE REFERRALS

Across all communities, 88% of EMPS-referred youth were referred to some type of behavioral health aftercare. The urban SBDI community had significantly more youth who were not referred to any services at discharge than the urban comparison community (28% vs. 15%). **Youth in the suburban SBDI community were more likely to be referred to Intensive Outpatient Services than youth in the suburban comparison community (7% vs. 1%).** See **Table 15** in Appendix A for details.

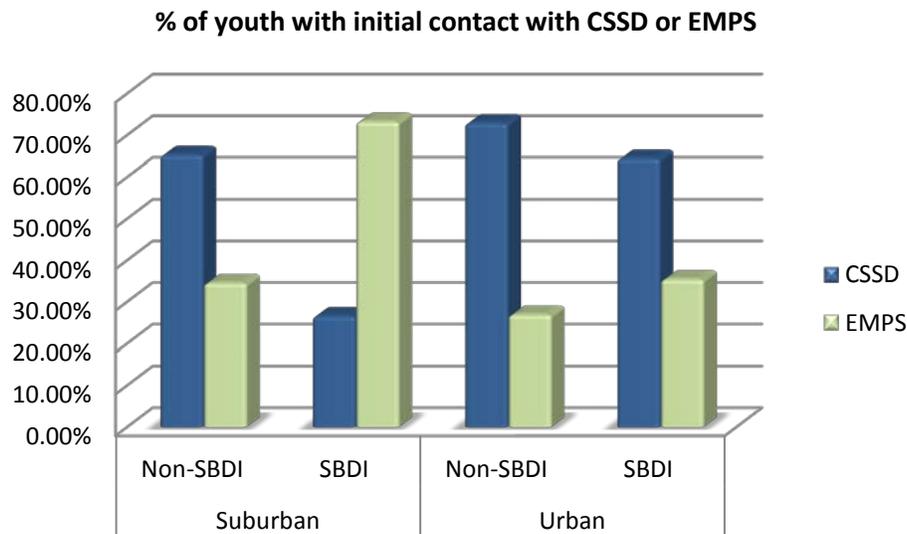


GOAL 3: REDUCE YOUTH CONTACT WITH JUVENILE JUSTICE

To reduce the number of youth that are arrested or come into contact with law enforcement and juvenile justice systems.

INITIAL REFERRAL TO EMPS VS. INITIAL CONTACT WITH COURT SUPPORT SERVICES DIVISION

From September 1, 2009 through August 31, 2010, 2348 youth had at least one referral to Emergency Mobile Psychiatric Services (EMPS) or contact with Court Support Services Division (CSSD) across the four communities. Thirty-five percent ($n = 816$) of the youth had their initial contact with EMPS and 1532 (65%) had their initial contact with CSSD. **The SBDI communities had significantly more referrals to EMPS than the non-SBDI communities (54% vs. 31%), $p < .01$.** In comparison to the urban SBDI community, the suburban SBDI community had significantly more initial referrals to EMPS (73% vs. 36%) and significantly fewer referrals to CSSD (27% vs. 65%), $p < .01$. **Table 16** (Appendix A) contains rates of initial contact with CSSD or EMPS by community.

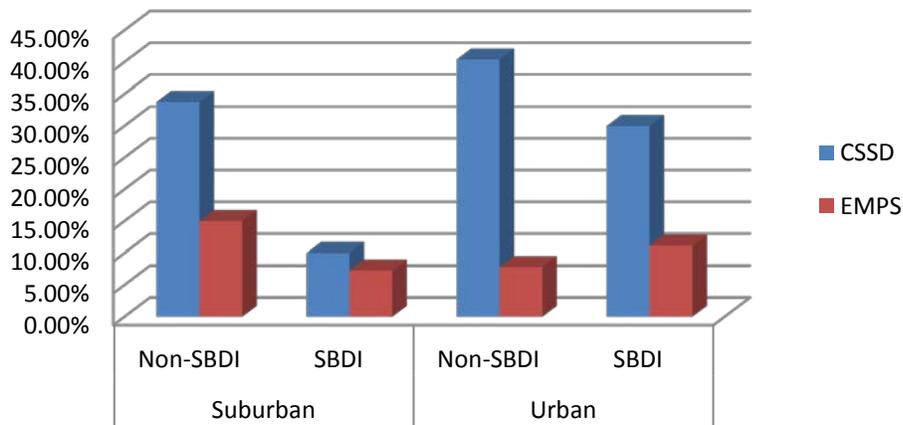


Of the 2348 youth, 22% ($n = 513$) had previous involvement with CSSD in the preceding year (September 1, 2008 through August 31, 2009). These youth were **significantly more likely to have initial contact with CSSD than EMPS (93% vs. 7%) than youth with no prior CSSD involvement.** Youth with initial CSSD contact during the index year, were also more likely to be male, older, and of color. Whereas youth that were referred to EMPS first, across the four communities, were more likely to be female, younger, Caucasian, and of Hispanic or Latino ethnicity. When examining demographic differences between each community we found that a significantly greater proportion of females were referred to EMPS in the Suburban SBDI community and the Urban Non-SBDI community. While youth of color were referred to CSSD at a higher rate than other youth in all four communities, Caucasian youth were only referred to EMPS at a higher rate in the urban communities. **Table 17** (Appendix) contains demographic information about the system of initial referral for youth during the index period.

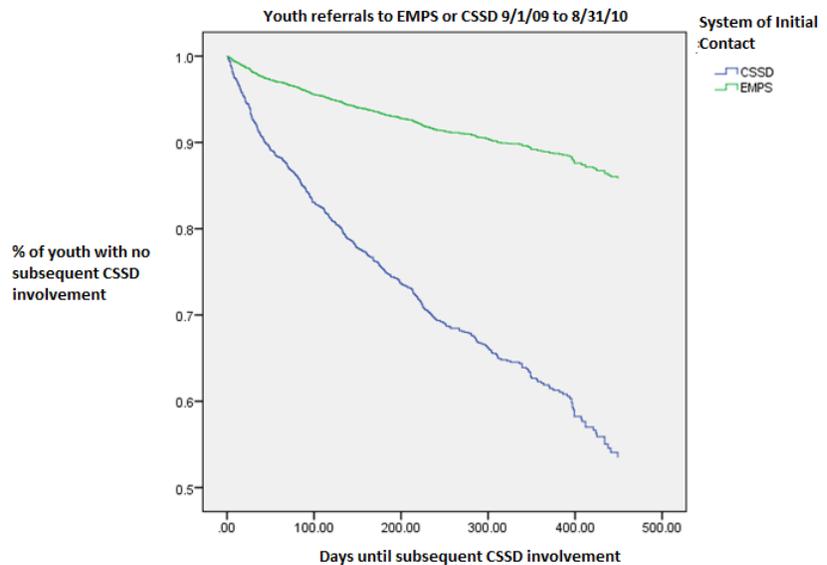
RATES OF SUBSEQUENT CSSD INVOLVEMENT AFTER CONTACT WITH INITIAL SYSTEM DURING INDEX YEAR

Of the 2348 youth examined, 34% of those with an initial CSSD contact ($n = 522$) and 10% of those with an initial EMPS contact ($n = 82$) had subsequent involvement with CSSD. Thus, **in all communities, an initial referral to CSSD significantly increased the likelihood for a subsequent referral to CSSD, although the re-offense rates were much lower in the SBDI communities (39% vs. 29%), $p < .001$.** Table 18 contains details about subsequent contact rates with CSSD and EMPS following initial contact.

% youth with subsequent CSSD involvement by system of initial contact

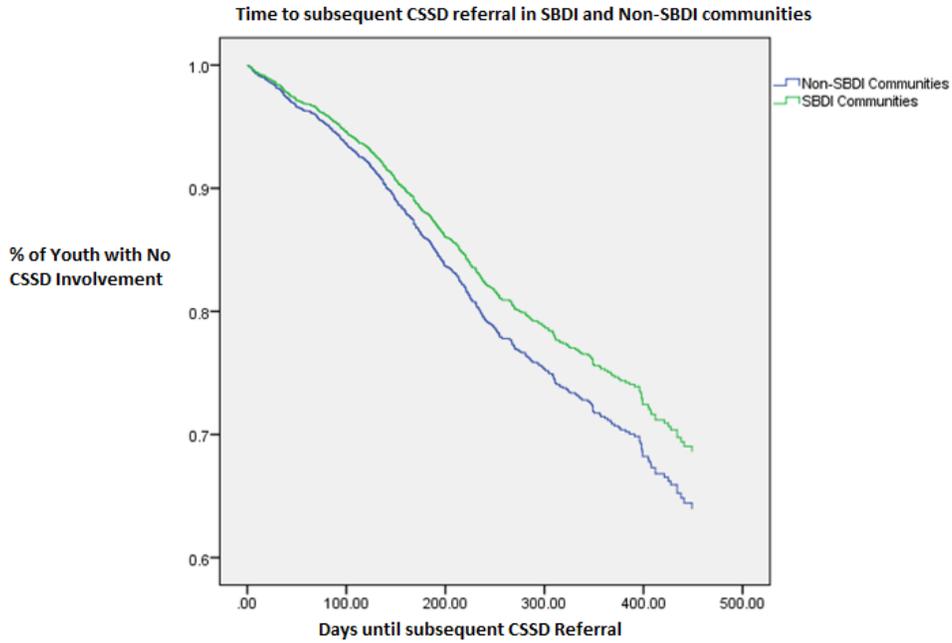


The greatest risk of subsequent CSSD involvement for EMPS-referred youth was within the first 30 days post referral, where 2 percent of the youth had a subsequent referral to CSSD. For youth with initial CSSD contact, the period of greatest risk was also within the first 30 days of contact with CSSD, followed by 30-60 days (5% re-offense) 210-249 days (5% re-offense), and 390-450 days (7.5% re-offense rate). The average length of time to subsequent CSSD contact was 240 days for youth with initial CSSD contact vs. 294 days for youth with initial EMPS contact.

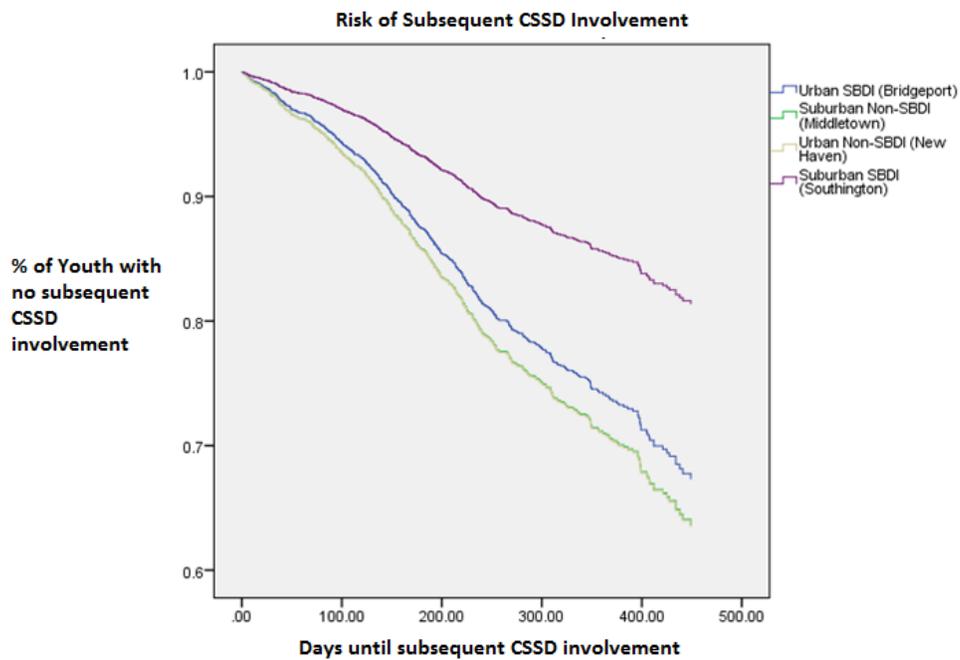


Goal 3: Reduce Youth Contact with Juvenile Justice

When controlling for pre-index year CSSD involvement, race, age, and gender, the risk of subsequent CSSD involvement remained significantly lower for youth in the SBDI communities than the non-SBDI communities (31% vs. 43%).

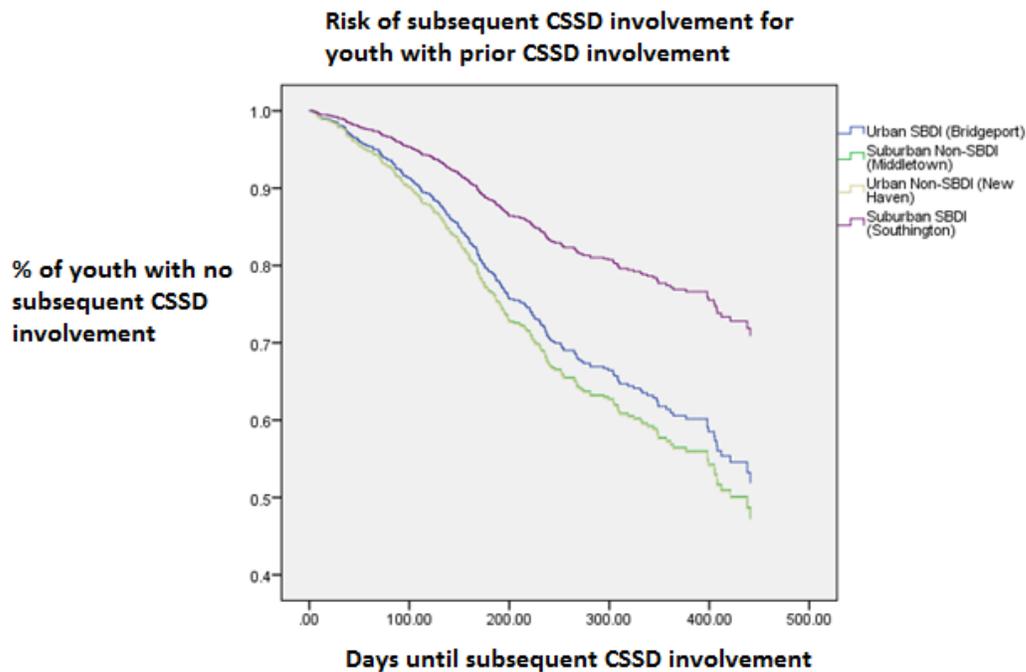


Youth in the suburban SBDI community had the lowest risk, followed by youth in the urban SBDI community, with significant differences between the suburban SBDI community and all the other communities, after controlling for prior CSSD involvement, gender, race, and age.



RE-OFFENSE RATES FOR YOUTH WITH PREVIOUS CSSD INVOLVEMENT

Of the 513 youth who had involvement with CSSD in the year prior to the observation period, 53% of those with initial CSSD contact during the index period had subsequent CSSD involvement versus 39% of EMPS-referred youth with prior CSSD involvement. **For youth with previous involvement with CSSD, rates of re-offense were significantly less in the SBDI communities than the non-SBDI communities (57% vs. 45%), $p = .006$.** Furthermore, the median time to subsequent CSSD referral for youth with prior involvement was 258 days in the non-SBDI communities vs. 398 days in the SBDI communities.



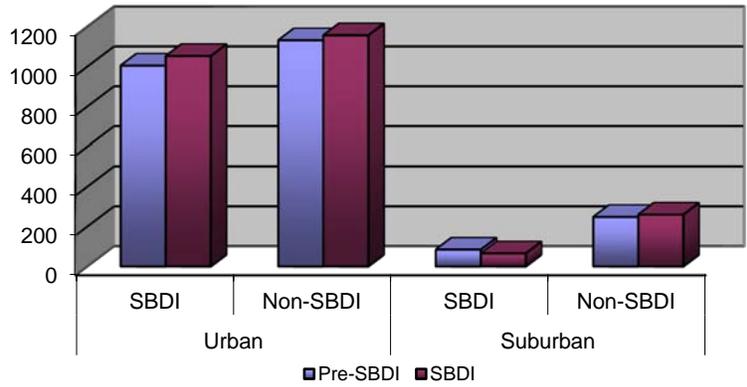
JUDICIAL BRANCH, COURT SUPPORT SERVICES DIVISION DATA

Aggregate data were collected for all juvenile court referrals for youth who lived in the four communities studied. Two time periods were analyzed: 1) from September 1, 2008 through August 31, 2009, and 2) September 1, 2009 through August 31, 2010. The first time period is considered “pre-SBDI” and the second time period is considered “SBDI”. Comparisons were made both within communities across time periods and between communities.

All communities except for the suburban SBDI community had a slight increase in referrals from the pre-SBDI year to the SBDI year.

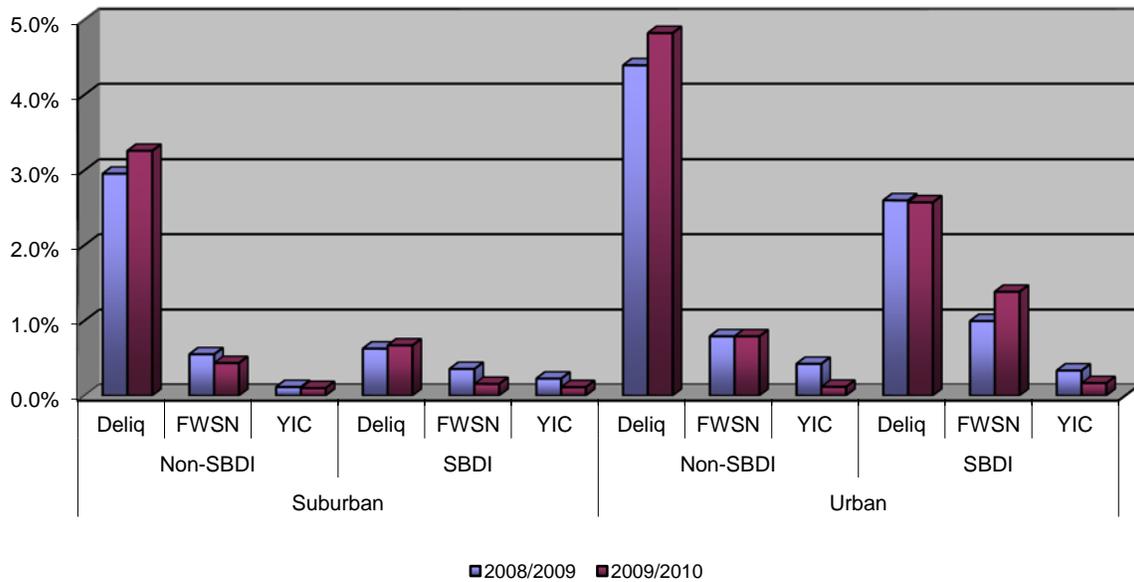
Goal 3: Reduce Youth Contact with Juvenile Justice

of Court Referrals from Towns



Beginning January 1, 2010, the state statutes changed to include 16 year olds with arrests for delinquency offenses under the jurisdiction of juvenile courts. Because of this change, we expected to see incremental increases in delinquency referrals across all four communities. However, when examining the referrals by type of offense, it was found that delinquency referrals actually decreased in the urban SBDI community by 1.1% from the pre-SBDI to SBDI year, while the urban comparison community had a 9% increase in delinquency referrals. The suburban SBDI community experienced a 6.4% increase in delinquency referrals from the pre-SBDI to SBDI year, as compared to a 9% increase in the suburban comparison community. It is important to note, that although the suburban SBDI community experienced a slight increase in delinquency referrals, the overall number of referrals decreased from the pre-SBDI to SBDI year, suggesting that the referrals that were made for these youth may have been for offenses that were most appropriately handled by the courts.

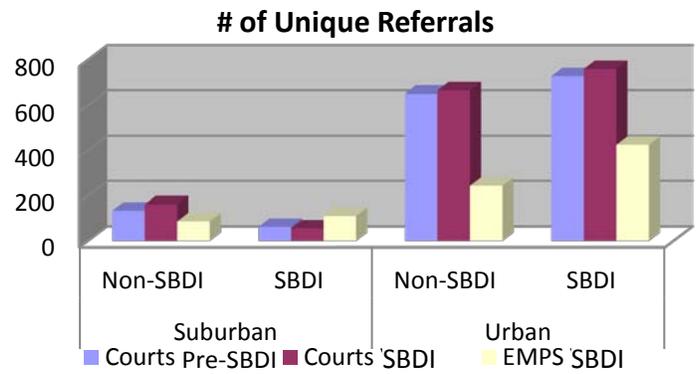
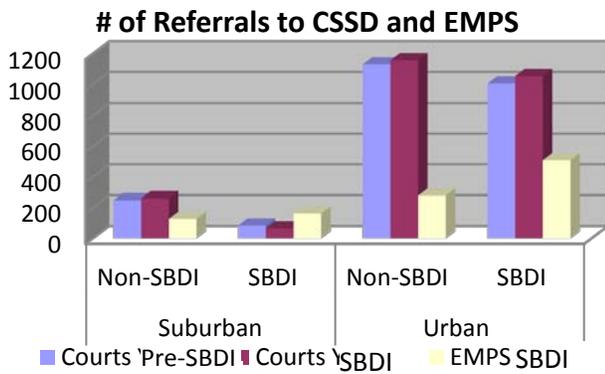
% of youth population referred by offense type



The majority of referrals across all communities were for males, with very little change in gender composition of referrals from the pre-SBDI (08/09) to the SBDI year (09/10). As expected based on the community demographics, court referrals in the suburban SBDI community were largely for Caucasian youth (64%), while referrals in other communities were mostly for youth of minority racial or ethnic backgrounds.

COMPARISON OF COURT REFERRALS AND EMPS REFERRALS

In terms of youth served by EMPS and juvenile courts, greater percentages of youth in SBDI communities utilized EMPS services (close to 1.5% in each community). **In the suburban SBDI community, more youth were referred to EMPS than to courts during the SBDI year.** As noted previously, although court referrals increased slightly overall in the urban SBDI community, there was a decrease in delinquency referrals to courts from that region.



CONCLUSIONS AND NEXT STEPS

Results indicate that the School Based Diversion Initiative may be effective in helping to maximize the most appropriate placement of youth in distress or at high risk for juvenile justice involvement. Although we cannot determine from the current data the extent to which individuals may have been diverted entirely from the court system, data indicate that rates of subsequent contact with juvenile courts were significantly reduced in youth who were referred to Emergency Mobile Psychiatric Services (EMPS) and for youth who resided in communities in which the SBDI was implemented. Data from the December 2010 progress report completed by CHDI substantiate the findings presented in this report and speak to the success and sustainability of the SBDI initiative-- not only are the original schools continuing to refer students to EMPS services after completion of the program, but Connecticut's SBDI project expanded over the 2010/2011 school year to include two schools in two additional communities (East Hartford and Meriden).

From September 1, 2009 through August 31, 2010, EMPS received referrals from a greater proportion of youth in the SBDI communities compared to the non-SBDI communities. Furthermore, in the suburban SBDI community, EMPS received significantly more referrals from schools than in the comparison community. A greater percentage of referred youth from the suburban SBDI community also had their first contact in the schools and were more likely to have a stabilization follow-up after the initial crisis response from the EMPS service provider in that community. As noted in the description of the intervention, SBDI training was more integrated into the routine practices in the SBDI-suburban school district by incorporating SBDI into required training activities and having early and strong buy-in and support from administration. As such, a larger number of school personnel regularly attended the training than in the SBDI-urban community where logistical issues prevented the same degree of integration. It is also likely that the greater degree of involvement of school personnel, not only in the training, but in the connection-building activities resulted in changes in practices of the EMPS service providers in the SBDI-suburban community in terms of location of service, types of follow-up, and referrals at discharge.

Referrals from SBDI schools in the urban SBDI community resulted in fewer mobile contacts and more deferred mobile contacts than non-SBDI schools in the same group. Also a greater percent of referrals from non-SBDI schools resulted in the initial contact taking place in the school. This finding deserves further exploration as one wonders if school contacts were impeded by some of the logistical issues that interfered with full integration of the SBDI in this district.

Other findings suggest that the SBDI trainings in both the suburban and urban communities may have been effective in educating school personnel on the identification of youth who are experiencing typically less outwardly disruptive psychological problems, such as depression and anxiety, as well as the identification of youth who have experienced trauma in their lives. Youth referred from the suburban SBDI community were more likely to be experiencing depression or harm/ risk of harm to self than youth referred from the other communities, and were also less likely to be referred for disruptive behavior. The urban SBDI community was also more likely to refer youth to EMPS for issues of depression than the urban comparison community. In both SBDI regions, the SBDI schools referred a greater proportion of youth with trauma histories and who were Seriously Emotionally Disturbed than the non-SBDI schools. If school personnel are both more sensitive to detecting issues of trauma, depression, and suicide risk *and* have the resources and linkages available to connect youth with appropriate care, it is possible that these schools might also experience decreases in incidents of bullying and suicide attempts in addition to reduced rates of criminal justice involvement. Further investigation into the relationship between SBDI involvement and these incidents is warranted.

In terms of diversion from the juvenile justice system, youth who had an initial contact with EMPS in the index year were less likely to have subsequent contact with CSSD than youth who had initial contact with CSSD, even after controlling for pre-index period involvement, race, age, and gender. This pattern of reduced risk of subsequent CSSD involvement for youth who had an initial contact with EMPS remained when examining just the youth with pre-index year involvement with CSSD. The greatest period of risk for all youth was within the first 30 days after the initial contact with either CSSD or EMPS. Moreover, the overall rates of subsequent CSSD involvement were significantly lower in the SBDI communities than the non-SBDI communities. At the level of the community, in contrast to what was expected to occur following the state law change giving juvenile courts jurisdiction over delinquent 16 year olds, the communities offering the SBDI initiative actually showed a decrease in delinquent referrals in the year 2009/2010, while non-SBDI communities showed an increase. These findings suggest that the collaborative efforts of EMPS and the SBDI may have been effective in reducing risk of subsequent CSSD involvement, even for youth who had prior involvement with CSSD. These findings also point to a critical period of intervention of 30 days after initial contact through which greater concerted by EMPS and the SBDI may reduce subsequent contact with the juvenile justice system even further.

In closing, findings from this evaluation of Connecticut's SBDI indicate that the initiative was largely successful in achieving its three goals of 1) building knowledge and skills of teachers and school staff to recognize behavioral and manage behavioral health issues in schools; 2) linking high-risk youth to alternative community-based supports; and 3) reducing the number of youth who have contact with the juvenile justice system. However, the degree of achievement on the three goals differed by community and may be attributable to different levels of teacher involvement and commitment to the SBDI training, differences in the way in which the local EMPS provider delivered services, the amount of resources available to youth, and/or environmental factors that contribute to youth involvement in different types of activities or the way in which youth negotiate the pressures of adolescence. These factors are worthy of further exploration in subsequent evaluations of the SBDI. Despite these caveats, the evaluation of data across the urban and suburban SBDI and comparison communities, suggest that youth who receive early and appropriate intervention for behavioral health issues may have a better chance at remaining out of the juvenile justice system over time than those who do not.

APPENDIX A: TABLES

TABLE 1. CENSUS DATA FROM THE FOUR CONNECTICUT COMMUNITIES INCLUDED IN THE SBDI EVALUATION

	Suburban Towns		Urban Cities	
	Middletown	Southington	New Haven	Bridgeport
	non-SBDI	SBDI	non-SBDI	SBDI
Population	47,702	42,077	123,628	136,715
Population: Age 5-17	6,868	6,995	20,180	25,574
Population: 25 yrs or over	32,111	29,800	72,810	83,867
High school graduate or higher	88.1%	91.5%	80.6%	73%
Bachelor's degree or higher	32.6%	34%	32.2%	15.2%
Black or African American	5,987 (12.6%)	323 (.8%)	44,678 (36.1%)	47,605 (34.8%)
White	36,951 (77.5%)	40,391 (96%)	54,689 (44.2%)	66,304 (48.5%)
American Indian/ Alaska Native	215 (.5%)	7 (0.0%)	508 (.4%)	151 (.1%)
Asian	2085 (4.4%)	7 (1.7%)	6,442 (5.2%)	3,416 (2.5%)
Native Hawaiian/Other Pacific Islander	0 (0%)	0 (0%)	0 (0%)	53 (0.0%)
Other Race	1289 (2.7%)	353 (.8%)	6,442 (5.2%)	16,609 (12.1%)
Hispanic or Latino	2,450 (5.1%)	1,077 (2.6%)	29,434 (23.8%)	45,796 (33.5%)
Foreign Born	4,942 (10.4%)	2,873 (6.8%)	20,450 (16.5%)	34,497 (25.2%)
Median Household Income	76,423	78,094	37,823	40,530
Families below poverty level	6.9%	2.7%	19.2%	17.0%
Individuals below poverty level	11.8%	4.2%	24.4%	20.0%
In labor force	26,439 (66.9%)	23,177 (68.6%)	63,049 (63.8%)	70,100 (67.0%)
Median house value	230,700	278,800	224,600	234,5000

TABLE 2. EMPS CALL INFORMATION: REFERRAL SOURCE AND TYPE

	Suburban Towns		Urban Cities	
	non-SBDI (n = 128)	SBDI (n = 164)	non-SBDI (n = 279)	SBDI (n = 508)
	N (%)	N (%)	N (%)	N (%)
Type of Call				
211-EMPS	102 (79.7%)	120 (73.2%)	229 (82.1%)	441 (86.8%)
Registered Call	26 (20.3%)	44 (26.8%) ^{1***}	50 (17.9%)	67 (13.2%)
Referral Source				
Self/Family	68 (53.1%)	73 (44.5%)	121 (43.4%)	177 (34.8%)
Family Advocate	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (0.4%)
School	24 (18.8%)	56 (34.1%)	96 (34.4%)	186 (36.6%)
SBDI School (% of school ref.)	0 (0%)	16 (28.6%) ^{1***}	0 (0%)	14 (7.5%)
Info-Line (211)	1 (0.8%)	0 (0.0%)	7 (2.5%)	5 (1.0%)
Other Program within Agency	1 (0.8%)	4 (2.4%)	3 (1.1%)	7 (1.4%)
Other Community Provider Agency	7 (5.5%)	9 (5.5%)	12 (4.3%)	12 (2.4%)
Emergency Department	20 (15.6%)	11 (6.7%)	18 (6.5%)	68 (13.4%)
Probation/Court	2 (1.6%)	0 (0.0%)	3 (1.1%)	11 (2.2%)
DCF	2 (1.6%)	6 (3.7%)	12 (4.3%)	20 (3.9%)
Congregate Care Facility	2 (1.6%)	4 (2.4%)	2 (0.7%)	0 (0.0%)
Foster Parent	0 (0.0%)	0 (0.0%)	1 (0.4%)	5 (1.0%)
Police	0 (0.0%)	0 (0.0%)	0 (0.0%)	13 (2.6%)
Physician	1 (0.8%)	1 (0.6%)	4 (1.4%)	2 (0.4%)
Type of ED Referral				
Routine Follow-up	14 (70.0%)	6 (54.5%)	15 (88.2%)	28 (41.2%)
Inpatient Diversion Case	6 (30.0%)	5 (45.5%)	2 (11.8%)	40 (58.8%) ^{3***}

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 3. EMPS REFERRALS: DEMOGRAPHIC INFORMATION

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%) or Mean (SD)	N (%) or Mean (SD)	N (%) or Mean (SD)	N (%) or Mean (SD)
Gender				
Male	84 (65.6%)	84 (51.2%)	149 (53.4%)	308 (60.6%)
Female	44 (34.4%) ^{2**}	80 (48.8%) ^{1*}	130 (46.6%) ^{3*}	200 (39.4%)
Age	13.25 (3.15)	13.53 (3.33) ^{1***}	12.40 (3.53)	12.16 (3.59)
Race/Ethnicity				
Hispanic	23 (18.5%) ^{2**}	17 (10.5%) ^{1***}	127 (45.5%)	225 (54.6%)
Asian	0 (0%)	1 (.6%)	4 (1.5%)	2 (.4%)
Black/ African American	19 (15.0%) ^{2**}	9 (5.6%) ^{1***}	116 (43.0%)	217 (47.4%)
Native Hawaiian	0 (0%)	1 (.6%)	1 (.4%)	0 (0%)
White	71 (55.9%) ^{2***}	143 (88.8%) ^{1***}	79 (29.3%)	144 (31.4%)
Other Race	45 (35.4%) ^{2***}	11 (6.8%) ^{1***}	78 (28.9%) ^{3*}	99 (21.6%)
Primary Language at home				
English	122 (95.3%)	153 (95.0%) ^{1***}	206 (73.8%)	379 (78.3%)
Spanish	5 (3.9%)	6 (3.7%)	69 (24.7%)	90 (18.6%)
Other	1 (.8%)	1 (.6%)	4 (1.4%)	7 (1.4%)
Language outside of home				
English	125 (100%)	161 (100%) ^{1***}	257 (92.1%)	449 (92.0%)
Spanish	0 (0%)	0 (0%)	22 (7.9%)	38 (7.8%)
Other	0 (0%)	0 (0%)	0 (0%)	1 (.2%)
Time in US				
< 1year	0 (0%)	0 (0%)	10 (3.6%)	7 (1.5%)
1-3 years	0 (0%)	0 (0%)	4 (1.4%)	13 (2.7%)
4-7 years	6 (4.7%)	7 (4.3%) ^{1***}	25 (9.0%) ^{3**}	87 (18.1%)
7 + years	105 (82.7%)	145 (88.4%) ^{1***}	217 (77.8%)	342 (71.1%)
Other	16 (12.6%)	12 (7.3%)	23 (8.2%)	32 (6.7%)

TABLE 3. EMPS REFERRALS: DEMOGRAPHIC INFORMATION

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%) or Mean (SD)	N (%) or Mean (SD)	N (%) or Mean (SD)	N (%) or Mean (SD)
Health Insurance- Intake				
Children's Health Insurance Program (HUSKY A)	53 (57.6%) ^{2**}	50 (35.7%) ^{1***}	165 (79.7%)	337 (75.4%)
Children's Health Insurance Program (HUSKY B)	1 (1.1%)	8 (5.7%)	0 (0.0%)	11 (2.5%)
Private Health Insurance	28 (30.4%) ^{2**}	70 (50.0%) ^{1***}	26 (12.6%)	63 (14.1%)
Medicaid (non-HUSKY)	0 (0.0%)	2 (1.4%)	1 (0.5%)	4 (0.9%)
Military Health Care	1 (1.1%)	2 (1.4%)	0 (0.0%)	0 (0.0%)
Medicare	0 (0.0%)	0 (0.0%)	1 (0.5%)	0 (0.0%)
No Health Insurance	3 (3.3%)	3 (2.1%)	12 (5.8%)	29 (6.5%)
Other	6 (6.5%)	5 (3.6%)	2 (1.0%)	3 (0.7%)
Health Insurance- Discharge				
Children's Health Insurance Program (HUSKY A)	14 (56.0%)	37 (37.8%) ^{1***}	65 (73.0%)	130 (72.6%)
Children's Health Insurance Program (HUSKY B)	0 (0%)	6 (6.1%)	1 (1.1%)	6 (3.4%)
Private Health Insurance	8 (32.0%)	47 (48.0%) ^{1***}	12 (13.5%)	29 (16.2%)
Medicaid (non-HUSKY)	0 (0%)	1 (1.0%)	3 (3.4%)	0 (0%)
Military Health Care	0 (0%)	2 (2.0%)	1 (1.1%)	0 (0%)
No Health Insurance	2 (8.0%)	3 (3.1%)	6 (6.7%)	12 (6.7%)
Other	1 (4.0%)	2 (2.0%)	1 (1.1%)	2 (1.1%)
Meets TANF Criteria	31 (33.7%) ^{2***}	48 (34.3%) ^{1***}	157 (75.8%) ^{3***}	220 (48.5%)
Does not Meet TANF Criteria	14 (15.2%)	62 (44.3%) ^{1***}	32 (15.5%)	93 (20.5%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 4. EMPS: PRIMARY PRESENTING PROBLEMS

	Suburban Towns		Urban Cities		Total
	non-SBDI	SBDI	non-SBDI	SBDI	
	n (%)	n (%)	n (%)	n (%)	
Disruptive Behavior	44 (34.6%) ^{2***}	30 (18.5%) ^{1***}	64 (23.2%) ^{3***}	168 (35.0%)	306 (29.3%)
Harm/Risk of Harm to Self	25 (19.7%) ^{2***}	64 (39.5%) ^{1***}	82 (29.7%) ^{3***}	78 (16.3%)	249 (23.8%)
Depression	15 (11.8%)	22 (13.6%)	38 (13.8%)	81 (16.9%)	156 (14.9%)
Harm/Risk of Harm to Others	15 (11.8%)	13 (8.0%)	16 (5.8%)	34 (7.1%)	78 (7.5%)
Anxiety	5 (3.9%)	9 (5.6%)	17 (6.2%)	39 (8.1%)	70 (6.7%)
School Problems	6 (4.7%)	7 (4.3%)	23 (8.3%)	11 (2.3%)	47 (4.5%)
Family Conflict	5 (3.9%)	2 (1.2%)	13 (4.7%)	20 (4.2%)	40 (3.8%)
Other	2 (1.6%)	5 (3.1%)	9 (3.3%)	14 (2.9%)	30 (2.9%)
Psychosis	2 (1.6%)	2 (1.2%)	5 (1.8%)	14 (2.9%)	23 (2.2%)
Hyperactive/Impulsive	2 (1.6%)	2 (1.2%)	4 (1.4%)	8 (1.7%)	16 (1.5%)
Peer Difficulties	2 (1.6%)	1 (0.6%)	1 (0.4%)	3 (0.6%)	7 (0.7%)
Running Away	0 (0.0%)	3 (1.9%)	3 (1.1%)	1 (0.2%)	7 (0.7%)
Substance Problem: Other Substances	0 (0.0%)	2 (1.2%)	1 (0.4%)	4 (0.8%)	7 (0.7%)
Problem Sexual Behavior	2 (1.6%)	0 (0.0%)	0 (0.0%)	3 (0.6%)	5 (0.5%)
Encopresis	2 (1.6%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	3 (0.3%)
Eating Disturbance	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)	1 (0.1%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 5. EMPS SECONDARY PRESENTING PROBLEM

	Suburban Towns		Urban Cities		
	non-SBDI	SBDI	non-SBDI	SBDI	Total
	n (%)	n (%)	n (%)	n (%)	n (%)
Depression	13 (11.4%) ^{2**}	43 (28.3%) ^{1***}	30 (11.4%)	61 (14.8%)	147 (15.6%)
Disruptive Behavior	19 (16.7%)	15 (9.9%)	52 (19.7%)	59 (14.3%)	145 (15.4%)
Family Conflict	24 (21.1%)	19 (12.5%)	35 (13.3%)	49 (11.9%)	127 (13.5%)
Harm/Risk of Harm to Self	6 (5.3%)	16 (10.5%)	26 (9.8%)	41 (10.0%)	89 (9.4%)
Harm/Risk of Harm to Others	12 (10.5%)	8 (5.3%) ^{1*}	20 (7.6%)	44 (10.7%)	84 (8.9%)
Anxiety	6 (5.3%)	9 (5.9%)	19 (7.2%)	42 (10.2%)	76 (8.1%)
School Problems	6 (5.3%)	9 (5.9%)	29 (11.0%)	29 (7.0%)	73 (7.7%)
Other	9 (7.9%)	8 (5.3%)	21 (8.0%)	17 (4.1%)	55 (5.8%)
Hyperactive/Impulsive	7 (6.1%)	13 (8.6%)	10 (3.8%)	19 (4.6%)	49 (5.2%)
Peer Difficulties	4 (3.5%)	5 (3.3%)	6 (2.3%)	16 (3.9%)	31 (3.3%)
Running Away	3 (2.6%)	1 (0.7%)	6 (2.3%)	8 (1.9%)	18 (1.9%)
Psychosis	1 (0.9%)	2 (1.3%)	1 (0.4%)	9 (2.2%)	13 (1.4%)
Substance Problem: Other Substances	1 (0.9%)	2 (1.3%)	4 (1.5%)	5 (1.2%)	12 (1.3%)
Inattentive	3 (2.6%)	1 (0.7%)	2 (0.8%)	5 (1.2%)	11 (1.2%)
Eating Disturbance	0 (0.0%)	1 (0.7%)	0 (0.0%)	3 (0.7%)	4 (0.4%)
Enuresis	0 (0.0%)	0 (0.0%)	1 (0.4%)	3 (0.7%)	4 (0.4%)
Problem Sexual Behavior	0 (0.0%)	0 (0.0%)	1 (0.4%)	2 (0.5%)	3 (0.3%)
Substance Problem: Alcohol	0 (0.0%)	0 (0.0%)	1 (0.4%)	0 (0.0%)	1 (0.1%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 6. ACADEMIC ISSUES

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	n (%)	n (%)	n (%)	n (%)
Parent/guardian rating of attendance during episode, compared to pre-admission				
Greater	0 (0.00%)	12 (12.37%)	11 (12.36%)	7 (4.17%)
About the Same	18 (72.0%)	73 (75.3%)	70 (78.7%)	140 (83.3%)
Less	1 (4.0%)	5 (5.2%)	4 (4.5%)	5 (3.0%)
Child too young for school	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
Child expelled from school	1 (4.0%)	1 (1.0%)	0 (0.0%)	1 (0.6%)
Child home schooled	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.6%)
Child dropped out of school	1 (4.0%)	0 (0.0%)	1 (1.1%)	2 (1.2%)
School not in session	4 (16.0%)	6 (6.2%)	3 (3.4%)	11 (6.5%)
Parent/guardian rating of child's school attendance in 6 months prior to admission				
Good (few or no days missed)	46 (50.0%)	90 (63.8%)	117 (56.5%)	292 (65.6%)
Fair (several days missed)	28 (30.4%)	30 (21.3%)	50 (24.2%)	97 (21.8%)
Poor (many days missed)	8 (8.7%)	16 (11.3%)	32 (15.5%)	39 (8.8%)
Child too young for school	1 (1.1%)	0 (0.0%)	0 (0.0%)	4 (0.9%)
Child expelled from school	1 (1.1%)	2 (1.4%)	1 (0.5%)	0 (0.0%)
Child home schooled	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Child dropped out of school	2 (2.2%)	0 (0.0%)	4 (1.9%)	7 (1.6%)
School not in session	6 (6.5%)	3 (2.1%)	3 (1.4%)	5 (1.1%)
Suspended or Expelled: Current Episode	2 (8.0%)	8 (8.3%)	14 (15.7%)	15 (9.1%)
Suspended or Expelled: 6-months prior to current episode	12 (13.2%)	15 (10.6%) ^{1***}	64 (30.9%)	122 (27.9%)

TABLE 6. ACADEMIC ISSUES

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	n (%)	n (%)	n (%)	n (%)
Issues that could negatively impact school performance at intake				
No Issues	6 (4.7%)	13 (7.9%)	9 (3.2%) ^{3*}	35 (6.9%)
Academic Issues	10 (7.8%) ^{2***}	42 (25.6%) ^{1***}	34 (12.2%)	77 (15.2%)
Social Issues	15 (11.7%) ^{2***}	56 (34.1%) ^{1***}	62 (22.2%)	91 (17.9%)
Behavioral Issues	13 (10.2%) ^{1***}	52 (31.7%) ^{1**}	54 (19.4%)	107 (21.1%)
Other Issues	4 (3.1%) ^{1***}	23 (14.0%) ^{1***}	9 (3.2%)	14 (2.8%)
Emotional Issues	2 (1.6%)	6 (3.7%)	9 (3.2%)	10 (2.0%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 7. ALCOHOL AND DRUG USE

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%)	N (%)	N (%)	N (%)
Problem with alcohol and/or drugs				
- Current Episode				
None	21 (84.0%)	87 (89.7%)	84 (94.4%)	172 (98.3%)
Alcohol	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Drugs	2 (8.0%)	5 (5.2%) ^{1**}	3 (3.4%)	2 (1.1%)
Alcohol and Drugs	2 (8.0%)	4 (4.1%) ^{1**}	2 (2.2%)	1 (.6%)
- Past 6 months				
None	84 (91.3%)	125 (88.7%)	192 (92.8%)	422 (93.8%)
Alcohol	1 (1.1%)	1 (.7%)	1 (.5%)	6 (1.3%)
Drugs	4 (4.3%)	8 (5.7%)	4 (1.9%)	14 (3.1%)
Alcohol and Drugs	3 (3.3%)	7 (5.0%)	10 (4.8%)	8 (1.8%)
- Lifetime				
None	85 (92.4%)	125 (88.7%)	191 (92.3%)	428 (94.5%)
Alcohol	0 (0%)	0 (0%)	2 (1.0%)	1 (.2%)
Drugs	4 (4.3%)	9 (6.4%)	4 (1.9%)	13 (2.9%)
Alcohol and Drugs	3 (3.3%)	7 (5.0%)	10 (4.8%)	11 (2.4%)

¹urban SBDI vs. suburban SBDI community comparison; ** p <.01

TABLE 8. ARRESTS

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%)	N (%)	N (%)	N (%)
Arrested during this episode	0 (0%)	2 (2.1%)	1 (1.1%)	4 (2.3%)
Arrested 6 months prior	17 (18.5%) ^{2*}	12 (8.5%)	10 (4.9%)	30 (6.6%)
Detained or incarcerated this episode	0 (0%)	1 (1.0%)	1 (1.1%)	2 (1.1%)
Past 6 months- detained or incarcerated	0 (0%)	1 (.7%)	3 (1.5%)	10 (2.2%)

²suburban SBDI vs. suburban non-SBDI community comparison; * p <.05

TABLE 9. TRAUMA HISTORY

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	n (%)	n (%)	n (%)	n (%)
Traumatic History	42 (32.8%) ^{2*}	81 (49.4%) ^{1***}	76 (27.2%)	171 (33.7%)
History of being a witness to violence	25 (19.5%)	20 (12.2%) ^{1**}	62 (22.2%)	119 (23.4%)
History of traumatic victim of violence	8 (6.3%)	19 (11.6%)	50 (17.9%) ^{3***}	44 (8.7%)
History of sexual victimization	4 (3.1%)	9 (5.5%)	24 (8.6%)	30 (5.9%)
History of disrupted attachment/multiple placements	9 (7.0%)	23 (14.0%)	53 (19.0%)	93 (18.3%)
History of other traumatic experience	18 (14.1%)	16 (9.8%) ^{1*}	43 (15.4%)	83 (16.3%)

¹urban SBDI vs. suburban SBDI community comparison; ²suburban SBDI vs. suburban non-SBDI community comparison; ³urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p <.001

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%)	N (%)	N (%)	N (%)
DCF Status of Client- Intake				
Dual Commitment (JJ and Child Protective Services)	0 (0.0%)	0 (0.0%)	1 (0.5%)	2 (0.4%)
Juvenile Justice (delinquency) commitment	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (0.2%)
Family with Service Needs (FWSN): In Home	1 (1.1%)	1 (0.7%)	0 (0.0%)	10 (2.2%)
FWSN: Out of Home	0 (0.0%)	1 (0.7%)	0 (0.0%)	0 (0.0%)
Voluntary Services Program	6 (6.5%)	3 (2.1%)	4 (1.9%) ^{3*}	24 (5.3%)
Termination of Parental Rights	1 (1.1%)	0 (0.0%)	1 (0.5%)	2 (0.4%)
Child Protective Services: In Home	12 (13.0%)	11 (7.8%)	32 (15.5%)	53 (11.6%)
Child Protective Services: Out of Home	1 (1.1%) ^{2**}	16 (11.3%) ^{1**}	12 (5.8%)	23 (5.0%)
Not DCF	71 (77.2%)	109 (77.3%)	157 (75.8%)	341 (74.8%)
Client Meets SED Criteria	37 (40.2%) ^{2***}	109 (77.3%) ^{1***}	139 (67.1%) ^{3***}	63 (14.0%)
DCF Status of Client- Discharge				
FWSN: In Home	0 (0%)	1 (1.0%)	0 (0%)	3 (1.7%)
Voluntary Services Program	2 (8.0%) ^{2*}	1 (1.0%)	3 (3.4%)	3 (1.7%)
Child Protective Services: In Home	4 (16.0%)	12 (12.2%)	12 (13.5%)	16 (8.9%)
Child Protective Services: Out of Home	0 (0%)	6 (6.1%)	6 (6.7%)	9 (5.0%)
Not DCF	19 (76.0%)	78 (79.6%)	68 (76.4%)	148 (82.7%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison
* p <.05; ** p <.01; *** p < .001

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	N (%)	N (%)	N (%)	N (%)
EMPS Mode of First Contact				
Mobile	81 (63.3%)	96 (58.5%) ^{1***}	133 (47.7%) ^{3***}	376 (74.2%)
Non-Mobile	38 (29.7%)	23 (14.0%)	84 (30.1%)	55 (10.8%)
Deferred Mobile	9 (7.0%) ^{2***}	45 (27.4%)	62 (22.2%)	76 (15.0%)
Type of Crisis Response				
Crisis Response: Phone Only	36 (28.1%)	23 (14.0%)	72 (25.8%)	49 (9.7%)
Crisis Response: Face-to-Face	67 (52.3%)	43 (26.2%)	119 (42.7%)	278 (55.3%)
Crisis Response Plus Stabilization F/U	25 (19.5%)	98 (59.8%) ^{1***}	88 (31.5%)	176 (35.0%)
Location of First EMPS Mobile Site				
Home	54 (60.00%)	76 (53.90%)	86 (44.10%)	250 (56.40%)
School	23 (25.60%) ^{2*}	50 (35.50%)	89 (45.60%) ^{3***}	132 (29.80%)
Other Community Site	1 (1.10%)	8 (5.70%)	17 (8.70%)	20 (4.50%)
Hospital Emergency Department	10 (11.10%)	4 (2.80%) ^{1***}	3 (1.50%)	41 (9.30%)
Congregate Care Facility	2 (2.20%)	3 (2.10%)	0 (0.00%)	0 (0.00%)
Reasons first contact not mobile				
After Mobile Hours	4 (10.53%)	4 (17.39%) ^{1**}	2 (2.38%)	0 (0.00%)
Family Not Available	8 (21.05%)	0 (0.00%)	7 (8.33%)	3 (5.77%)
Family Declined Mobile	22 (57.89%)	17 (73.91%)	69 (82.14%)	44 (84.62%)
EMPS Decision	4 (10.53%)	2 (8.70%)	6 (7.14%)	5 (9.62%)
EMPS First Contact Non-Mobile Site				
Telephone	37 (97.4%)	23 (100%)	71 (84.5%)	48 (88.9%)
Office Visit	1 (2.6%)	0 (0%)	13 (15.5%)	6 (11.1%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison,

* p <.05; ** p <.01; *** p < .001

TABLE 12. EMPS SERVICES				
	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Length of Stay	3.31 (9.56) ^{2***}	20.71 (21.44)	12.38 (14.80) ^{3**}	16.85 (17.87)
# of ED visits for psychiatric/ behavioral health reasons				
Current episode of care	0.20 (0.41)	0.19 (0.49)	0.17 (0.46)	.16 (.43)
6 months prior to EMPS	0.48 (0.84)	0.41 (0.89)	0.23 (0.55)	.32 (.91)
# psychiatric/ behavioral health hospitalizations				
Current episode	0.08 (0.28)	0.10 (0.39)	0.13 (0.43)	.10 (.47)
6 months prior to EMPS	0.09 (0.28)	0.18 (0.55)	0.12 (0.45)	.15 (.49)
Lifetime	0.35 (0.75)	0.50 (1.29)	0.37 (1.18)	.42 (1.70)
# of mobile contacts	0.91 (0.87) ^{2***}	1.80 (1.69) ^{1***}	0.92 (0.90) ^{3***}	1.40 (1.17)
# of office-based visits	0.03 (0.28)	0.00 (0.00) ^{1***}	0.48 (1.12)	.66 (1.34)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 13. TREATMENT INVOLVEMENT AND SATISFACTION

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Satisfaction with MH Services	4.71 (1.55)	5.16 (.71) ^{1***}	5.14 (.83) ^{3***}	5.63 (.59)
Extent of parent participation in treatment planning	5.29 (1.43)	5.07 (.94) ^{1***}	5.38 (.95) ^{3**}	5.73 (.62)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 14. FUNCTIONING AT INTAKE AND DISCHARGE

	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Functioning				
Parent rating- Intake	22.92 (21.71) ^{2***}	42.63 (16.17)	44.92 (15.84) ^{3***}	37.44 (20.99)
Parent rating- Discharge	24.45 (21.19) ^{2**}	44.18 (18.59) ^{1**}	47.52 (14.67) ^{3***}	29.84 (23.72)
Worker rating- Intake	33.81 (12.72) ^{2*}	39.01 (11.23)	41.27 (13.94)	40.07 (13.74)
Worker rating- Discharge	32.16 (13.83) ^{2*}	42.17 (12.45)	43.38 (16.28)	43.84 (15.90)
Problem Severity				
Parent Intake	19.51 (19.01)	26.67 (17.04)	28.69 (18.24)	27.14 (19.58)
Parent Discharge	20.15 (18.91)	19.26 (13.63)	22.55 (17.57)	21.90 (20.91)
Worker Intake	30.97 (13.95)	33.64 (13.40)	30.59 (15.70)	31.76 (15.66)
Worker Discharge	32.64 (14.92)	30.09 (13.37)	24.25 (15.46)	25.22 (15.61)
Parent rating of capability to deal with child's problems- Intake	4.16 (1.06)	4.13 (1.32) ^{1***}	4.13 (1.41) ^{3***}	4.61 (1.16)
Parent rating of capability to deal with child's problems- Discharge	4.22 (.85)	4.47 (1.40) ^{1**}	4.52 (1.38) ^{3**}	5.08 (.98)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p <.05; ** p <.01; *** p < .001

TABLE 15. REFERRAL AT DISCHARGE				
	Suburban Towns		Urban Cities	
	non-SBDI	SBDI	non-SBDI	SBDI
	n (%)	n (%)	n (%)	n (%)
No referral for care at d/c	25 (19.5%)	38 (23.2%)	43 (15.4%) ^{3***}	142 (28.0%)
Referred to Care Coordination	6 (4.7%)	5 (3.0%)	8 (2.9%)	22 (4.3%)
Referred to other out of home services	3 (2.4%)	2 (1.2%)	3 (1.1%)	8 (1.6%)
Referred to other community based services	26 (20.6%) ^{2***}	7 (4.3%) ^{1*}	48 (17.3%) ^{3***}	7 (1.4%)
Referred to hospital care	5 (3.9%)	10 (6.1%)	25 (9.0%)	39 (7.7%)
Referred to residential Treatment	0 (*0%)	1 (.6%)	1 (.4%)	5 (1.0%)
Referred to Group Home	3 (2.3%)	3 (1.8%) ^{1*}	2 (.7%)	1 (.2%)
Referred to partial hospital program	5 (3.9%) ^{2*}	1 (.6%)	28 (10.1%) ^{3***}	1 (.2%)
Referred to IOP	1 (.8%) ^{2**}	11 (6.7%)	13 (4.7%)	36 (7.1%)
Referred to Intensive In-Home Services	13 (10.2%)	13 (8.0%)	11 (3.9%)	26 (5.1%)
Referred to extended day treatment	8 (6.3%)	7 (4.2%) ^{1***}	8 (2.9%) ^{3**}	2 (.4%)
Referred to outpatient services	71 (55.5%)	78 (47.9%)	139 (50.4%)	237 (46.9%)

¹ urban SBDI vs. suburban SBDI community comparison; ² suburban SBDI vs. suburban non-SBDI community comparison; ³ urban SBDI vs. urban non-SBDI community comparison

* p < .05; ** p < .01; *** p < .001

TABLE 16. SYSTEM OF INITIAL CONTACT DURING INDEX YEAR

	Suburban		Urban		Total N (%)
	Non-SBDI (Middletown) N (%)	SBDI (Southington) N (%)	Non-SBDI (New Haven) N (%)	SBDI (Bridgeport) N (%)	
CSSD	151 (65.4%)	40 (26.7%)	624 (73.0%)	717 (64.5%)	1532 (65.2%)
EMPS	80 (34.6%)	110 (73.3%)	231 (27.0%)	395 (35.5%)	816 (34.8%)
Total	231 (100.0%)	150 (100.0%)	855 (100.0%)	1112 (100.0%)	2348 (100.0%)

TABLE 17. YOUTH DEMOGRAPHICS BY SYSTEM OF INITIAL CONTACT DURING INDEX YEAR

System of Initial Contact	Suburban Non-SBDI		Suburban SBDI		Urban Non-SBDI		Urban SBDI		Total	
	CSSD	EMPS								
	N (%) or Mean (SD)									
Gender										
Male	96 (63.58%)	49 (61.25%)	27 (67.50%)	49 (44.55%)*	410 (65.71%)	127 (54.98%)**	437 (60.95%)	237 (60.00%)	970 (63.3%)	462 (56.6%)**
Female	55 (36.42%)	31 (38.75%)	13 (32.50%)	61 (55.45%)*	214 (34.29%)	104 (45.02%)**	280 (39.05%)	158 (40.00%)	562 (36.7%)	354 (43.4%)**
Age	14.86 (1.48)	12.94 (3.38)	15.39 (1.42)	13.65 (3.32)	15.00 (1.49)	12.40 (3.58)	15.02 (1.71)	12.00 (3.69)	15.01 (1.59)	12.43 (3.62)
Race										
American Indian/ Alaskan Native	0 (.00%)	0 (.00%)	0 (.00%)	0 (.00%)	1 (.19%)	0 (.00%)	0 (.00%)	0 (.00%)	1 (.1%)	0 (0%)
Asian/Pacific Islander	0 (.00%)	0 (.00%)	0 (.00%)	1 (.93%)	1 (.19%)	3 (1.30%)	5 (.83%)	1 (.26%)	6 (.4%)	5 (.6%)
Black/African- American	50 (39.06%)	11 (13.92%)**	5 (15.15%)	4 (3.74%)*	373 (70.11%)	92 (39.83%)**	336 (55.63%)	172 (45.38%)**	764 (49.9%)	279 (34.2%)
White	77 (60.16%)	51 (64.56%)	27 (81.82%)	99 (92.52%)	147 (27.63%)	128 (55.41%)**	255 (42.22%)	188 (49.60%)*	506 (33.0%)	466 (57.1%)
Biracial	1 (.78%)	4 (5.06%)	1 (3.03%)	2 (1.87%)	10 (1.88%)	5 (2.16%)	6 (.99%)	3 (.79%)	2 (.1%)	32 (3.9%)
Other	0 (.00%)	13 (16.46%)	0 (.00%)	1 (.93%)	0 (.00%)	3 (1.30%)	2 (.33%)	15 (3.96%)**	18 (1.2%)	14 (1.7%)
Latino/Hispanic	23 (21.50%)	14 (17.72%)	0 (.00%)	13 (12.04%)	124 (30.69%)	114 (49.35%)**	237 (46.93%)	200 (52.49%)	235 (15.3%)	20 (2.5%)
Prior CSSD Involvement	42 (27.81%)	5 (6.25%***)	7 (17.50%)	3 (2.73%***)	236 (37.82%)	8 (3.46%***)	190 (26.50%)	22 (5.57%***)	475 (31.0%)	38 (4.7%***)
Any CSSD referral after initial referral	51 (33.8%)	12 (15.0%***)	4 (10.0%)	8 (7.3%)	252 (40.4%)	18 (7.8%***)	215 (30.0%)	44 (11.1%***)	522 (34.12%)	82 (10.0%)

* p <.05; ** p <.01; *** p <.001

TABLE 18. SUBSEQUENT REFERRALS AFTER INITIAL CONTACT DURING INDEX YEAR

Initial System of Contact	CSSD (n = 1532)	EMPS (n = 816)
	N (%) or Mean (sd)	N (%) or Mean (sd)
Second referral		
none	977 (63.8%)	583 (71.4%)
CSSD	501 (32.7%)	64 (7.8%)***
EMPS	54 (3.5%)	169 (20.7%)***
Any CSSD referral after initial referral	522 (34.12%)	82 (10.0%)
Time to CSSD (for youth with CSSD referrals after initial referral)	130.44 (108.94)	131.02 (106.70)
Time to end without CSSD	236.58 (124.91)	293.95 (109.90)***

***p <.001